Optegra UK Limited

Optegra Yorkshire Eye Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- 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 mostly 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 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.
- 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.

However:

- Compliance with two key mandatory training modules was low and did not meet the service target. Hand hygiene audits were not completed in a timely way in line with the service policy. We saw one box of out of date gloves stored in the surgical department. Records in surgery were not always stored securely in the surgical department. Staff in outpatients did not always wear gloves correctly for infection prevention control. Three-point patient ID checking was not consistently in place for patient identification in outpatients.
- Complaint responses did not always meet the service target and we did not see information displayed in the department to support patients to make a complaint if they needed to.
- The mechanism for monitoring actions plans and timely responses was not robust. The service did not always record identified actions to reduce the impact of identified risks and issues.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this location stayed the same. We rated it as good because: • 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 mostly 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 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. • 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

Summary of findings

accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Compliance with two key mandatory training modules was low and did not meet the service target. Hand hygiene audits were not completed in a timely way in line with the service policy. We saw one box of out of date gloves stored in the surgical department. Records in surgery were not always stored securely.
- Complaint responses did not always meet the service target and we did not see information displayed in the department to support patients to make a complaint if they needed to.
- The mechanism for monitoring actions plans and timely responses was not robust. The service did not always record identified actions to reduce the impact of identified risks and issues.

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

Outpatients

Good

Our rating of this service stayed the same. We rated it as good because:

- 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 mostly 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 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.

Summary of findings

- 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.
- 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.

However:

- Compliance with two key mandatory training modules was low and did not meet the service target. Staff were not always wearing gloves correctly for infection prevention control. Three-point patient ID checking was not consistently in place for patient identification.
- Complaint responses did not always meet the service target and we did not see information displayed in the department to support patients to make a complaint if they needed to.
- The mechanism for monitoring actions plans and timely responses was not robust. The service did not always record identified actions to reduce the impact of identified risks and issues.

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

Summary of findings

Contents

Summary of this inspection

Background to Optegra Yorkshire Eye Hospital

Optegra Yorkshire Eye Hospital is operated by Optegra UK. The hospital provides a range of ophthalmic services to NHS funded and private fee-paying adults only. These include refractive, ocular plastic and retinal diagnostic and surgical services and ophthalmic disease management. The service is registered to provide surgical procedures and treatment of disease, disorder and injury and diagnostic and screening procedures.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 23 and 24 November 2021. The last inspection was carried out was on 07 and 14 November 2017. There was a registered manager in post during the inspection.

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

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

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

How we carried out this inspection

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

During the inspection we spoke with 18 clinical, nursing and support staff, two managers and we followed the pathway of three patients in the surgical area and eight patients in the outpatients area which included patients receiving pre-operative imaging. We reviewed 15 patient records and 11 staff and practicing privileges files, including checking the service had completed fit and proper persons checks in line with the regulation.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Service wide

Summary of this inspection

- The service should improve the documentation of risk registers to clearly document controls in place, acted upon or pending to evidence actions being taken to reduce or mitigate known risks.
- The service should ensure it acknowledges and responds to complaints in a timely way and in line with the service policy.

Surgery

- The service should ensure that out of date stock, or stock that is no longer in use, is disposed of appropriately.
- The service should ensure that all patient records are stored securely.
- The service should ensure that staff have completed all mandatory training and safeguarding training modules their role requires so they have the necessary skills to carry out their role.
- The service should consider monitoring timescales of actions that are a result of governance meetings to ensure items are responded to in a timely way.
- The service should ensure all staff receive an appraisal and clinical supervision (where it is required).
- The service should ensure that local audits are completed in a timely way, in line with the policy.
- The service should display information in public areas on how to complain.

Outpatients

- The service should ensure that staff have completed all mandatory training and safeguarding training modules their role requires so they have the necessary skills to carry out their role.
- The service should ensure all staff receive an appraisal and clinical supervision (where it is required).
- The service should ensure that hand hygiene audits are completed in a timely way, in line with the policy.
- The service should ensure staff wear gloves correctly as per the service policy.
- The service should ensure that appropriate three-point identity checking is taking place to ensure correct patient is being seen.
- The service should display information in public areas on how to complain.
- The service should improve the documentation of risk registers to clearly document controls in place, acted upon or pending to evidence actions being taken to reduce or mitigate known risks.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are Surgery safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, compliance with two key mandatory training modules was low, and did not meet the service target.

Staff received and kept up-to-date with their mandatory training. The service target for compliance with mandatory training was 90%. Average training compliance showed that staff who worked in surgery had a compliance rate of 92% which met the target.

There were six modules out of 25 that did not meet the service target, four were at 86-88% compliance and only marginally below the target. This was equal to one or two staff members who had not completed the module.

However, there were particularly low levels of compliance in infection control (26.6% compliance) and intermediate life support (66.6% compliance).

Staff had all completed infection control training within the same month in October 2020 and compliance was low as the training was one month out of date. Since the inspection, the service managers told us that the training was now completed for all clinical staff.

Managers told us that it was a challenge to get all staff who required intermediate life support trained because it was face to face training. There was a plan in place, and we saw in the training matrix staff had been completing this module across the most recent five months. Managers told us they ensured there was always a staff member on shift with intermediate life support training to make sure patients were safe.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients living with dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw the training tracker was automated and flagged when training was due for completion in the coming month.

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, however not all staff had completed the training.

The service had a safeguarding adult's policy that was version controlled and in date. The policy covered expected areas for the type of service and included references to when it might be appropriate to consider safeguarding children or young people in transitional care, as the service only treated adults aged 18 and over. The policy included the training requirements for staff groups, which met the safeguarding intercollegiate guidelines, and included information on completing safeguarding supervision for staff members, and when that might be required.

Staff received training specific for their role on how to recognise and report abuse. The service target for compliance with safeguarding training was 90%. Average training compliance showed that staff who worked in surgery had a compliance rate of 93.3% for safeguarding adults' level 2 and safeguarding children level 2 training; this met the target.

The service provided also provided prevent training as part of its mandatory training programme; compliance was 86.6% which was below the service target. This equalled two out of 15 staff members in the department who had not completed the module.

The service also provided level 3 safeguarding children and adults training for eligible staff which included prevent training; compliance for this module was 100% and met the service target.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We talked to staff about safeguarding during the inspection and they knew where to find details for the local safeguarding authority and could describe when they had considered safeguarding and what they would do if they had a concern. This was in line with the service policy.

The service had not made any adult safeguarding referrals in the previous 12 months.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We saw cleaning records for the service for the three weeks prior to the inspection and they were completed in line with the service requirements.

The service generally performed well for cleanliness. We observed staff during the inspection and saw they washed their hands between patients and wore gloves when required.

Good

Surgery

We reviewed the most recent hand hygiene audit that the service had completed. Five staff members across the service were audited and the compliance was 100%, this exceeded the service target of 90%. However, the service's hand hygiene policy stated that compliance will be monitored through regular monthly auditing of hand hygiene practices. We asked the service for their most recent hand hygiene audit; it was completed in February 2021; therefore, we did not see evidence that hand hygiene audits were completed in a timely way in line with the service policy.

We reviewed three audits of five steps to safer surgery in practice that had been completed in the last 12 months; they all met the target of 90%, ranging from 96% to 100% and there were no areas of non-compliance that related to cleanliness, infection control or hygiene.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had a COVID-19 risk assessment in place which described the mitigating actions that had been taken to reduce the risk to patients attending the hospital and staff. This included personal protective equipment (PPE) requirements, hand sanitising, social distancing and actions to take in the event of an outbreak. It had been updated in the month leading up to the inspection and reflected national guidelines. We saw staff adhered to the guidelines.

Staff cleaned equipment after patient contact, and we observed this happening routinely during the inspection.

Staff worked effectively to prevent, identify and treat surgical site infections.

As part of the admission and pre-assessment criteria, patients were asked infection control screening questions. This meant any infection risks could be managed, for example patients could be added to the end of a list so that appropriate decontamination could be completed.

The service had a process in place to provide appropriate treatment to patients to prevent surgical site infections. This was being reviewed at the time of the inspection, and the approach was evidence based.

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.

Staff carried out regular safety checks of specialist equipment. We reviewed the resuscitation trolley checks for October and November 2021. Checks had been completed regularly and any issues were documented and escalated.

There was signage in theatres to warn staff and patients that lasers were used in the department.

The service had suitable facilities to meet the needs of patients' families. There was disabled access to the hospital site, including a lift to the first floor where the surgical ward was.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

The service had a fire safety procedure in place that included roles and responsibilities in the event of a fire. The fire alarms were scheduled to be tested weekly.

Good

Surgery

We reviewed four pieces of documentation which evidenced that there was regular servicing of equipment in place at the hospital. All items had been serviced in the last 12 months and there were no outstanding actions to be completed. We asked managers about their oversight equipment servicing and they told us that there was a centralised database so they could track equipment that was due a service and any actions that may be required relating to each item of equipment.

We completed a dip sample of stock within the store cupboards in the Surgery areas. We looked at 15 items and found one box of gloves that were passed their use by date of October 2020. There were no other out of date items. We escalated this to a manager who disposed of the gloves and told us they were no longer in use in theatres.

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

The service had a policy for managing a deteriorating patient. It was in date and version controlled. The policy followed national guidance and best practice and provided staff with the appropriate tools to monitor patients and manage potential deterioration. There was also an overview of the policy on a page to assist staff as an aide memoire.

The service had a specific quarterly meeting to discuss adherence to resuscitation guidelines and ensure there was the correct training and equipment in place. We looked at the minutes from the last meeting in October 2021 and saw that issues with training compliance, due to the COVID-19 pandemic, were discussed and appropriate actions were put in place to improve compliance.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service had an admission and pre-assessment policy in place that was based on national guidelines. It detailed patients who could and could not be treated at the service and described how staff could escalate queries about the suitability of patients for the service. Specific exclusions were listed, and the policy used a nationally recognised scoring system to assess the suitability of patients.

Staff knew about and dealt with any specific risk issues. Sepsis and venous thromboembolism (VTE) were included in the risk assessments and observations recorded while patients were being treated in the service.

Shift changes and handovers included all necessary key information to keep patients safe. The service used a nationally recognised handover document to make sure information shared was relevant and appropriate.

We reviewed three audits which checked compliance with the five steps to safer surgery guidelines. All three were deemed as compliant (above 90%). We looked at the audits for February, July and September 2021. Both February and July audits were at 100% compliance. In September, the audit showed 96% compliance. It met the service target and actions were documented to address the eight areas on non-compliance which were all relating to not properly recording the checks that took place. During the inspection, we observed staff working in theatres and did not find any concerns with this process in practice; we found that it adhered to guidelines and good practice. We observed staff completing the World Health Organisation Surgical Safety Checklists and the process appeared to be embedded in the working practice.

Good

Surgery

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.

The service had enough nursing, medical and support staff to keep patients safe. The service was able to schedule clinics and surgeries based on the available staffing and did not carry out scheduled activity if there were not enough staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients and the surgery lists that had been scheduled. Managers we spoke with told us that if there was short notice absence, they would cancel a surgical list, or move cross trained staff and did not operate without enough staff to keep patients safe.

The service had low and/or reducing vacancy rates. The service had two whole time equivalent (WTE) nurse vacancies, however one was in the process of being filled during the inspection.

The service had enough medical staff who worked under practicing privileges to meet the needs of the patients who were scheduled into clinics. There were plans in place to increase the clinical staff capacity and to shorten the referral to consultation time from 12 to six weeks.

The service had low and/or reducing sickness rates. The sickness rate for nursing staff was 2.5%, this met the service target which was 2.5%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Records

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

Patient notes were comprehensive and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw staff moving paper records between the outpatients, diagnostic imaging and surgical areas of the service in a timely way.

The service completed a records audit in October 2021. The target was 90% compliance, and this was exceeded with 100% compliance. There were no actions to make improvements identified as no errors were noted. Ten sets of records had been reviewed.

During the inspection we reviewed five sets of records across the surgical areas. We saw they were all completed appropriately and in line with the service and national guidelines.

However, records were not always stored securely.During the inspection we saw the records trolley in the ward area was not locked. We spoke to staff who told us that the trolley was not routinely locked as there was only one key. We saw two computers in the ward area that were routinely unlocked; there was an auto lock function that we saw activated after approximately 15 minutes. We observed staff in the area at all times, therefore the risk was low. However, this was a risk to patients as records could be accessed by staff or members of the public or did not have authorisation to view them.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The service had a medicines management and administration policy. It was in date, version controlled and its contents included principles and guidelines for the prescription, administering, storage and disposal of medicines as well as competency requirements for staff who are able to handle medicines and information about the use of unlicensed and off-label medications. During the inspection we saw staff administering medication in the surgical department and found they followed the correct national guidelines and practices.

Staff completed medicines records accurately to keep them up-to-date and audits to monitor this met the target. We reviewed two recent medications audits for the service. The service target was 90% compliance and both audits exceeded this at 100% in September 2021 and 91% in November 2021. The areas of non-compliance were around accurate recording of medicines, including the time they were administered or checked and full signatures that were not legible. The service discussed the issues identified in the regular staff training day to make sure all staff were appraised.

Staff stored and managed all medicines and prescribing documents safely. We reviewed the storage of medicines and had no concerns, this included appropriate refrigeration of medicines that required it. Medication fridge checks had been completed in line with policy.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice. We saw that when issues were identified relating to medicines, they were scheduled to be discussed at all staff training days. This meant all staff were aware of issues or concerns.

We asked the service about compliance rates for staff in medicines management. We did not receive any compliance figures, however the service told us that all staff were attending medicines management training in December 2021 as part of their regular training days.

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.

Good

Surgery

The service had an incident reporting policy which was in date and version controlled. We reviewed the policy and saw that it defined the roles and responsibilities of different staff groups and provided guidance and checklists to support staff with the relevant training to investigate incidents and produce reports. The policy referenced the duty of candour appropriately and referred to other appropriate policies that were in place, for example the Reporting of injuries, Diseases and Dangerous Occurrences (RIDDOR) Policy.

Staff knew what incidents to report and how to report them, they did so in line with the service policy. Staff knew how to report and respond to serious incidents.

The service reported 43 incidents in the previous six month and 60% (22) related to surgery and the surgical areas in the hospital. We reviewed the incidents and found that they were graded appropriately based on the information provided. The service had one moderate harm incident, four where low harm was identified and 15 where no harm was found to patients. Staff we spoke with during the inspection knew how to report incidents and told us managers would support them to make incident reports and provided feedback once they had been investigated. Staff knew about recent incidents that had occurred service wide and described actions that had been taken to prevent similar occurrences in the future.

The service had zero never events in the last 12 months.

Managers investigated incidents thoroughly. The service had reported one serious injury in the reporting period. There was a root cause analysis investigation and the service identified learning and action to be taken to reduce the risk of reoccurrence. The incident report was shared with staff at this service, and with other services in the provider to share learning across sites. Staff we spoke with during the inspection knew about the changes that had been made to improve systems following a recent serious incident.

Managers shared learning with their staff about never events that happened elsewhere. Incidents were discussed at quarterly governance meetings. We looked at meeting minutes and saw that information was shared across different locations in the region to aide learning across sites

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff we spoke with described the duty of candour during the inspection well and understood the importance of putting it into practice. We reviewed the most recent duty of candour letter that was sent to a patient and found it was in line with the requirements set out in the duty of candour regulations.

Are Surgery effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

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.

Good

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed seven full policies across the service and saw that they reflected national guidance and good practice principals. They were based on evidence and we saw that the overarching provider completed audits for the whole organisation which were evidence based. They were shared with this service.

Staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Best interest meetings took place for patients who had additional needs, and this was in line with guidelines.

Patients had risk assessments completed at the preassessment stage, which included venous thromboembolism (VTE). Patients who have had a VTE event within three months of a surgery date were not seen at the hospital to reduce the risk. This was part of the hospital patient criteria that we reviewed. The service planned to complete audits on a monthly basis that included VTE; we saw the last three audits met the service target compliance of 90%, and there were no areas of non-compliance with recording of VTE assessment.

However, the service audit plan was to complete this audit on a monthly basis and when we asked the service for their most recent three audits, they provided audits for February, July and September 2021. This meant that the audits were not completed as regularly as planned.

The service had a process in place to provide appropriate treatment to patients to prevent surgical site infections. This was being reviewed at the time of the inspection, and the approach was evidence based.

The service included national clinical audits in their audit plan, and this included national benchmarking. When we asked managers about benchmarking, they told us they also benchmarked their performance against other services in the region and that this service performed well.

Pain Relief

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

Staff prescribed, administered and recorded pain relief accurately. Pain relief was administered in the form of anaesthetic eye drops prior to surgery or procedures. Patients were asked about pain levels during and after procedures.

Patients given advice on pain relief and recovering at home during discharge. They were given a 24-hour helpline number and were told if they were in severe pain to attend their local accident and emergency department.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Hot drinks, water and snacks were available in the department and we saw patients were routinely given their choice of drinks and snacks following surgical procedures.

Patients waiting to have surgery were not left without food or drinks for long periods.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Good

Surgery

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

The service had an audit plan for 2021/2022. We reviewed the plan and saw it was split into three sections; audits relating to guidelines, national clinical audits and improvement audits. The audits we reviewed were in line with the audit plan. It was clear to see when an audit was due for completion and the service evidenced they planned participation in national audits. It was good practice to include improvement audits in the audit plan.

Managers and staff used the information and results to improve patients' outcomes. They investigated outliers and implemented local changes to improve care and monitored the improvement over time.

The service compared their performance across the national organisation for patient outcomes. We reviewed the performance report for July 2020 to June 2021 relating to laser vision correction, multifocal intraocular lenses and monofocal intraocular lenses. The results were split into type of correction or surgery and identified where results deviated from the industry benchmark. Out of 75 results across the year, the service deviated in four areas (0.05%), all in the monofocal intraocular lens (cataracts) procedures. The service had reviewed the results and noted that as there was no community care and only up to 20% of cases received face to face post-operative follow up, this may account for the decline. The service had plans in place to improve outcomes by re-instating face to face follow ups.

Improvement was checked and monitored.

The service had an electronic performance dashboard that gave managers oversight of unexpected outcomes from surgeries. This meant that leaders could be responsive to any concerns or issues relating to individual cases.

The service had completed three local clinical audits in October 2021 relating to patient flow, care and support and scrub procedures. They all exceeded the 90% service target and were 100% compliant. As there were no areas of non-compliance, the service did not need action plans, and they told us the results had been shared with staff. This meant the service had checked staff were following guidance and processes to keep patients safe.

We saw that the provider had low complication rates in cataract surgery and were continuing to complete audits to evidence that care and treatment provided good outcomes for patients and to monitor performance.

At the last inspection, we told the service they should submit data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA). At this inspection we saw the service was engaged in the Private Healthcare Information Network (PHIN); they had submitted data in 2020/2021 and they were awaiting data outputs for their submissions in 2021/2022.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work.

Good

Surgery

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers had completed 100% of appraisals for non-clinical staff in the service and all staff had set objectives and had a half year review.

Managers had completed 86.3% of appraisals for clinical staff. Of the staff whose appraisal had been completed, only three had not had a half year review.

We did not see the service target so could not determine if clinical staff appraisals were in line with the expected rates.

The service did not complete clinical supervision at the time of the inspection, but managers told us there were plans in place to commence these in 2022.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw information from team meetings displayed in the staff area of the service. The service completed monthly training days with all staff, where they ensured no patients were scheduled so all staff who were on the rota could attend. This meant they could provide regular updates and training to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff working in each area were required to have competencies signed off by an experience staff member or manager. This meant if staff wanted to progress to work in a new area of the service, there was a structured offer available to support them and ensure they were competent to provide the care required.

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

Managers identified poor staff performance promptly and supported staff to improve. We spoke to managers about poor performance and they gave examples of how they had helped and supported staff to improve in the surgical division, including monitoring of the improvements once they had been implemented.

Multidisciplinary working

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

Staff held effective multidisciplinary meetings to discuss patients and improve their care.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including diagnostic tests, during opening hours.

Senior staff were on call until all patients had left the hospital and patients were given access to a 24-hour telephone line to gain clinical advice if they needed it following surgery which was available service wide.

Health promotion

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

Good

Surgery

The service had relevant information promoting healthy lifestyles and support on wards/units.

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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff we spoke with told us about best interest decision meetings that took place in the department when patients did not have the capacity to make decisions about their care.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The service had standardised consent forms for the procedures they completed that were in line with guidelines. The consent forms provided information on procedure, including the main benefits and risks associated with the procedure. We observed three patient pathways and saw consent being gained for surgery; we did not have any concerns relating to the practice of staff.

At the last inspection we told the provider they should include reference to the licensing authority for medicines in the UK in the patient consent forms explaining the off-licence. During this inspection we saw this had been completed and the consent forms now specifically referenced off-label drug requirements.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training included Mental Capacity Act Deprivation of Liberty Safeguards and dementia awareness modules, and we saw staff met the service target for these modules.

Are Surgery caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We saw several positive comments from patients in the patient feedback the service provided. This included "Staff are approachable, helpful and polite".

Staff followed policy to keep patient care and treatment confidential.

Good

Surgery

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff put patients at ease when they were waiting for a surgical procedure and talk to them about their concerns. We spoke to service managers who told us if patients needed additional support, theatre lists could be slowed down; we also heard examples of additional staff holding patients' hands in theatre to provide support when they needed.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We asked staff how they managed distressed patients and they told us they had access to offices where they could take patients who needed a private conversation. Staff gave us an example of a patient who had become distressed in the department due to a recent bereavement; they took them to a quiet place, offered a drink and comforted the patient before supporting them to return to the surgery department.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service policy made sure that patients did not leave the hospital unattended so that they were not put at risk. Staff told us about an example where they arranged a taxi for a patient who had no support to get home, and the service paid for this.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make informed decisions about their care. We saw that patient consent forms for procedures offered at the service included information about the benefits and risks. This was also verbally explained to patients. We saw patient feedback that was shared with the service, included "Everything explained clearly, lots of attention to detail and made me feel at ease".

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

The service gathered feedback from patients using feedback forms. In the three months prior to the inspection (August to October 2021), feedback forms received from patients had increased from 79 in August to 227 in October. Patients provided comments such as "The staff are very professional, empathetic and make you feel welcome" and "Everything about Optegra has always been excellent, helpful and considerate. The care is excellent".

Good

Surgery

Are Surgery responsive?

Good

Our rating of responsive stayed the same. We rated it as 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.

Managers planned and organised services so they met the needs of the local population. Managers told us that they had amended the setup of their appointments to meet the needs of the patient population and offer longer appointments and surgical slots to patients who had dense cataracts. This was because the theatre lists were becoming delayed and the service recognised that due to the COVID-19 pandemic, patients had waited for longer than prior to the pandemic for treatment, therefore patients sight could have deteriorated more than the service would usually expect to see.

Facilities and premises were appropriate for the services being delivered. The hospital had challenges as it had been developed in an old building, however the premises had been remodelled to meet the needs of the service, and there was an accessible lift to the first floor. Managers told us they had plans in place to improve the premises further in 2022, including gaining support from local dementia services to make environmental changes to make the service more appropriate for their patient base.

Managers monitored and took action to minimise missed appointments. Appointments were managed through the central booking team and managers had added additional clinics or patient lists when required to meet the demands of patients. Managers reviewed theatre lists on a weekly basis to ensure patients were correctly allocated and that any amendments required were made prior to a patient's attendance; this reduced the likelihood of late notice cancellations.

Managers ensured that patients who did not attend appointments were contacted.

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.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff supported patients living with dementia. There was a dementia folder in the ward area, to provide staff with information to help support and butterfly stickers used in patient notes to identify patients living with dementia.

The service had information leaflets available in languages spoken by the patients and local community and in large print.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment.

The service had access to translation services, chaperones, large print information and a hearing loop. This information was displayed in five languages, including English, in the surgery ward area.

Good

Surgery

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 admit, treat and discharge patients were in line with national standards.

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

The service referral to consultation time was 12 weeks at the time of the inspection. There was a plan in place to reduce this to six weeks by the end of February 2022. The service planned to increase the number of consultants to increase the capacity across two days at the hospital and to provide additional theatre days. There was a capacity plan in place which showed how this would work in practice from the date of the inspection to the end of the plan. The national standard for referrals was 18 weeks for non-urgent cases, and the service were already meeting the standard; they strived to improve this to one third of the national standard waiting time.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers worked to keep the number of cancelled operations to a minimum. The service had a standard pathway in place for pre-operative assessments which were completed before patients came into the hospital for surgery. This meant there had been no surgeries cancelled because there had been inappropriate pre-operative assessments.

Learning from complaints and concerns

People gave feedback and raised concerns about care received. The service investigated them and shared lessons learned with all staff. However, complaint responses did not always meet the service target and we did not see information displayed in the department to support patients to make a complaint if they needed to.

Patients, relatives and carers knew how to complain or raise concerns. We saw that complaints had been made and the service had increased patient feedback response rates. This included areas for improvement. We saw they had actions in place to address areas for improvement.

Staff understood the policy on complaints and knew how to handle them. The service had a complaints policy which described the roles and responsibilities of staff members in the management of complaints and claims. It included target timescales for the resolution of complaints at each stage and details of the independent resolution body available to patients if this was required. There were also templates in the policy to support staff to produce written responses to complaints.

Managers investigated complaints and identified themes. The service had received three complaints since April 2021. Managers reviewed complaints to identify themes, however they had not found any in the low number of recent complaints about the service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed the complaint response of the most recent complaint relating to the surgery service provided at the hospital. The response offered an apology to the patient when things went wrong or were not at the standard the patient expected and the response letter addressed the concerns raised in the complaint and offered resolution to the patient and was in line with the service policy.

Good

Surgery

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

There had been no complaints and 41 compliments reported in the three months prior to the inspection (August to October 2021). The service provided us with the details of their three most recent complaints, but we did not have the dates to determine when they had been made.

However, we reviewed the response times of two complaints in the surgical department. Both complaints required a response. One out of two (50%) received an acknowledgment within the service target of two working days. One of the two complaints had been completed and did not meet the 20-day response target. The second complaint was ongoing; however, could not determine if it was outside of the response times as the date the complaint was made was not provided. Following the inspection, the service provided additional information and confirmed that the complaint had now been resolved and this was in line with the service target. This meant that patients complaints were not always responded to in line with the service policy.

We did not see clearly displayed information about how to raise a concern in patient areas.

Are Surgery well-led?

Good

Our rating of well-led stayed the same. We rated it as 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 hospital management structure included a regional director, hospital director, operational manager and a clinical services manager. We interviewed the registered manager and service level manager as part of the inspection.

The service had managers in place who understood the service. There was no theatre manager in post at the time of the inspection, however the theatre manager from another regional site had worked in the department and provided off site support when it was needed. The manager of the outpatient areas also managed surgical services on a day to day basis and was knowledgeable and passionate in the role.

Managers were visible in the service and staff we spoke with told us they were approachable.

Good patient care and experience for patients was at the forefront of the managers in the service and actions they took had this focus.

We spoke to managers in the service during the inspection and they could describe the progress that had been made in the previous year and the direction the service was going to make further improvements.

Good

Surgery

Managers had support from regional and national leaders and regularly met and discussed the service. There were also direct links to other departments, such as human resources and the medical advisory committee, so managers could access relevant support.

There were plans in place to ensure succession planning. Organisation wide, there were management apprenticeships available to staff, and senior staff offered shadowing and mentoring opportunities.

Leaders in the service had considered the impact of human factors on staff practice. They shared resources with staff to raise awareness and had completed an exercise on human factors with staff in September 2021 as part of a training day with all staff.

There was a national Medical Advisory Committee (MAC) in place who met quarterly. The MAC chair was easily accessible to leaders of the service and there was a governance structure in place to ensure appropriate meetings fed information into the MAC.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

There was an organisation wide vision and strategy which built on the previous vision from 2007 that had been achieved. The organisation had developed four core values and we saw them displayed in the service. We reviewed the quality account which set out the vision for services in the organisation and saw it focused on safety, quality care and outcomes for patients. It displayed ambitions to support national health services COVID-19 recovery and strengthening relationships at a local and system level for each hospital.

The service made sure they followed the most up to date national guidelines; we saw that they monitored published guidance, National Institute for Health and Care Excellence (NICE) advice and quality standards and made updates to their own guidelines and procedures when required. There had been no relevant updates to the service in the 12 months prior to the inspection, but we saw evidence managers had checked the guidelines to be sure.

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.

Staff we spoke with during the inspection told us they felt valued and supported by both leaders and other staff members. Managers and leaders were described as open and supportive. We heard staff that they worked well together across areas.

All policies we reviewed as part of the inspection had equality impact assessments. This meant the service considered the impact of its policies on people with protected characteristics and made adjustments where they were required.

The service had a duty of candour policy which met the regulatory requirements of being open and honest when things go wrong. Staff we spoke with understood the principals of the duty of candour and gave examples of when they would follow them.

We reviewed the most recent duty of candour letter that was sent to a patient and found it was in line with the requirements set out in the duty of candour regulations.

Good

Surgery

Governance

Leaders operated effective governance processes, throughout the service and, however the mechanism for monitoring actions and timely responses was not robust. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

All policies we reviewed as part of the inspection referenced national guidance. They were all in date and the equality impact assessment considered how outcomes would be measured in the service. This meant that it was clear how managers monitored that policies were adhered to, for example through audits and trend analysis of performance data.

The service had quarterly meetings to discuss risks, issues and concerns. There was a clinical governance meeting, infection prevention and control, medicines management, and resuscitation meeting, as well as a quarterly optometrist regional meeting. We saw that risks and issues were discussed routinely and items covered were appropriate, including training, competencies, incidents, feedback, equipment and staffing. The risk register was also discussed quarterly.

There was an overarching action log from all of the quarterly meetings. This meant that managers and leaders had oversight of progress against actions for all meetings that took place. However, there was not enough detail in the overarching action log to monitor if actions were on or off track, as there were no timescales attached to any actions.

The service had a Medical Advisory Committee (MAC) in place that was a national committee with representatives from each hospital location. We saw that the agenda covered matters you would expect, including clinical activity reports, practicing privileges reviews, national guideline implementation and incidents. We spoke to the chair of the MAC during the inspection and they were aware of the hospital and recent incidents and events and advice that had been provided.

Issues that may affect clinical effectiveness were discussed at the Medical Advisory Committee (MAC) meetings. Minutes were recorded and shared amongst staff to raise awareness and learning from incidents. We saw there was leaders regularly attended the meeting and there was appropriate discussion relating to both the service and the other hospitals that the provider ran. This meant that information was shared across sites to support learning and improvement.

All consultant applications for practising privileges were signed off by the hospital director and agreed by the MAC chair following review of required documentation. We saw evidence that a robust process operated for the granting of practising privileges. All appropriate checks such as disclosure and barring service (DBS), General Medical Council (GMC), indemnity insurance, specialist registration and health screening were carried out before practising privileges were granted.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues however they did not always record identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had a risk register in place. There were four risks relating to this service, which all scored either an eight or a nine out of a possible high score of 25. This was rated as a significant risk. We saw that review dates were documented on the risk register and there were controls documented for one of the four risks. However, there were three risks with no control actions documented, either implemented or outstanding. This meant we could not see what actions had been considered to reduce the risks to target levels or meant that there had been no action taken regarding these risks.

Good

Surgery

The service had electronic performance dashboard that managers and leaders used to monitor performance. It gave an overview of information including the activity, number of surgeries completed, any unplanned outcomes, incidents, compliments and complaints. This meant that managers and leaders could review current information and monitor any issues that may arise.

The service had quarterly meetings to discuss risks, issues and concerns. There was a clinical governance meeting, infection prevention and control, medicines management, and resuscitation meeting, as well as a quarterly optometrist regional meeting. We saw that risks and issues were discussed routinely and items covered were appropriate, including training, competencies, incidents, feedback, equipment and staffing. The risk register was also discussed quarterly.

There was an overarching action log from all of the quarterly meetings. This meant that managers and leaders had oversight of progress against actions for all meetings that took place. However, there was not enough detail in the overarching action log to monitor if actions were on or off track, as there were no timescales attached to any actions.

The service had a maintenance schedule which included servicing. We saw this was monitored and the log flagged when an item was due for servicing. We saw that backup generators were included in this log and they had routine servicing in place.

Information Management

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. Data or notifications were consistently submitted to external organisations as required.

The service had a data retention policy which managed the privacy, retention period, storage, and disposal of patients' personal data in line with national guidance.

The service used results from staff surveys to measure improvement from staff perspective. These results were compared with other sites to benchmark.

Although during treatment paper records were used, the service had an electronic patient record system to upload patient information to. The appointment system was electronic, and the organisation were able to measure performance against national targets through the system.

There was an electronic dashboard in place that managers used to monitor performance and the service completed audits on an electronic programme. This meant that they could analyse themes and trends from the data stored.

The service submitted required data to national external organisations as required and could demonstrate this. For example, they submitted required data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements.

Engagement

Leaders and staff actively and openly engaged with patients, staff.

The service used feedback forms to note areas for improvement from patients. In October 2021, areas for improvement included waiting times, number of patients in the hospital and staff rushing elderly patients in corridors. Action points were noted, and the bulletin was shared with staff.

Good

Surgery

There was an employee engagement survey completed in 2021 which covered six areas; strategy, structure, process, leadership, team environment and engagement. The service had improved in all six areas from the previous survey and the level of engagement had risen to 85%; this was the highest level of engagement across all of the hospitals in the provider group.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff we spoke with during the inspection told us there had been changes and improvements made in the service over the past 12 months, including changes to pathways, and they felt supported by leaders to implement changes.

The service had been nominated for and won the organisation wide "Star Award for delivering outstanding change" by the organisations Chief Executive Officer. An "extraordinary change in all aspects of the running of the hospital" had been cited as a large part of the decision to recognise the hospital, and included positive aspects such as a "significant culture change, both new staff and existing, driving the changes required".

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Staff were not all kept up-to-date with their mandatory training. The service target for mandatory training compliance was 90%. Overall compliance for staff in the department met the target of 90%. However, infection control training was required annually and the overall compliance for this module was low; 32% of staff had completed the training in outpatients and 25% of staff had completed this training in diagnostic staffing. This was a risk to patient safety as staff were not up to date with training on how to prevent infections.

Staff had all completed infection control training within the same month in October 2020 and compliance was low as the training was one month out of date. Since the inspection, the service managers told us that the training was now completed for all clinical staff.

Managers provided monthly staff training sessions. These had been delivered online during the pandemic and were now face to face at team meetings.

However, the mandatory training policy did not indicate the complete training needs required for each staff role including their programme of continuing professional development (CPD) modules.

Specific training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia was included in the mandatory or job specific training information that the service provided. This meant staff ensure they have the knowledge and skills required to care for and meet the needs of all patient groups.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service recorded staff training attendance in each member of staff's training file, and these were checked as part of monthly audits by the registered manager. There was an automatic alert system set up for all staff training to alert the manager on completion and on anything outstanding.

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 received training specific for their role on how to recognise and report abuse. The service target for compliance with safeguarding training was 90%. The average training compliance showed that staff who worked in outpatients had a compliance rate of 91.7% for safeguarding adults' level 2 and safeguarding children level 2 training; this met the target.

Staff we spoke with could describe how they would recognise potential abuse and actions they would take. All staff that we spoke to were able to confirm their safeguarding training levels and the name of the safeguarding lead.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us what they would do and who they would inform to make a safeguarding referral. Staff knew how to escalate concerns in the service and to external bodies.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The areas were all clean and had minimal furnishings. This meant that the area had plenty of space and was free from clutter for keeping clean.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that cleaning records were up-to-date to maintain safety and hygiene standards and demonstrated that all areas were cleaned regularly to address the additional risks presented by COVID-19.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). The service had a COVID-19 risk assessment in place which described the mitigating actions that had been taken to reduce the risk to patients attending the hospital and staff. Staff used PPE in the department, however they did not always change it appropriately. We saw examples of staff wearing the same gloves to handle equipment, use cleaning products and then administer eye drops. This was not in line with The National Institute for Health and Care Excellence (NICE) guidelines for infection prevention and control. This was a risk to patients because it increases risk of infection. However, staff did use new PPE for each patient they saw. We saw staff also washed their hands between each patient, however this was not always done while the patient was with them which would be best practice.

The service policy states that gloves must be changed between patients and different procedures on the same patient. It also states that gloves must not be worn when using computer keyboards, answering the phone or writing in patients care records. This was not always practised in what we saw on inspection.

Although temperature checking is not a government requirement, we saw staff checking and recording patient temperatures on the day of inspection at reception upon arrival into the service.

The COVID-19 risk assessment had been updated in the month leading up to the inspection and reflected national guidelines.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaned equipment routinely after each patient.

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 service had enough suitable equipment to help them to safely care for patients. The equipment used in clinical outpatient rooms was fit for purpose and appropriate to the needs of the patients.

Fire extinguishers were accessible, stored appropriately and there were clear fire exit signs. The fire alarms were scheduled to be tested weekly.

Staff disposed of clinical waste safely. When we observed the department, we saw staff disposed of clinical waste correctly and in line with service policy.

We reviewed four pieces of documentation which evidenced that there was regular servicing of equipment in place at the hospital. All items had been serviced in the last 12 months and there were no outstanding actions to be completed. We asked managers about their oversight equipment servicing and they told us that there was a centralised database so they could track equipment that was due a service and any actions that may be required relating to each item of equipment.

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

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We saw the same process for each patient we observed including a risk assessment on arrival for every patient. COVID-19 risk questions and processes were the same for each patient we observed which adhered to the providers COVID-19 risk assessment process. During the inspection we observed the patient journey in diagnostic imaging. We saw four patients from booking in at reception through to end of diagnostic treatment. In all four patients we did not see appropriate three-point identity checking taking place. The Clinical Imaging Board state it is good practice for the patient to give their name, address and date of birth. For each of the four patients the name was provided for the patient to agree to and they were then asked for their date of birth. We did not see any evidence of address checks in our time in the area.

Staff shared key information to keep patients safe when handing over their care to others. Staff had an established process which we saw in documenting information in patient records to ensure effective handover. This meant key information was shared to keep patients safe. The service had an admission and pre-assessment policy in place that was based on national guidelines. It detailed patients who could and could not be treated at the service and described how staff could escalate queries about the suitability of patients for the service. Specific exclusions were listed and the

policy used a nationally recognised scoring system to assess the suitability of patients. The policy was based on national guidelines, and detailed patients who could and could not be treated at the service. It described how staff could escalate queries about the suitability of patients for the service and listed specific exclusions, including a nationally recognised scoring system.

Shift changes and handovers included all necessary key information to keep patients safe.

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 staff a full induction.

The clinic manager planned staffing rotas at least four weeks in advance. The registered manager was on call at all times the clinic was open.

Medical staffing worked between outpatients and surgery. The managers that we spoke with told us they move staff with the necessary skills where needed and would not operate without enough staff to keep patients safe.

The service had low and/or reducing vacancy rates. The service had two whole time equivalent (WTE) nurse vacancies, however one was in the process of being filled during the inspection. The service was able to schedule clinics and surgeries based on the available staffing and did not carry out scheduled activity if there were not enough staff.

The service had enough medical staff who worked under practicing privileges to meet the needs of the patients who were scheduled into clinics. There were plans in place to increase the clinical staff capacity and to shorten the referral to consultation time from 12 to six weeks.

The service had low and/or reducing sickness rates. The sickness rate for nursing staff was 2.5%, this met the service target which was 2.5%.

Managers limited their use of bank staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

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.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 10 patients records and these were completed appropriately and in line with service and national guidelines.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw records being handed over to outpatients from diagnostic area when we visited. This meant that patients records and information were shared promptly and safely to ensure all staff had relevant information regarding the patient. The service completed a records audit in October 2021. The target was 90% compliance, and this was exceeded with 100% compliance. There were no actions to make improvements identified as no errors were noted.

Records were stored securely.

The service kept electronic diagnostic image records and consent forms. Staff stored patient paper records in a locked filing cabinet with restricted access.

We observed staff maintaining the confidentiality of patients. They locked computer screens when unattended, ensured printed confidential information was not left unattended and ensured conversations were discreet.

The service had a data retention policy which managed the privacy, retention period, storage, and disposal of patients' personal data in line with national guidance.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We saw this when observing patients in appointments who required a prescription. We also reviewed the most recent audit carried out by the service in November 2021 with a 91% compliance rate. The areas that were not compliant were that each medication was not always entry timed in every situation. Although each medication was initialled, it was not always signed and where it was signed, it was not always legible. These issues were discussed with staff on a training day to ensure the importance of accurate record keeping in patient files.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. 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.

Staff knew what incidents to report and how to report them. Staff were able to describe how to report an incident and provides examples of situations this would apply to. This matched the Incident Policy that the provider had in place.

The service had no never events in the last 12 months.

Staff raised concerns and reported incidents and near misses in line with provider policy. We reviewed incidents for the service and they had been reported in line with the provider policy.

Staff reported serious incidents clearly and in line with trust policy. The incidents we reviewed have been reported in line with trust policy.

Managers shared learning with their staff about never events that happened elsewhere. Incidents were discussed at quarterly governance meetings. We looked at meeting minutes and saw that information was shared across different locations in the region to aide learning across sites

Good

Outpatients

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff we spoke with described the duty of candour during the inspection well and understood the importance of putting it into practice

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. There were recommendations and lessons learned from an incident we reviewed which resulted in changes in practice within the service as well as shared wider organisational learning.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff we spoke with during the inspection knew how to report incidents and told us managers would support them to make incident reports and provided feedback once they had been investigated.

Are Outpatients effective?

Inspected but not rated

We do not rate effective within Outpatients.

Evidence-based care and treatment

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed seven full policies across the service and saw that they reflected national guidance and good practice principals. They were based on evidence and we saw that the overarching provider completed audits for the whole organisation which were evidence based. They were shared with this service.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

There was water and hot drinks available to patients attending for appointments in the waiting area. This was well stocked and easily available.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. We reviewed the patient flow audit, The National Institute for Health and Care Excellence (NICE) evidence reviews, care and support audit and scrub procedures audit that took

place in October 2021. The patient flow audit was 100% compliant in its results. The scrub procedures audit and care and support audit both were 100% complaint upon reviewing them. It was clear to see when an audit was due for completion and the service evidenced they planned participation in national audits. It was good practice to include improvement audits in the audit plan.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service compared their performance across the national organisation for patient outcomes. We reviewed the performance report for July 2020 to June 2021 relating to laser vision correction, multifocal intraocular lenses and monofocal intraocular lenses. The results were split into type of correction or surgery and identified where results deviated from the industry benchmark. Out of 75 results across the year, the service deviated in four areas (0.05%), all in the monofocal intraocular lens (cataracts) procedures. The service had reviewed the results and noted that as there was no community care and only up to 20% of cases received face to face post-operative follow up, this may account for the decline. The service had plans in place to improve outcomes by re-instating face to face follow ups.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service compared their performance across the national organisation for patient outcomes.

Managers used information from the audits to improve care and treatment.

Managers used audit findings to make immediate improvements to the service and discussed and shared outcomes with staff at team meetings. The service had an electronic performance dashboard that gave managers oversight of unexpected outcomes from surgeries. This meant that leaders could be responsive to any concerns or issues relating to individual cases.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. We spoke to staff who told us they have regular meetings with managers. Managers told us they supported staff to develop through regular meetings and additional training. We reviewed appraisal staff figures and 100% of staff have received annual appraisals to date in outpatients.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw information from team meetings displayed in the staff area of the service. The service completed monthly training days with all staff, where they ensured no patients were scheduled so all staff who were on the rota could attend. This meant they could provide regular updates and training to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff working in each area were required to have competencies signed off by an experience staff member or manager. This meant if staff wanted to progress to work in a new area of the service, there was a structured offer available to support them and ensure they were competent to provide the care required.

Good

Outpatients

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

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

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Seven-day services

Services were available between Monday to Friday with out of hours support available and referral to hospital seven-day services when needed.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. We saw leaflets available to give to patients in Outpatient consulting rooms that were regularly given out to patients where appropriate. These were shown to us by staff when we inspected.

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. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. The service had standardised consent forms for the procedures they completed that were in line with guidelines. The consent forms provided information on procedure, including the main benefits and risks associated with the procedure. We observed three patient journeys through diagnostic and outpatient appointments, and we saw staff ensuring patients fully understood the information provided; we did not have any concerns relating to the practice of staff.

Staff clearly recorded consent in the patients' records. The service had standardised consent forms for the procedures they completed that were in line with guidelines. The consent forms provided information on procedure, including the main benefits and risks associated with the procedure. We observed three patient pathways and saw consent being gained for surgery; we did not have any concerns relating to the practice of staff.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training included Mental Capacity Act Deprivation of Liberty Safeguards and dementia awareness modules, and we saw staff met the service target for these modules.

Are Outpatients caring?

Good

Outpatients

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients. All staff including reception staff and non-clinical staff, were observed to be compassionate and respectful to every patient who used the service. Patients told us that staff were friendly and we observed this in action during the inspection. We observed that staff and consultants introduced themselves when patients were called from the waiting area, for their appointment.

Patients said staff treated them well and with kindness. We spoke to eight patients in the outpatients department and they all said staff listened to them and were caring. We saw several positive comments from patients in the patient feedback the service provided. This included “Staff are approachable, helpful and polite”.

Staff followed policy to keep patient care and treatment confidential. Patient records were kept safe and in line with policy. Conversations were held with patients in private consultation rooms with the door closed. This meant the information regarding the patient was confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff giving patients emotional support and more time for understanding information when appropriate in appointments.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw staff checking patient understanding and explaining treatment in an alternative way to help understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback forms were encouraged to be completed. We reviewed completion rates of feedback forms and they had increased month on month between August and November 2021.

Good

Outpatients

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. 90% of patients completing feedback forms rated their care and treatment as ‘very good’ at the service between August and November 2021. Patients provided comments such as "The staff are very professional, empathetic and make you feel welcome" and "Everything about Optegra has always been excellent, helpful and considerate. The care is excellent".

Are Outpatients responsive?

Good

Our rating of responsive stayed the same. We rated it as 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.

The service was designed to provide outpatient clinic appointments for adult patients across a range of specialties, including acute macular degeneration, cataract care, vitrectomy, glaucoma, and ocular plastics. Adult patients were seen from across Yorkshire. The service also accepted patients from outside of this area.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

Managers monitored and took action to minimise missed appointments. There was a central system in place to book appointments for patients and a system within this for offering alternatives up to three times for missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

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.

Patients were able to declare any reasonable adjustments they needed to attend their outpatient appointment safely and comfortably at the booking stage, by telephone or at arrival at the clinic.

Staff had completed equality and diversity training which ensured patients with protected characteristics received care free from bias.

The entrance door to the service was on ground level and wide enough for wheelchair and pushchair access. The outpatient rooms were accessible to wheelchairs.

The service had access to translation services, chaperones, large print information and a hearing loop.

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 admit, treat and discharge patients were in line with national standards.

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

The service referral to consultation time was 12 weeks at the time of the inspection. There was a plan in place to reduce this to six weeks by the end of February 2022. The service planned to increase the number of consultants to increase the capacity across two days at the hospital and to provide additional theatre days. The national standard for referrals was 18 weeks for non-urgent cases, and the service were already meeting the standard; they strived to improve this to one third of the national standard waiting time.

Managers worked to keep the number of cancelled appointments to a minimum.

The service kept delays and waiting times to a minimum and we heard from patients that staff communicated any delays. We observed appointments running to time when we inspected.

Learning from complaints and concerns

People gave feedback and raised concerns about care received. The service investigated them and shared lessons learned with all staff. However, complaint responses did not always meet the service target and we did not see information displayed in the department to support patients to make a complaint if they needed to.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with in outpatients told us they knew how to complain if they had a concern by asking staff, however there were no posters or information displayed in the service to help guide staff to the complaint's procedure. Staff knew the process and could support patients when they were asked.

Staff understood the relevant policies on complaints and knew how to respond to and escalate complaints.

The registered manager had overall responsibility for reviewing, investigating, and responding to complaints and feedback. They logged details of the complaint along with any actions taken and reported any identified themes to the central teams for national learning.

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

Staff could give examples of how they used patient feedback to improve daily practice.

However, we reviewed the response time of the one complaint in the outpatient's department. This complaint received an acknowledgement outside of the service target of two working days. The service did not meet their target response time for the complaint of 20 days.

Good

Outpatients

Are Outpatients well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

See surgery section for information under this sub-heading.

Vision and Strategy

See surgery section for information under this sub-heading.

Culture

See surgery section for information under this sub-heading.

Governance

See surgery section for information under this sub-heading.

Management of risk, issues and performance

See surgery section for information under this sub-heading.

Information Management

See surgery section for information under this sub-heading.

Engagement

See surgery section for information under this sub-heading.

Learning, continuous improvement and innovation

See surgery section for information under this sub-heading.