Leicestershire Consultant Eye Surgeons LLP @ The Stoneygate Eye Hospital

Quality Report

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

Ratings

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

Overall summary

Stoneygate Eye Hospital is operated by Leicestershire Consultant Eye Surgeons Limited Liability Partnership (LLP).

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection between 5 and 6 September 2017, along with an unannounced visit on 19 September 2017.

Summary of findings

The hospital provides surgery, services for children and young people, and outpatient clinics. We inspected surgery, outpatients and services for children and young people. The main service is surgery. Following our visit in September 2017 it ceased offering children's services in outpatients and surgery and we have not rated this service due to the very low numbers of children treated, and insufficient evidence.

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 core service.

We rated this hospital as requires improvement overall.

We found the following issues that the service provider needs to improve:

- Managers did not share learning from incidents with all staff.
- Staff did not always ensure medicines and eye drops were stored securely.
- Staff did not always ensure patient records were stored securely for example, leaving records on desks in open consulting rooms.
- Four out of five patient records we reviewed in outpatients were either not legible, signed, or dated in line with general medical council (GMC) standards
- The service did not monitor the effectiveness of pain relief or document levels of pain in patient records.
- Despite using patient outcome forms the hospital did not audit them to measure clinical effectiveness.
- Managers did not use competency frameworks to assess staff competency in undertaking their duties.
- Nursing staff did not receive regular one to one meetings or team meetings which meant there was no ongoing formal support process for them.
- Patients sometimes experienced long waits once they had arrived in clinic to see a consultant or for their treatment.
- Outpatient services did not have written materials available in other languages for patients whose first language was not English. This included pre-appointment information.
- The hospital had a vision but no medium to long term strategy plan with clear aims and objectives. There were no strategic plans to support the development of quality, safety or performance.
- The hospital did not have fully developed arrangements to manage risk or performance, and lacked quality, safety or performance dashboard for the full range of its activities
- Policies were not tailored to the needs of the hospital
- Management resources were stretched

We found the following areas of good practice:

- Clinicians recorded and analysed any clinical or non-clinical incidents and learned from them. Clinicians acted in line with the duty of candour
- Track record of incidents and infection control compared with similar organisations
- Theatres, diagnostic rooms and consulting rooms were visibly clean and well equipped
- Theatres were staffed with nurses and support staff in line with good practice
- Clinicians assessed patient risks before operations and theatre teams used the World Health Organisation (WHO) Surgical Safety Checklist for Cataract Surgery, and five steps to safer surgery checklist
- Appropriate emergency back up arrangements were in place
- Surgery was based on national guidance and conducted clinical audits. Clinicians kept upto date with best practice.
- Technology was used to monitor patient's conditions accurately so that clinicians could give the best advice possible
- The service contributed to the Royal College of Ophthalmology expected outcomes audit on cataracts and its results were better than the national average for acuity, with a low complication rates.
- Patients we spoke with found the staff to be reassuring and compassionate and we observed this during operations

Summary of findings

- After patients had an operation, nurses explained to them in a very understandable way how they could self-care.
- Patients had a choice of clinic and surgery times including evenings
- Consultants used an interactive display screen which covered a range of languages, to illustrate and explain procedures to patients
- Patients did not have to wait very long for NHS cataract surgery – when we inspected they were waiting approximately nine weeks from referral to surgery
- The service responded to patient views. They installed a larger waiting area, different seating and alternative refreshments in response to patient feedback.
- The hospital had a track record of technical and clinical innovation.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notice(s) that affected outpatients and surgery. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as requires improvement overall because the service did not formally share learning from incidents with staff at all levels of the organisation.Changing facilities for theatre staff were not ideally located to minimise infection risk to patients, because clinicians had to walk through areas shared with other staff and the public.We found some resuscitation trolley items which had broken packaging or beyond their expiry date. Staff were unclear who to contact about this.The hospital did not have robust arrangements for medicines management and did not store medicines in a safe and appropriate manner Safeguarding arrangements did not include female genital mutilation (FGM) There was a lack of governance arrangements such as medium term strategic planning, comprehensive risk management, which meant that risks such as medicines management and out of date resuscitation materials had not been identified.
Services for children and young people	Not sufficient evidence to rate 	Children and young people's services were a very small proportion of hospital activity, and the service operated on only one child in 2016 – 2017, and 17 children had outpatient appointments at the hospital during this time. The hospital ceased its children's services in September 2017. We have not rated this service due to the small numbers of children involved and insufficient evidence.

Summary of findings

Outpatients and diagnostic imaging

Requires improvement 

Few patients visited the hospital for outpatients services only. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. There were 4,002 outpatient attendances in the reporting period Apr 2016 to March 2017. Of these, 81% were NHS funded and 19% were private or self-funded patients.
We rated outpatient services as requires improvement because medicines and records were not always stored securely. Medicines management was not robust. Patient records were not in line with general medical council (GMC) standards. The hospital did not have a full range of written materials in large print for patients with visual impairments or for patients whose first language was not English. There was no strategy for the hospital and quality and performance only recorded for NHS contracted services. However, we saw positive and compassionate patent interactions. Staff involved patients in their care and treatment and patients were positive about their care and treatment at the hospital. The hospital provided a flexible range of appointments and enabled patients to access appointments quickly.

Summary of findings

Contents

Requires improvement

Stoneygate Eye Hospital

Services we looked at

Surgery; Services for children and young people; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Leicestershire Consultant Eye Surgeons LLP @ The Stoneygate Eye Hospital

Stoneygate Eye Hospital is operated by Leicestershire Consultant Eye Surgeons LLP. The hospital opened in 2013. It is a privately-run eye hospital in Leicester. The hospital primarily serves the communities of the Leicester, Leicestershire and Rutland areas. It also accepts patient referrals from outside this area. There are nine eye surgeons and a practice manager/registered manager along with nursing and administrative staff.

The registered manager has been in post since 2013. The hospital's regulated activities are surgery, treatment of diseases, disorder and infections and diagnostic and screening procedures. This was the first CQC inspection at Stoneygate Eye Hospital. It took place on the 5th and 6th September 2017 followed by an unannounced inspection on the 19th September 2017.

Our inspection team

The team that inspected the service comprised three full time equivalent CQC inspectors, two specialist advisers and a CQC inspection manager. The inspection was overseen by Simon Brown Inspection Manager.

Information about Leicestershire Consultant Eye Surgeons LLP @ The Stoneygate Eye Hospital

The main service offered at Stoneygate was eye surgery. The hospital saw some patients for outpatient consultation only but consultants saw most outpatients before surgery and as a follow up after surgery. Therefore most outpatients were on a surgery pathway. The majority of patients were NHS cataract patients, who were subcontracted from a company that was commissioned by the local clinical commissioning group..

During the inspection, we visited the two theatres, consulting rooms, waiting room, recovery room, store rooms and diagnostic room. The hospital had a range of specific eye diagnostic equipment. We spoke with 17 staff including nurses, theatre 'runners' reception staff, medical staff, and managers. We spoke with seven patients and one relative. We also received one 'tell us about your care' comment cards which patients had completed before our inspection. During our inspection, we reviewed 12 sets of patient records.

- In the period April 2016 to March 2017, there were the following episodes of care for adults:
- 1923 Phacoemulsification of cataract with posterior chamber lens implant (NHS Cataract Surgery)
- 91 Intravitreal injections for wet and dry age-related macular degeneration
- 41 Entropion/Ectropion/ptosis correction
- 32 Eyelid biopsy/excision
- 27 class four laser for posterior capsular opacification
- There was one surgical procedure for on a child patient - corneal collagen cross linkage..

Never Events

In the reporting period (April 2016 to March 2017) there have been no never events. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Summary of this inspection

Clinical Incidents

In the reporting period (April 2016 to March 2017) there were seven clinical incidents. Of these incidents six were categorised as no harm and one was categorised as low harm. There was one clinical incident and no non-clinical incidents within Surgery or Inpatients. There were six clinical incidents and no non-clinical incidents within Other Services. There were no clinical incidents and one non-clinical incident within outpatients and diagnostic Imaging.

Serious injuries

For the reporting period (April 2016 to March 2017) in regard to serious injuries and mortality the provider stated 'N/A'.

Mortality

For the reporting period (April 2016 to March 2017) in regard to inpatient deaths the provider stated 'N/A'.

Methicillin-resistant Staphylococcus aureus (MRSA)

In the reporting period (April 2016 to March 2017) there were no incidents of hospital acquired MRSA.

Methicillin-sensitive Staphylococcus aureus (MSSA)

In the reporting period (April 2016 to March 2017) there were no incidents of hospital acquired MSSA

Clostridium difficile (C.difficile)

In the reporting period (April 2016 to March 2017) there were no incidents of hospital acquired C.difficile

Escherichia Coli (E-Coli)

In the reporting period (April 2016 to March 2017) there were no incidents of hospital acquired E-Coli.

Services provided at the hospital under service level agreement:

- Interpreting services
- Maintenance of medical equipment
- Pathology

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The service did not formally share learning from incidents with staff at all levels of the organisation
- There was no safety or quality dashboard for private patients
- Changing facilities for theatre staff were not ideally located to minimise infection risk to patients, because clinicians had to walk through areas shared with other staff and the public
- We found some resuscitation trolley items which had broken packaging or beyond their expiry date. Staff were unclear who to contact about this
- During clinics records were not always secure or confidential
- Windows did not have restrictors on them in one upstairs consulting room and upstairs waiting area.
- The hospital did not have robust arrangements for medicines management and did not store medicines in a safe and appropriate manner
- Safeguarding arrangements did not include female genital mutilation (FGM)

However, we found that:

- The service recorded and analysed any clinical or non-clinical incidents and learned from them. Clinicians acted in line with the duty of candour
- Track record of incidents and infection control compared well with similar organisations
- Theatres, diagnostic rooms and consulting rooms were visibly clean and well equipped
- Theatres were staffed with nurses and support staff in line with good theatre practice
- Clinicians assessed patient risks before operations and theatre teams used the World Health Organisation (WHO) Surgical Safety Checklist for Cataract Surgery, and five steps to safer surgery checklist
- Appropriate emergency backup arrangements were in place.

Are services effective?

Good

We rated effective as good because:

- The service was based on national guidance and conducted clinical audits. Clinicians kept up to date with best practice.

Summary of this inspection

- Technology was used to monitor patients conditions accurately so that clinicians could give the best advice possible
- The service contributed to the Royal College of Ophthalmology expected outcomes audit on cataracts and its results were better than the national average for acuity, with a low complication rate.
- The hospital had policies and procedures regarding consultants practising privileges, including arrangements to manage poor performance if necessary
- There was a 24 hour helpline for patients, which connected them directly with a consultant, if they had a concern
- Patients had the necessary time and information to consider their consent to surgery. Interpreters were available for NHS patients.

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

- There was no pain scoring system to record levels of pain in patients before, during or after surgery
- The service did not track patient outcomes systematically for surgery other than cataracts.

Are services caring?

Good

We rated caring as good because:

- Patients we spoke with found the staff to be reassuring and compassionate and we observed this during operations
- After patients had an operation, nurses explained to them in a very understandable way how they could self-care.
- Consultants and nurses offered glaucoma patients emotional and lifestyle support

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

- We did not observe staff offering patients chaperones during the inspection

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Once patients arrived for surgery they sometimes waited one to two hours to be seen
- Patients had to request large print information and there was no information in languages other than English

However, we also found:

Summary of this inspection

- The hospital was a bright airy building with a car park and public transport access.
- Patients had a choice of clinic and surgery times including evenings
- Patients did not have to wait very long for NHS cataract surgery – when we inspected they were waiting approximately nine weeks from referral to surgery.
- The hospital had a procedure to investigate complaints and to learn from them.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The hospital had a vision but no medium to long term strategy plan with clear aims and objectives. There were no strategic plans to support the development of quality, safety or performance
- There was no comprehensive competency and appraisal framework.
- The hospital did not have fully developed arrangements to manage risk or performance, and lacked a quality, safety or performance dashboard for the full range of its activities
- Policies were not tailored to the needs of the hospital
- Management resources were stretched.

However, we found that

- There was strong clinical leadership. Staff understood the organisation's values and demonstrated them in their day to day working
- The hospital responded positively to feedback from staff and patients and used it to improve services
- The service invested in innovative diagnostic equipment which benefitted patients. It also looked to improve efficiency and was implementing a new stock control system, which had the potential to save time and money.

Requires improvement

Surgery

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

Are surgery services safe?

Good

The main service provided by this hospital was eye 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 section.

We rated safe as **good**

Incidents

- There were no never events, serious injuries or mortality between April 2016 and March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service had started to record incidents on a new electronic recording system, which also included complaints and training. Managers had not yet fully implemented the system, so they could not give us a print out of the most recent incidents. Staff had received training.
- There were seven clinical incidents between April 2016 and March 2017. Six incidents were categorised as no harm and one as low harm. There were no specific themes and trends and varied from a medication concern to issues regarding the discharge procedure. More recently, there were two incidents in July 2017 - leaving the fire door open overnight, and a product recall from an equipment supplier.
- Clinicians reviewed incidents, clinical risks and alerts. They raised the concern immediately and the registered manager investigated the issue and kept records. Clinicians made changes to practice if necessary. We heard an example of how the name of a medication had been misheard on transcription and the GP noticed the prescription error. Clinicians ensured this would not happen again by spelling out the names of medications when they recorded letters for typing.
- The hospital held a medical advisory committee (MAC) meeting approximately every three months where they discussed clinical incidents. The registered manager, financial manager and the clinicians attended this meeting. The meeting reviewed incidents and safety alerts. Staff told us they heard informally about incidents and related learning, but incidents were not a standard item on administrative or nursing team meetings.

The Duty of Candour

- Clinicians described how the hospital apologised to patients and explained what had gone wrong, in line with the duty of candour, and tried to put things right. They would also write a formal letter to the patient. However, not all nurses were sure of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Requires improvement

Surgery

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

- The hospital monitored safety for most of its patients. The commissioning provider completed a dashboard for NHS cataract patients. The dashboard reported on quality measures such as never events and serious incidents, medication errors and surgical site infections.
- However, there was no clinical quality dashboard for private patients, or patients having operations other than cataracts, for example, eyelid biopsies, or intravitreal injections.
- The hospital did not formally record or analyse numbers of patients who returned to surgery due to infection or unexpected visual acuity results.

Cleanliness, infection control and hygiene

- There were no incidents of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) or MSSA (Methicillin sensitive Staphylococcus aureus), E-coli or Clostridium difficile (C.difficile) recorded between April 2016 and March 2017.
- Consulting rooms, theatres and the recovery room were visibly clean. The cleaner used different cloths and mops for different areas to prevent cross contamination. Some sinks in consulting rooms were not elbow operated. Staff undertook cleaning daily with a deep clean once a year.
- Liquid hand gel was available at numerous points in the premises and staff used these frequently. Staff and clinicians were 'bare below elbows' in line with infection control good practice.
- Staff kept equipment that came into contact with patients eyes clean. The service used universal wipes for clinical and diagnostic equipment. The service did not use specialist optical wipes.
- The hospital had arrangements to ensure theatre instruments were sterile. Many of the instruments were for single use. Where they were not, the hospital contracted with a provider, which collected, sterilised and tracked the instruments three times a week.
- The location of changing facilities did not facilitate infection control in theatre. The changing room where clinicians changed into theatre scrubs was on the first floor while the operating theatres were on the ground floor. Clinicians in theatre scrubs had to walk through communal areas to the operating theatre, so the changing area was suitable for infection control. The hospital had looked at changing these arrangements but managers said local planning regulations and lack of space-restricted developments. As a result, the changing facilities remained in a location that did not optimise infection control.
- Staff knew what to do if a patient arrived with an infection or had a contagious disease. They referred the patient to the local trust and sought advice from microbiologists at the local NHS trust.
- Managers carried out environmental and hand hygiene audits twice a year in February and August 2017. So far, everyone had been compliant with hand hygiene and the hospital's infection control policy, so these had not resulted in any actions.
- The hospital had systems in place to control legionella in its water system. It risk assessed its water safety and took action to address the areas at highest risk, for example the preparation room, where it had a deep clean. An external consultancy flushed and tested the temperature of the water supply monthly and carried out a full bacteriological test every quarter. The most recent test and flushing of the water system was on 18th September 2017. We also saw records showing that hospital cleaning staff flushed the taps weekly. This limited the risk of Legionnaire's disease.
- Surgical site infection rates at the hospital were better than the England average for cataracts. The national standard was one infection in 1000 operations but the hospital had not had any infections in 7000 operations. They attributed this to their practice of putting antibiotics into the patient's eye at the end of the procedure.
- During the same time, one eyelid malposition patient had a post-operative infection and the consultant identified this at a follow up appointment and treated the infection.

Environment and equipment

- Theatres were well equipped with laminar flow and an air handling unit, which ensured that airflow systems could modify temperature and humidity.
- The hospital maintained equipment under contracts with the companies supplying the equipment and was up to date with portable appliance testing. The hospital acquired equipment on a scientific merit basis and was proud of its state of the art diagnostic machines.
- Emergency equipment was not effectively monitored. . There was one defibrillator and piped oxygen in the

recovery room. According to hospital policy, staff should check resuscitation equipment weekly. However, staff did not always check the equipment weekly. We checked hospital records and saw that between 1 July 2017 and 19 September 2017, there were four occasions of gaps of nine days or more between checks. On one occasion, there was a gap of 18 days. Staff we spoke with did not know the policy on checking resuscitation equipment. We checked the resuscitation and associated equipment in the recovery room. We found two transfusion sets, which were out of date (April 2017). We found other products that were approaching their expiry date or that had broken packaging. Staff did not know about any system to alert managers to this. This meant emergency equipment might not always be ready for use in the event of an emergency.

- The hospital did not have a hoist and could not treat bariatric patients or patients with severe mobility difficulties. However, the hospital did not treat bariatric patients as part of their contractual arrangements. Bariatric patients could be treated at the local NHS acute hospital.
- The hospital stored clinical waste in separate bins and staff transferred the waste to a locked bin in the car park area. Staff kept the key for the bin locked away and nurses took the clinical waste out at the end of each day. Sharps were clearly labelled and kept separate.
- The hospital was introducing a computer system to improve stock control and track instruments and consumables. They had established an inventory. This would ensure staff accessed the right instruments, equipment and medication at the right time.

Medicines

- The hospital used mostly topical or intra-ocular medicines and had antibiotics for intraocular infections only. The Chief Nurse, Registered manager and lead clinician for medicines had keys to the store and audited regularly.
- The hospital had lockable drugs fridges and staff recorded temperatures daily. There was a large fridge in the recovery room, which was fitted with an alarm in case of the temperature dipping below agreed norms.
- We saw staff documented patient allergies in patient records. Consultants asked patient about their allergies prior to administering treatment and care.
- In one patient record we reviewed, dilating drops were not recorded in the notes. Consultants wrote details of the post-surgery medication on the preliminary discharge letter and instructions were abbreviated and not specific.
- All medications we checked were all within date. The matron checked stocks weekly. However, we observed three packs of glucogel about to go out of date (dated September 2017) and when asked, nurses could not tell us the procedure for raising this issue and getting medicines replaced.

Records

- Data from the hospital showed staff saw no patients without their medical records between April 16 and March 17.We reviewed eight sets of medical records. We found in half of the records we looked at records were either not complete or in line with General Medical Council (GMC) standards. For example, we saw records not signed, dated or legible.
- Clinicians completed entries for pre-operative assessments including risk assessments, allergies and consent for all of the records. Administrative staff ensured blank pre-operative assessment forms were included in patient records prior to clinics. This meant forms were readily available to consultants or nursing staff to fill in.
- Staff integrated notes from optometrists and consultants working under practising privileges into the medical records. Medical records did not leave the hospital and a third party provider scanned records for NHS patients onto an electronic system. Therefore, staff had access to integrated hospital records.
- Staff kept patient records in a lockable trolley. We observed consultants occasionally leaving patient records on their desks while they left the room for a few minutes, instead of locking them away.

Safeguarding

- There were no safeguarding concerns reported to the CQC between April 16 and March 17.
- Data from the hospital showed consultants held level three in safeguarding. The hospital trained nurses and healthcare staff in level two safeguarding. This was in line with intercollegiate guidance, 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' published in March 2014 states all

clinical and non- clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three in safeguarding.
- The hospital's safeguarding policy identified the registered manager as the child safeguarding lead. This was inconsistent with what staff told us during the inspection. Staff told us there were two consultants who were child-safeguarding leads.
- The hospital's child and adult protection policies were not comprehensive and did not include guidance on Female Genital Mutilation (FGM) in line with Intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' published in March 2014.

Mandatory training (if this is the main core service report all information on the ward(s) here.

- The hospital offered staff one day of face to face mandatory training. At the time of inspection, the hospital had 60 members of staff, five of which were new starters in September 2017. The 60 members of staff consisted of employed and contracted staff. The registered manager monitored mandatory training rates using an electronic system.
- Data from the organisation showed 50% of staff attended in house mandatory training in June 2017. This included 18 contracted and 11 employed staff. The second part of the training (August 2017) was attended by 16 staff, made up of 11 contracted and five employed staff. The remaining staff had provided evidence of NHS training.
- Hospital managers placed informative posters on the theatre walls to re-enforce messages delivered during mandatory training. The posters provided staff with instructions on advanced life support algorithms, conducting WHO checks, hand washing, and the disposal of clinical waste.

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

- The hospital had clear admission criteria relating to their NHS cataract work. The NHS contract for cataracts excluded higher risk patients including patients younger than 18; those who were pregnant; with a body mass index greater than 45; needing general anaesthetic; patients with severe learning difficulties or who could not lie flat and still for more than 30 minutes. They also excluded certain ophthalmic, cardiovascular and respiratory conditions.
- Clinicians understood the major risks to patients. They categorised the likely risks to patients as: surgery/ injection related complications; the risk of not carrying out safety checks and risks to patient confidentiality.
- Theatre teams used the World Health Organisation (WHO) Surgical Safety Checklist for Cataract Surgery, and five steps to safer surgery checklist, but there was potential to make this more effective. These checklists have been proven to minimise harm to patients in the operating theatre. Checklists were completed, but the operating surgeon did not lead or involve the whole of the theatre team and the patient. We observed one operation where the nurse read out the patient's name instead of asking the patient to identify him or herself.
- We observed in some operations the team did not do the 'stop and check' stages of the process to check understanding and details. This meant there was a risk staff might ask the patient closed questions about their identity or site of surgery or other members of the theatre team would not be fully engaged in the process.
- The theatre team had a briefing meeting (a huddle) at the start of each day to discuss risks and approaches for the patients they would see. They also had a huddle at the end of the day to discuss any learning and action to take.
- Lenses were re-checked prior to implant and a swap and instrument count was completed. They gave the patient antibiotics, completed the WHO sign out and the theatre register. Theatre equipment was cleaned after the patient left.
- We reviewed five sets of notes and saw consultants assessed pre-operative risk in patients, in line with guidance.
- The hospital had a service level agreement with another provider to provide a pathology service. These meant consultants could identify any risks to patients through blood test results prior to surgery.
- Theatre staff monitored patients closely during the operation. They observed the patient's heart rate and blood pressure before surgery started.
- Clinicians were clear about when to escalate issues and transfer patients for treatment. They had an agreement with the local NHS trust and patients requiring transfer

went with a transfer form and a nurse to accompany them. One clinician gave us an example of a patient who he had referred for an urgent angiogram. The hospital did not formally use early warning scores.
- Clinicians minimised risks to patients by carrying out procedures in clinically controlled environments. For example, they used the operating theatre when giving injections to prevent growth of abnormal blood cells to patients with age related macular degeneration.
- There was no sepsis policy or sepsis toolkit. The hospital did not have guidelines about identifying sepsis in patients who arrived for surgery.

Nursing and support staffing

- Bank nurses employed by other NHS providers staffed the operating theatre and admissions process. They received mandatory training at the local NHS trust
- The service had appropriate numbers of staff for theatre sessions. The hospital had 15 full time equivalent posts(FTE) for theatre nurses and four FTE posts for theatre 'runners' (theatre assistants) and health care assistants in April 2017. We observed theatre staffing and there was a consultant, two trained nurses and two runners. One nurse admitted patients and then helped them in the recovery area, and discharged them. This is in line with Royal College of Nursing guidance.
- The hospital made adjustments to ensure patients were protected from avoidable harm. Consultants operated on fewer patients if one nurse was scheduled to attend theatre instead of the usual two nurses.

Medical staffing

- The hospital employed nine consultants through practising privileges. Consultants held clinics on a weekly basis mainly for private or self-funding patients. They held clinics based on need and the number of patients they had. Consultants held specialist clinics based on their skills and experience for example, glaucoma, retina and cataract clinics. The service did not use locum consultants or doctors.
- The service reported no medical staff sickness between April 2016 and March 2017.
- Consultants responded to the out-of- hours telephone helpline, which operated 24 hours a day, seven days a week. The system directed the call to the consultant on duty and if he/she was speaking to another patient or unavailable, the system re-directed the call on a hunt group basis to find a consultant who was available to answer. The consultants were in a position to examine a patient within 30 minutes but they could also ask patients to attend eye casualty at the local trust.

Emergency awareness and training

- The hospital had arrangements in place for business continuity in emergencies. They had an uninterruptible power supply for the new laser and for four electricity sockets in theatre. This meant that treatment would continue in theatre in the event of a power cut.
- The hospital had emergency lighting arrangements to carry patients downstairs on stretchers if the lift did not work. There was hand operated resuscitation equipment in case of a power cut. The landline phone and internet system automatically transferred to mobiles in an emergency.
- Staff conducted monthly fire drills. Fire safety information was visible on the walls of waiting rooms and staff knew their responsibilities and fire safety procedures.
- An external company risk assessed the hospital's new laser installation to ensure it was safe for staff and patients.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The service had clinical audits based on national outcomes and guidance. For example, the service conducted clinical audits against Royal College of Ophthalmologists (RCO) expected outcomes for cataracts alongside other providers. For long term conditions such as glaucoma the service kept a regular follow up pattern to ensure constant monitoring of complex conditions. This also applied to macular degeneration.
- Clinicians kept up to date with best practice and attended Royal College of Ophthalmology meetings. Some carried out research or taught at local hospitals.
- Consultants used best practice to develop services. Clinicians attended conferences and learnt techniques

for difficult cataracts, such as treating seated patients. Consultants attended conferences to improve their knowledge, for example to learn how to improve their techniques for treating watery eyes.

- Consultants followed national guidance when delivering care and treatment. For cosmetic and eyelid operations, consultants followed British Oculo Plastic Surgeons Society guidance. Consultants followed national guidelines on skin cancers and transferred patients to dermatologists at the local NHS trust when necessary.
- The hospital had a non-clinical audit schedule for 2017. This included a WHO Checklist Audit carried out in July 2017, a Medicines Register Audit, Infection Control Audit, Consent Form Audit (July 2017), Clinical Records Audit and Complaints Audit.
- The hospital analysed the results of audits. The WHO checklist audit showed the service was not 100% compliant. patient consent was recorded in 70% of cases, surgical site was marked in 80% of cases and issues such as special notes and allergies, team introductions and swaps and sharps count were 90% complete. The registered manager had emailed nurses to ask them to complete WHO checklists fully. However, the WHO checklist approach should be led by the senior clinician and should involve the whole theatre team.
- The hospital used technology to enhance the delivery of effective care and treatment. We saw how the hospital invested in new accurate diagnostic machines and a high performance laser. This enabled them to monitor patient's eyes and to support them in managing their condition.

Pain relief

- Clinicians monitored patient's levels of pain during surgery. We observed consultants asking patients about levels of pain. However, the hospital had no specific documentation to score pain and staff did not record levels of pain either during or after surgery. Patients told us they experienced little pain during or after their surgery.
- Consultants explained they would bring in an anaesthetist for higher risk patients, but usually they used topical anaesthetic.

Nutrition and hydration

- The patient information booklet for cataract surgery stated patients should have something light to eat and drink before leaving home. There was no formal printed advice for other operations.

Patient outcomes

- The hospital contributed to the national Royal College of Ophthalmologists expected outcomes for cataracts. The hospital displayed outcomes from its 2015 – 2016 audit of the reception area for patients to see, with 88.5% of results within expected range. This is in line with results nationally. The hospital asked patients to attend a follow up appointment if their visual acuity had not improved enough. Nationally, 90% of patients have a visual acuity of zero and the hospital achieved this for 91% of patients.
- The most recent results for the cataract audit (on a monthly rolling average in 2017 from January to August) showed the average complication rate nationally was between 2 and 5% and the hospital complication rate was 0.69%.
- However, the hospital did not have a comprehensive programme of clinical audits because in some specialities the number of patients was too small. Clinicians who treated patients with age related macular degeneration or who needed eyelid operations did not have enough patients at the hospital to have a statistically valid audit for the location, but combined numbers to audit their own practice. However, consultants who operated on eyelid malposition were 95% successful after six weeks.
- Clinicians did not contribute to patient reported outcome measures (QPROMs) for eyelid surgery. They carried out two eyelid operations between April 2016 and September 2017 and they explained this would not be a statistically valid sample. They also contributed to audits of corneal surgery work. This formed part of the total audit of their work, as they worked at other hospitals. This meant they did not record outcomes specifically for Stoneygate. The hospital monitored patient satisfaction as an indicator of patient outcome.
- Some complications of surgery could include a tear at the back of the lens capsule or bleeding inside the eye. If this happened, the service referred the patient to eye casualty at the local NHS trust. The service did not formally monitor this.
- When we inspected, the hospital was preparing to submit data to the Private Healthcare Information

Network (PHIN) in November 2017. The PHIN is a not-for-profit organisation that exists to produce robust comparative information about private healthcare available.
- The hospital planned clinical audits measuring patient outcomes for the future. This included an audit of the outcome of premium lens implants.

Competent staff

- The hospital had policies and procedures regarding consultants practising privileges. The organisation expected consultant anaesthetists and ophthalmologists to provide copies of their regular appraisal, training and development, professional registration and indemnity on an annual basis. Consultants informed the hospital immediately if they were under evaluation or investigation at any time. The organisation reviewed fitness to practise monthly for all consultants.
- The service had procedures for managing poor performance. The organisation used the Medical Advisory Committee (MAC) meetings to discuss poor performance should it be necessary to do so or if there has been any cause for concern.
- The hospital ensured consultants working under practising privileges had the skills and competencies for their roles. For example, all consultants employed had skills and experience in a range of eye conditions and performed similar work in a local NHS trust.
- We heard how new clinicians worked with more experienced consultants before carrying out surgery on their own. They were clinically supervised during their induction period.
- Everyone in the organisation received advanced customer care training, including consultants. If a patient complained about rudeness, the registered manager investigated in a one to one meeting with the person concerned.
- For nurses who worked on a bank basis, the hospital was dependent on receiving details of their mandatory training and appraisals from the local NHS trust. Data from the organisation said they had received 40% of appraisal documents between April 2017 and September 2017. However when we reviewed staff files we saw no evidence of nursing staff appraisal documents. Therefore, we could not be assured staff received meaningful appraisals
- Arrangements to assess performance and to help staff to develop were not structured. The hospital did not have a competency framework linked to strategic aims and objectives.

Multidisciplinary working

- Consultants also worked at the local NHS trust so they had a range of professional contacts there if they needed to refer patients on, for example for examination or diagnostics in a speciality other than ophthalmology. They asked patients to go to eye casualty at the local NHS trust if there was a need for urgent treatment. If consultants suspected eye/skin cancer, they referred the patient to the multidisciplinary team at the local NHS trust.
- The hospital made timely arrangements to transfer patients who needed immediate review. We observed consultants arranging to transfer a patient with serious eye problems to eye casualty at the local NHS trust. The hospital had transfer forms to ensure that transferred patients were prioritised but theyl could not show us any formal agreements or transfer policies.
- The hospital worked well with local GPs, however there were occasional problems with patients running out of medication.
- The hospital arranged follow up appointments for patients and informed their GP of treatment. We saw staff documented this on a treatment plan.

Seven-day services (only if this is provided, if it is a day surgery service please remove this subheading)

- The hospital had a 24 hour, seven days a week telephone helpline. Patients could call the consultant on duty and if they were speaking to another patient, then the system would divert the patient to another consultant on a hunt group basis. If the consultant identified a problem, they saw the patient as soon as possible for examination at the hospital.

Access to information

- Consultants communicated patient discharge to GPs primarily by letter. These included care summaries to ensure continuity of care within the community. Where urgent contact with GPs was required, consultants telephoned GPs directly. Consultants dictated letters to hospital administrative staff who typed the letters the same or following day. The hospital did not audit or review the timeliness of letters sent to GPs.

Requires improvement

Surgery

- Consultants had appropriate procedures to share information with other providers when patients moved between services. Consultants used a range of methods including telephone, email, letter and fax to ensure other providers had access to information about patients.
- The hospital had electronic procedures to ensure medical records generated by staff holding practising privileges were available to staff (or other providers). Staff scanned paper records onto an electronic system used by other NHS providers. A third party organisation based at the hospital provided this service.
- Staff had access to records and policies to deliver effective care. When we asked staff about policies and procedures, they knew where to find them, and they had timely access to patient records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants ensured they explained the surgical procedures to patients, and a copy of the consent form was included in the cataract surgery booklet, which the service issued to patients in advance of the operation.
- Patients having eyelid surgery had at least two weeks to consider their consent. Consultants carried out eyelid surgery for therapeutic reasons, because infected eyelids could compromise cataract or other eye surgery, so this needed treating first. For this sort of surgery, consultants were careful to discuss patient's expectations in detail.
- For patients living with dementia, it was more complicated to get informed consent. Due to the levels of risk presented by these patients, consultants transferred them to the care of the local NHS trust where they could have a general anaesthetic and an overnight stay. This limited the anxiety for the patient and the risk of unexpected movement.
- Many patients in the local population were Gujarati speakers, a language spoken by most of the consultants. They could explain the surgery and consent these patients in Gujarati if needed. For the NHS cataract service, the service could access a telephone interpreting service for patients if they needed it. This was not available to private patients.
- Mandatory training at the hospital included the Mental Capacity Act, Deprivation of Liberty Safeguards and dementia awareness training.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- In May 2017 93% of patients responded that they would recommend the service to Friends and Family, 98% in June 2017 and 99% in July 2017. The response rate was not high but improving. The hospital had an 11 - 15% response rate between April and June 2017. In July, the patient response rate increased to 45%.
- Patients we spoke with were very pleased with their cataract surgery. They found the nurses and doctors to be compassionate and patient. Patients reported very little pain, and that staff told them what to expect and what was happening. Patients we spoke with were pleased with the results and felt that their sight had vastly improved.
- We observed two operations. The operating surgeon and their team reassured the patient frequently during the operation and asked the patient several times if they were okay. If there was any sign of discomfort, they showed compassion and offered pain relief. We observed a nurse holding a patient's hand during one procedure.
- Patients were fully clothed for their operations, and did not need to bring a change of clothes. This preserved patient dignity.
- We did not observe staff offering patients a chaperone at any point during the inspection. The hospital did not have posters advertising chaperones in waiting areas or clinic rooms. We raised this with managers at the hospital. The hospital responded by ensuring they displayed chaperone posters in reception, waiting areas and consulting rooms.

Understanding and involvement of patients and those close to them

- Staff informed private patients about possible costs when they first enquired on the telephone. The hospital did not have any complaints about misunderstood costs. Consultants and nurses took time to explain

surgery to patients and gave them time to ask questions. They checked that patients had transport home. Where patients had to wait, nurses apologised to patients.
- We observed a nurse giving a bag of eye drops, saline and gauze to patients. This included instructions, emergency contacts and a GP discharge letter, prescription letter and list of NHS follow up providers. The nurse gave a good, easy to understand explanation and checked the patient's understanding of how to self-care for their eye after the operation.

Emotional support

- We heard how consultants offered glaucoma patients emotional and lifestyle support throughout the development of their condition.
- The service did not have access to counselling services.

Are surgery services responsive?

Requires improvement

We rated responsive as **requires improvement.**

Service planning and delivery to meet the needs of local people

- Commissioners contracted the hospital to deliver the NHS cataract service to meet local need. There were regular contract monitoring meetings between the commissioner and hospital staff, which dealt with for example, capacity planning issues.
- The hospital was a light, bright two-storey building. The décor was fresh and modern in the public areas, and the reception area had adequate seating and a coffee machine. There was a lift between the ground and first floor. There were recent improvements to facilities including a second high specification laminar flow operating theatre, a newly fitted recovery room and automatic doors.
- The location of the hospital was convenient for patients and on a bus route. The service tried to make the most of its small car park by staggering appointment times where possible.
- The service offered flexibility, choice and continuity of care. Patients had a choice of clinic and surgery times, and the hospital offered evening surgery and clinic times for patients who could only get transport at these times.

Access and flow

- During the inspection, the waiting room appeared very busy partly because surgery was running late and a number of patients were invited to attend at similar times. Treatment was centred on individual patients and the admitting nurse discharged a patient before admitting a new patient. This ensured that patients received necessary treatment and attention before they left.
- NHS cataract patients did not have long waiting list times. The hospital monitored the referral to treatment times (RTT) for NHS patients. In 2017 patients had to wait nine to ten weeks for surgery. Data from the July hospital and commissioner operational meeting minutes showed RTT wait times for first appointment reduced in June to 20.6 days (previously 27.1 in May 2017) and 61.0 days for surgery (previously 69.9 in May 2017). However, the theatre figure was still above the contracted target of 56 days. The hospital did not monitor waiting list times to surgery for private patients.
- The hospital did not inform patients of any delays to their appointments once they had arrived in the waiting area. Although the hospital staggered appointments, theatre sessions and clinics did not always run on time. Appointments could run up to two hours late. Staff did not inform patients about the extent of the delay. This meant that patients could not leave the premises to do anything else and did not have enough information to re-arrange their transport home. We informed the hospital about this and during our unannounced inspection, we saw staff informing patients about delays.
- On discharge, staff gave patients contact details for the operating surgeon and matron. The service had an out of hours telephone advice service operated on a rota system, which transferred telephone calls to the duty consultant. This enabled patients to seek advice outside of clinic hours.
- The hospital very rarely cancelled surgery.

Meeting people's individual needs

Requires improvement

Surgery

- Staff informed patients during their first telephone call of any potential charges for surgery. The service's leaflets and letters to patients stated charges for the surgery where this applied.
- Consultants used an interactive display screen with patients to illustrate and explain procedures. This was available in a variety of languages.
- The service had a range of informative leaflets but these were not immediately available in suitable formats, for example in languages, other than English. Patients could request them. A cataract surgery information booklet and had a range of informative leaflets about eye conditions on display in reception. Large print versions were available for some conditions and for cataract surgery, if patients specifically requested them.
- Post operation information sheets were available for cataract surgery, eyelid surgery and after retinal injections. This information contained 'dos and don'ts' and information for the on-call consultant and services at local NHS trusts, for example eye casualty.
- The hospital ensured continuity of patient care. After their operation, patients came in for a follow up appointment. If the hospital carried out an operation on a patient transferred from the local NHS trust, they ensured that they sent regular updates of progress.
- The hospital adapted care for patients with claustrophobia. They had a clear towel to put over patients faces while surgery was under way to make the environment seem less enclosed.
- The service tried as much as possible to meet patient's needs but if patients had high clinical risks then service referred them on to the local NHS. This was because the hospital did not have specialist equipment such as hoists. Staff discussed patients with complex needs in their team brief at the beginning of the day. They would ensure that any patients with complex needs would have their surgery or treatment at the start of the theatre list, to minimise delay or distress.
- The hospital gave patients information, informing them they should not drive after a pre-operative eye drops dilating pupils, and that they should not drive immediately after a cataract operation. It recommended that patients brought someone with them to drive them home. If patients had a retinal injection, consultants advised them not to drive for 72 hours. Staff advised them to get someone to fetch them from the clinic. Nurses always checked whether this was the case, and if not, they organised a taxi for the patient.
- Nurses offered patients tea and a biscuit when they were in the recovery room after their operation. When we inspected, the hospital was reviewing this and the possibility of offering more choice of refreshments and snacks to patients.
- Staff could access translation services through a third party provider for NHS patients. Translation services were not available to private patients therefore consultants used other members of staff, including cleaning staff, or patient relatives to act as translators. This was not in line with best practice and it meant there was a risk that people without clinical experience or knowledge would relay clinical information to patients.
- Signs in the hospital were small and difficult for patients with visual impairments to see. It did have signage which conformed to visually impaired patients interest group guidance such as black print on a yellow background with large fonts. We discussed this with the hospital and they arranged for a local representative group for people with visual impairments to advise them about the signage.

Learning from complaints and concerns

- The complaints system was easy to use. The service had a compliment, comments and complaints leaflet which explained the official complaint process, what to expect and how patients could refer their complaint to the General Medical Council if needed. Patients we spoke with were confident that they would know how to complain.
- The organisation had a complaints policy and a clear process for handling complaints. The medical director oversaw the investigation of complaints and supported by the registered manager. The registered manager conducted the complaint investigations and ensured that attendees at the Medical Advisory Committee (MAC) meetings discussed and learnt from the complaints. The registered manager displayed any learning on staff noticeboards providing this did not conflict with confidentiality.
- There were four official complaints received in the period from April 2016 to March 2017. No complaints were referred to the Ombudsman. The complaints concerned issues such as consultant rudeness, length of wait for a private operation, and GPs complaining about lack of communication from the clinic about patient discharge. The registered manager explained that relevant staff had received training as a result.

Requires improvement

Surgery

- The complaints procedure did not differentiate between adults and children. Children aged 16 or 17 were assumed to have the same capacity as an adult. There was a time limit of 12 months in which to complain, but at the discretion of the management of the organisation.

Are surgery services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership / culture of service related to this core service

- There was strong clinical leadership within the organisation. The daily clinical activity and direction of the organisation was consultant led. A practice manager (the registered manager) led the operational elements of hospital activity including the management of administrative staff. Staff told us the registered manager was well regarded and approachable
- Staff told us they enjoyed working at the hospital. Clinicians expressed a desire to promote wellbeing and to work with other staff. They had joint social events. Employees worked to promote themselves and the hospital to the wider community.
- However, the hospital had grown in size and activity without the management structure to support this. The registered manager had many governance and administrative related responsibilities, some of which had not been formalised. This meant in the absence of the registered manager, there was a lack of leadership and specialist management knowledge, which made the organisation less resilient. In response to this, the hospital started to develop new ideas for recruitment of leaders on the non-clinical side.

Vision and strategy for this core service

- The hospital had a vision 'To be the Centre of Excellence for Eye Care in the East Midlands providing urgent care within 24 hours wherever possible, routine clinical care, investigations and day care surgical procedures for various eye conditions.'
- Its mission statement was 'To offer very high quality service at the only dedicated eye surgical centre in the East Midlands for insured and at affordable prices for self-funding patients. Local teaching hospital eye consultants will be using some of the most advanced equipment in the region to provide clinical investigations and surgical procedures to exceptional standards.'
- The hospital did not have clearly defined aims and objectives or a medium to long term strategic plan with limited action planning for quality improvement, safety or responsiveness. Clinicians had plans to expand facilities and to start laser surgery but there were no supporting project plans or action plans, or formal arrangements to monitor the progress of plans.
- The hospital had four values it promoted to staff: committed, approachable, respective and exceptional. We saw staff work to these values by being friendly, approachable and committed to delivering the best care they could for patients.

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

- The hospital had a basic management structure to support the day-to-day running of the hospital. A medical director had overall oversight supported by the practice manager, an account manager and one deputy. A part-time matron who worked one day a week had oversight of nursing staff. The practice manager acted as line manager to other administrative and reception staff.
- Performance management and risk management were not embedded in the organisation but were the practice manager's responsibility. In the absence of the practice manager other senior members of staff did not know about risk assessments, procedures and policies.
- The hospital had a business plan to support the running of the hospital. The hospital had identified threats and weakness as part of their business plan, however there was no action plan to identify how to address them.
- The hospital did not have its own comprehensive competency framework and appraisal system. We reviewed the files and there was an appraisal for the matron, but not for three nurses. Where we found personal objectives in staff files, staff had linked them to the values of the local NHS trust.
- The hospital did not have a medium to long term strategic plan with aims and objectives or specific quality plans. This limited what could be cascaded

down to staff as personal objectives. As a result, the organisation could not base its individual performance and development review on commonly understood Stoneygate organisational goals.

- There was a medical advisory committee (MAC) meeting held approximately every three months. These meetings reviewed audits of medical notes, incidents and the ongoing cataracts audits, and they made decisions about new treatments together.
- The hospital had a systematic programme of internal audit but clinical audits were limited to cataract outcomes under the NHS contract. It did not audit other forms of eye surgery because the numbers involved were too small to be statistically valid. Instead, individual consultants combined outcomes of the hospital patients with other patients to audit their own practice.
- In addition to the MAC meeting, the hospital used meetings to support and undertake quality and risk monitoring. The hospital had a clinical governance committee that reviewed complaints and incidents and discussed feedback from staff meetings. The practice manger reviewed and took responsibility for an action log which recorded actions identified and progress against them. However, we saw very little discussion regarding hospital performance and quality measurement. Hospital staff team meetings were very business orientated focussing on business priorities rather than risks and the quality of services.
- There was no overall assurance system. Some aspects of performance, for example, referral to treatment times, were measured as part of the NHS cataracts contract arrangements. The hospital did not have its own dashboards, targets or measures for safety, quality or responsiveness. For example, it did not openly report trends in infection rates or patient in-clinic waiting times. It did not measure performance for private patients. The hospital put measures in place to audit the WHO checklist and handwashing monthly. However, managers did not report these findings openly on a dashboard.
- Arrangements for identifying, recording and managing risks were not robust. The hospital did not have a comprehensive risk register. It had a risk register for the NHS cataract work and a premises risk assessment, but did not have an overarching risk register which covered all organisational risks, such as the risks we identified regarding medicines management, outlined in the safe section of the outpatient's report.
- The hospital had not fully tailored their policies to reflect their activities. The hospital had a range of policies to offer staff guidance on 'how to do'. These included Management of outbreaks, Incident reporting, Complaints , Access to Medical Records, Medicines Management, Patient Dignity, Vulnerable Adults and Child Protection Chaperones and Consent. We found, for example, that managers did not follow the Medicines Management Policy.
- The hospital acknowledged that they did not have a clear policy or understanding on the Fit and Proper Persons Requirement for directors and implemented a policy in response to our inspection feedback. When we inspected, not all checks were in place to meet this requirement when we reviewed files. A number of checks were missing which we requested, for example the search of insolvency and bankruptcy, or information about capacity to lead. Managers provided the inspection team with some checks but managers completed these on the day of the inspection.
- The hospital employed consultants employed under practising privileges. They had to provide copies of documents such as their regular appraisal, training and development, professional registration and indemnity annually. They all had enhanced disclosure and barring service (DBS) checks in place. However, the consultant recruitment file had some gaps. For example, not all files contained references from the most recent job; and one file did not contain evidence of professional registration.
- The provider held public liability, employer's liability and corporate indemnity insurance. Each partner held professional indemnity on a personal basis as a consultant ophthalmic surgeon, licensed by the General Medical Council (GMC).
- Workforce Race Equality Scheme legislation applied to the hospital, because its income from the NHS was over a certain threshold. The hospital was not aware of this and had not submitted a return detailing the composition of its workforce. When we informed the hospital about this they took action immediately to meet the requirement.
- The hospital had service level agreements to manage working arrangements with partners and third party

providers. For example, it had a service level agreement with a commissioner for cataract surgery. There were monthly contract monitoring meetings, which included discussing incidents, complaints and patient feedback.

Public and staff engagement (local and service level if this is the main core service)

- The hospital reported their Friends and Family Scores to their commissioners. They had an 11 - 15% response rate between April and June 2017. In July, the patient response rate increased to 45%. This demonstrated increased engagement with patients.
- The service used feedback questionnaires to obtain patient feedback from both NHS and self-funding patients. The service provided pre-paid envelopes to encourage patients to respond.The service discussed patient feedback with commissioners and identified actions such as providing a wider range of food and refreshments post treatment. Data from the July 2017 meeting with commissioners showed feedback rates had reduced from 15% to 11% between May 2017 and June 2017. The commissioned target was 25%.
- The service responded to patient views. They installed a larger waiting area, different seating and alternative refreshments in response to patient feedback.
- The hospital surveyed staff every year. Feedback from the 2017 survey, still to be formally analysed was generally positive. The 2016 staff survey resulted in several staff suggestions for improvement. For example: ‘ a better quality of re-usable instruments, a drawer to keep unit pack instrument in, widening the theatre room, better lighting, more accurate consultant times, proper washable theatre shoes, proper theatre register with patient time in and out, would like to see soap dispensers at all sinks.
- In response to the 2016 staff survey, hospital managers arranged for the implementation of additional sinks and hand gel dispensers. This helped develop a new clean preparation area. In addition the hospital built a larger second theatre, fitted LED lighting from suspended ceilings to reduce the occurrence of blown bulbs. The hospital introduced new ordering processes for staff uniforms and footwear, larger waiting and recovery areas and improved communication by installing a staff notice board for up to date information.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The service was keen to innovate and bought the most recent diagnostic equipment so consultants could monitor eye disease in patients with the best accuracy. In addition, the hospital had plans to install a new corneal laser. This enabled the service to better support patients with degenerative eye conditions through lifestyle advice.
- In addition, the hospital looked to improve its own systems and process. The hospital was introducing a computer system to improve stock control and track instruments, which would ensure that the right instruments, equipment and medication were available at the right time.

Not sufficient evidence to rate

Services for children and young people

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

Are services for children and young people safe?

Not sufficient evidence to rate

The hospital did not routinely see children or young people. One operation was carried out on a child between April 2016 and March 2017. There was one child who had an operation. Outpatient services saw 17 children between April 2016 and March 2017. These patients received topical eye treatment only. All children attended with their parents and clinicians described their outpatient treatment in terms of sight problems, eye allergies and blepharitis. The hospital sent written confirmation that they ceased all work regarding children and young people on 25 September 2017.

Incidents

- Never Events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The service reported no Never Events between April 2016 and March 2017.
- There had been no incidents for the period April 2016 to March 2017.
- For further information on incidents please refer to the surgery and outpatients reports.

Cleanliness, infection control and hygiene

- For information on cleanliness, infection control and hygiene please refer to the surgery and outpatients reports.

Environment and equipment

- The environment had not been risk assessed for children. Risks to children included the automatic door, coffee machine and unrestricted windows on the first floor. We discussed the windows with the hospital and they arranged to install restrictors.
- We reviewed the resuscitation trolley in the recovery room. It lacked size two in its set of paediatric airway devices, did not have a size one oropharyngeal (throat) airway and did not have the appropriate size cannulas for children (24G).
- Some items in the resuscitation trolley were out of date or in damaged packaging. We found two paediatric masks with split packaging and two transfusion sets with April 2017 expiry dates. Staff we spoke with did not know hospital procedures for escalating stock issues or processes for replacing them.

Medicines

- The hospital did not have any formal dosage or prescription guidance for children.
- For our detailed findings on medicines please see the Safe section in the surgery and outpatients reports.

Records

- We reviewed 13 sets of children's medical records. Consultant's writing was illegible for five records and there was no signature for three records. This was not in line with general medical council (GMC) standards. In five records, 'about you' forms were completed but one lacked detail about next of kin.

Safeguarding

- There had been no safeguarding incidents at the hospital since it was established.

Not sufficient evidence to rate

Services for children and young people

- Intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' published in March 2014 sets out non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers should be trained to level two in child safeguarding. It also states all clinical and non- clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three in safeguarding.
- Data from the hospital showed 11 members of staff (including consultants) were trained to Level three and 45 members of staff trained to level two. Therefore there were enough members of staff with the appropriate levels of safeguarding training.
- The hospital had two consultant ophthalmologists who led on child safeguarding. However, the safeguarding policy identified the practice manager as the safeguarding lead. Staff we spoke with all identified the two consultants as their safeguarding leads. However, they said they would normally escalate any concerns through the practice manager.
- Staff had safeguarding processes in place for children who did not attend clinics. Staff knew what the processes were and what to do if a child did not attend an appointment. Staff would send a letter on the first occasion and on the second contact, the appropriate authorities and agencies involved with the patients care.
- The hospital's child protection policy did not include action to take on female genital mutilation (FGM) and one consultant did not know what to do about it. There had been no specific awareness raising or training.
- There were no alerts or flagging systems to identify children with special requirements (for example learning disabilities) or the care status of children, for example if they were looked after children.

Mandatory training

- For further details of mandatory training, please refer to the main core service report (surgery).

Nursing staffing

- The hospital did not have a paediatric trained nurse on duty when children attended clinic. The hospital had not assessed nurse staffing for children's clinics. However outpatient clinics were consultant led and nurses were not present.

Medical staffing

- The hospital employed nine consultants through practising privileges. Consultants held clinics on a weekly basis mainly for private or self-funding patients. Consultants were experienced in treating children and young people through their work in NHS settings.

Emergency awareness and training

- For further details of mandatory training, please refer to the main core service report (surgery).

Are services for children and young people effective?

Not sufficient evidence to rate

We did not rate effective for services for children and young people.

Evidence-based care and treatment

- No national audits were carried out specifically for children
- For further information on evidence based care and treatment see the surgery report.

Pain relief

- If children needed treatment, consultant anaesthetists with advanced paediatric life support training were booked to ensure adequate anaesthetic services. Seven consultant surgeons were also advanced life support trained. The hospital ceased children's surgery services in September 2017 after our inspection.

Nutrition and hydration

- For information on nutrition and hydration please refer to the outpatients and surgery reports.

Patient outcomes

- The hospital did not record any specific clinical outcomes for children.

Competent staff

- Two members of staff were trained in paediatric basic life support/paediatric intermediate life support or equivalent. Two members of staff were trained to advanced paediatric life support (APLS) level or

Not sufficient evidence to rate

Services for children and young people

equivalent. Consultant anaesthetists were on site for children's bookings for treatment. After we inspected, the hospital arranged to train all nurses in intermediate life support.

Multidisciplinary working

- For further information on multidisciplinary working, please refer to the surgery and outpatient reports.

Access to information

- For further information on access to information working, refer to the surgery and outpatient reports.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants assessed the competency of young people over 16 to give their own consent. Consultants did not see children under 16 without parental consent and supervision. The hospital used consent forms to record the consent of parents and young people.

Are services for children and young people caring?

Not sufficient evidence to rate

We did not rate caring for services for children and young people.

Compassionate care

- We did not observe any care of children and were not able to contact any parents. We reviewed six records of children's care and noticed that patients brought a younger sibling to the hospital after the first child had received successful treatment. The patient notes we reviewed indicated a positive and compassionate relationship between consultants and child patients and their parents.
- In general, staff displayed a supportive attitude to patients and put their needs first. All staff enquired whether patients wanted a drink and were comfortable.. We observed consultants encouraging and supporting patients during clinics, especially during eye examinations. Patients we spoke with all said they felt staff were caring and staff were quick to meet their care needs.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a way, which enabled patients to understand what was happening about their care and treatment. We saw consultants telling patients what tests they were undertaking and why they were necessary. They explained to patients in simple terms any complicated or technical terms. Consultants gave patients plenty of time to ask questions and checked with patients they had understood what consultants told them.

Emotional support

- Staff understood the impact care, treatment or the condition had on patient wellbeing and on those close to them, both emotionally and socially. We saw in children's medical notes that consultants were supportive about child allergy-related eye conditions.

Are services for children and young people responsive?

Not sufficient evidence to rate

We did not rate responsive for services for children and young people

Service planning and delivery to meet the needs of local people

- The hospital had no service plan for children. They undertook surgery for one child and outpatient consultations for 17 others between April 2016 and March 2017. Most of these children were aged three to 15 years. The service had no designated facilities for children or young people.
- The hospital environment was not tailored to children. There were no rooms which were decorated in a child friendly way. Children were seen in the same consulting rooms and theatres as adults, and shared a waiting area. There were no toys for smaller children who were patients or who were accompanying older relatives.
- The service offered clinics at a variety of times throughout the day, evenings and weekends to fit in

Not sufficient evidence to rate

Services for children and young people

with local people's needs. The hospital offered most of the appointments during evenings and Saturdays so young people could access appointments out of school time.

- The hospital did not have any admission criteria for children.
- The hospital informed us that from 25 September 2017 they were no longer treating or seeing children and young people for surgical or outpatient appointments. The hospital said children and young people formed such a small part of their activity it meant it was not financially viable.

Access and flow

- There were 4,002 outpatient total attendances in the reporting period April 2016 to March 2017. Seventeen of these appointments were for children and young people.
- The hospital did not record waiting list (referral to treatment) times for children. However, the hospital did not see or treat a large proportion of children.
- The service had a children's pathway document which was a procedure for staff to refer to other services.

Meeting people's individual needs

- The hospital had pictorial vision charts for children who could not identify letters.
- There were no age appropriate toys, activities or books to keep children and young people amused while they were waiting for their clinic appointment.

Learning from complaints and concerns

- The hospital had not received any complaints involving children from April 2016 to March 2017.
- For further information on complaints and concerns, please refer to the surgery report.

Are services for children and young people well-led?

Not sufficient evidence to rate

We did not rate well-led

Leadership and culture of service

- For information on leadership and culture of the service please refer to the surgery report.

Vision and strategy for this core service

- The hospital did not have a strategic plan for children and young people. There was no specific service plan or action plan to develop child friendly facilities.
- For further information on vision and strategy, please refer to the surgery report.

Governance, risk management and quality measurement

- The hospital did not have formal risk assessments for children's outpatient services. Managers did not refer or discuss services for children and young people during governance and performance meetings.
- The hospital evidenced the suitability of clinicians to treat children, for example, all clinician had level 3 safeguarding and enhanced disclosure and barring service records on file.
- For more information on governance, risk management and quality measurement please refer to the surgery report.

Public and staff engagement

- The hospital sought feedback from children and young people using patient feedback forms.
- For information on public and staff engagement please refer to the surgery and outpatients reports.

Innovation, improvement and sustainability

- For information on innovation, improvement and sustainability, please refer to the surgery report.

Requires improvement

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The service reported no never events between April 2016 and March 2017.
- For the period April 2016 to March 2017, staff reported one non-clinical incident for outpatient services. This concerned a patient whose chair slipped while they were leaning forward for a diagnostic eye test.The registered manager conducted a root cause analysis and ensured the hospital fitted locking castors on chairs in the diagnostic room. These kept patients in a stable position during examination.
- The outpatient service did not report any clinical incidents, serious incidents, injuries or patient deaths for the same period.
- The hospital had an incident management policy, which outlined the arrangements for reporting, managing and learning from incidents arising from any activities undertaken by employed staff. Staff reported incidents using paper-based and electronic reporting systems including incident forms. Managers had not yet trained all staff on the electronic system at the time of inspection. The practice manager investigated all reported incidents.
- Managers and clinicians reviewed and investigated incidents appropriately. Staff said they raised concerns immediately and the practice manager investigated the issue and kept records. Clinicians or the hospital matron investigated clinical incidents and made changes to practice if necessary.
- Consultants and managers discussed learning from incidents at the medical advisory committee (MAC). We saw incidents were a standard agenda item for MAC meetings. We saw managers also discussed incidents and any learning with commissioners at operational governance meetings.
- The majority of outpatient staff we spoke with did not know about incidents occurring within the service or about any learning resulting from them. Hospital consultants said they did not share learning with some staff, for example administrative staff.

Duty of Candour

- The duty of candour is a regulatory duty requiring providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- The service reported no notifiable safety incidents, which triggered the duty of candour. Clinicians explained the hospital apologised to patients and explained what had gone wrong and tried to put things right. They would also write a formal letter to the patient. However, three out of four staff we spoke with did not know about the duty of candour or its principles.

Requires improvement

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- The service had reported no incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C Difficile) or Methicillin -sensitive Staphylococcus Aureus (MSSA) in the reporting period between April 2016 and March 2017. MRSA, MSSA and C.difficile are all infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.Difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics.
- Between April 2016 and March 2017 the service reported no incidents of acquired Escherichia coli (E.coli). E.coli is a bacteria that can cause infections in the body.
- The hospital commissioned an independent infection control audit of clinic rooms and the environment. The audit aimed to identify any areas where the department were not meeting national standards and guidance. Results from the audit showed the department had met national standards for cleanliness.
- Results from the June 2017 hand washing audit showed all staff had met all hospital requirements for hand washing.
- The environment was visibly clean. The hospital had clear cleaning schedules and procedures including different coloured mops for different areas to reduce the spread of germs and bacteria. Staff cleaned consulting rooms, toilets and waiting areas daily. Domestic staff undertook weekly and daily cleaning checks. We saw staff completed records of checks.
- Hand gel was available at the entrance to clinics, consulting rooms and in the waiting areas. We observed staff using the gel to clean their hands in accordance with hospital policy and good practice guidelines, for example National Institute for Health and Care Excellence (NICE) QS61 statement three: staff cleaning hands before and after each episode of care.
- We observed all staff were bare below the elbow, in keeping with hospital policy to help prevent the spread of infection.
- Consultants had infection control procedures to reduce the risk and spread of infection including cleaning equipment such as slip lamps in between patient appointments. We observed consultants cleaning their equipment in between patient appointments.

Environment and equipment

- The environment was appropriate for delivering safe care and treatment. The environment was well lit and uncluttered. Consulting rooms were organised and were appropriate for private conversations. Equipment was stored in appropriately sized rooms allowing staff to move and freely examine patients. The hospital had the latest up to date equipment to support delivering safe patient care.
- However, we saw windows did not have restrictors on them in one upstairs consulting room and upstairs waiting area. The Workplace (Health, Safety and Welfare) Regulations 1992, regulation 15 states, “Where there is a risk of falling from height, the approved code of practice (ACOP) requires provision of devices that prevent the window opening too far (for example window restrictors).” This meant staff and patients could be at risk of falling accidentally or through acts of self-harm. In response to our findings, the hospital fitted restrictors onto the windows within a fortnight.
- The hospital had procedures in place to check, test and service equipment. The hospital used external companies to check and test all equipment. We saw the hospital monitored and managed service level agreements (SLA) with these companies. We checked ten pieces of equipment. All equipment had been tested and checked in accordance with hospital policies. Consultants calibrated diagnostic equipment daily.
- The hospital had arrangements for safely managing clinical waste. We saw sharps bins labelled, initialled and dated in accordance national guidance. Staff disposed of clinical waste in dedicated colour coded bags in the dirty utility. At the end of each day staff disposed of the clinical waste bags in dedicated bins outside. Staff locked the bins and placed them inside a locked garage.
- Staff had access to resuscitation equipment located in the theatre recovery area. For further information on resuscitation equipment, please see the surgery report.

Medicines

- Staff stored eye drops in all consulting rooms in labelled drawers. Hospital policy stated staff should lock unattended rooms, including overnight. We saw staff locked clinic rooms at the end of clinics and overnight. However, we observed consultants leave clinic rooms unlocked during busy clinic sessions. This meant

patients or members of the public could access the rooms and access eye drops. We raised this with managers at the hospital and in response, we saw they had purchased lockable trolleys and drugs storage for consulting rooms.

- We checked 59 boxes of eye drops and eye solution. All boxes we checked were in date.
- The service did not conduct an outpatient survey asking patients whether staff explained medicines or eye drops, side effects or reasons for changing medication. However, we observed consultants explaining the reason or medications, possible side effects and reasons for changing the type of eye drops. For example using steroid eye drops could cause other conditions affecting the eye such as glaucoma. Therefore consultants changed types of eye drops to reduce the risk to the patient.
- Staff did not store medicines in a safe and appropriate manner. On our unannounced inspection, we observed a red drugs bag on top of the resuscitation trolley. This bag was not lockable and contained drugs for emergency use such as adrenalin, salbutamol, adult and child epipens, atropine and nifedidine. Patients used the recovery room, and sometimes nurses were not present. This meant there was a risk patients could access medications unsupervised. We pointed this out to the hospital and they arranged to lock the bag away when nurses were not in the room. .
- The hospital did not have fully developed governance arrangements relating to who could give medications. Nurses administered dilating and anaesthetic drops to patients waiting for their operation. The medicines policy stated a valid prescription was required unless there was a local procedure, which directed otherwise. We found no patient group direction within the policy. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. We raised this with clinicians and in response, they showed us their eye dilating regime form. The form specified how many and how often different types of eye drops should be administered.
- Staff did not issue prescriptions in an auditable way, because there were several prescription pads and staff did not log consecutive serial numbers. This meant there was no effective failsafe to ensure that the prescription issue system was not abused.
- In response to these findings, the hospital gave the matron and a consultant responsibility for medicines management and for developing improved prescription and medication control. In addition, the hospital were arranging weekly support from a pharmacist to help with this.

Records

- The service had processes and procedures to ensure records were complete and available on time for clinics. Staff prepared the records up to a week in advance of clinics and ensured all relevant paperwork was present in the records. Prior to clinics records were stored in a locked cabinet.
- The service monitored the number of patients seen without their medical records present. For the period April 2016 to March 2017 the service reported 100% of patents seen at clinics with their medical records present.
- The service said they did not permit case notes to leave the hospital. We observed staff stored patient records in locked rooms when not required for clinics. If case notes went missing, then staff said they would follow the incident pathway. Staff could produce temporary sets of notes for NHS patients, as records were also stored electronically.
- During clinics we observed staff did not always ensure records were secure or confidential. Staff kept patient records on the hospital reception desk faced down (to hide patient details). The reception desk was staffed the majority of the time. However we saw occasions where the receptionist had to leave the desk, for example visiting the toilet. The reception area did not have lockable cabinets for storing patient records meaning there was a risk staff could leave records unattended. We observed consultants leaving patient records in consulting rooms unlocked and unattended which meant patient records were not secure during the time they were out of the consulting room.
- The hospital had processes to ensure staff working in other providers could see medical records generated by hospital staff. Where consultants treated NHS patients, staff submitted records to the contracting NHS provider who had a system to share documentation to other NHS providers electronically.
- We reviewed five sets of patient records. Four out of five we reviewed were either not legible, signed, or dated in line with general medical council (GMC) standards.

Requires improvement

Outpatients and diagnostic imaging

- All patient records we reviewed contained patient risk assessments, records of appointments and preoperative assessments. All the sets were in chronological order meaning the most recent clinic appointment was at the front of the notes.
- The service conducted audits of the quality of their records. Audits provided by the hospital demonstrated records met hospital standards. An audit for June 2017 showed a sampling of 10 patient records. Nine out of the 10 records were complete and contained all necessary information. The audits showed there was no evidence consultants had assessed the patient medical questionnaire in one patient record.
- The outpatient service had procedures to dispose of confidential waste. Staff used cross shredders, which ensured confidential information could not be visible, or seen by other patients or members of the public. Staff placed the waste in bags and in a locked bin outside the premises.

Safeguarding

- The hospital had clear guidance and processes on safeguarding vulnerable adults and children. The service reported no safeguarding concerns to CQC for the period April 2016 to March 2017. The service had two consultant ophthalmologists as safeguarding leads for adults, children and young people. However, this was contradictory to the hospital safeguarding policy which identified the registered manager as the safeguarding lead.
- All staff we spoke with identified the two consultants as their safeguarding leads and the processes to report any concerns. Staff also said they would report concerns to the practice manager (registered manager). Safeguarding procedures were visible behind the reception desk and in staff areas of the hospital.
- The service trained administrative staff in level two safeguarding using an external provider and formed part of the yearly mandatory training update.

Mandatory training

- Staff received mandatory training yearly and attended training days which included fire safety, customer service, basic life support (BLS) and safeguarding. The practice manager had responsibility for ensuring all staff attended the training. All staff we spoke with said they had attended mandatory training
- For further details of mandatory training, please refer to the main core service report (surgery).

Nursing staffing

- There were no nurses allocated to outpatient clinics. There were scrub nurses on site who could make themselves available for clinics should consultants require them.
- There were appropriate numbers of staff trained to care for patients who become seriously unwell. Consultants had advanced life support (ALS) training and all staff had received training in basic life support (BLS) as part of their mandatory training programme.

Medical staffing

- The hospital employed nine consultants through practising privileges. Consultants held clinics on a weekly basis mainly for private or self-funding patients. Therefore they planned their work based on need and the number of patients they had. They held specialist clinics based on their skills and experience for example glaucoma, retina and cataract clinics. The service did not use locum consultants or doctors.
- The service reported no medical staff sickness between April 2016 and March 2017.

Assessing and responding to patient risk

- Staff did not routinely use early warning scores within outpatient areas. If a patient became unwell, during their attendance, staff escalated to consultants who were on hand to treat deteriorating patients immediately. Staff had access to resuscitation trolleys and could call for further urgent assistance using telephone or remote radios located in consulting rooms. The hospital had procedures to transfer patients to the local emergency department for those needing emergency care.
- We observed in patient records staff recorded patients blood pressure and heart rate prior to any clinical procedure. Consultants also asked patients about any other medication taken, medical history and allergies. We observed consultants doing this in clinics and in all patient records we viewed. Consultants we spoke with said they would not continue with procedures if the results of these assessments presented risks to a patient.

Requires improvement

Outpatients and diagnostic imaging

- Consultants had procedures to refer patients who were not critically ill but required urgent treatment or scans. For example we observed a patient referred to the local NHS provider for an urgent scan within 24 hours of their appointment.

Emergency awareness and training

- The hospital had procedures in place to support business continuity in the event of an incident such as fire or loss of IT or power. The hospital had action plans to support staff in undertaking the right procedures if such an incident occurred.
- Staff conducted monthly fire drills. Fire safety information was visible on the walls of waiting rooms and staff knew their responsibilities and fire safety procedures.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for outpatient service as we do not currently have sufficient evidence to rate.

Evidence-based care and treatment

- The service carried out clinical audits based on national outcomes and guidance. For example, the service conducted clinical audits against Royal College of Ophthalmologists (RCO) expected outcomes for cataracts alongside other providers. For long term, conditions such as glaucoma the service kept a regular follow up pattern to ensure constant monitoring of complex conditions. This also applied to macular degeneration.
- The service conducted local audits for example infection control and medical records audits. However, we could not see evidence of managers sharing results with staff.
- Consultants kept up to date with the latest guidance and standards to ensure they provided up to date evidenced based care and treatment. Consultants were members of the RCO and received updates and guidance. Consultants used newsletter, attended conferences and conducted research on conditions affecting the eye. Consultants could demonstrate detailed knowledge of their specialism during the care and treatment of patients.
- Consultant knowledge of national guidelines and evidenced based research influenced the purchase of up to date equipment to improve care and treatment. For example consultants used electronic screens as visual aids to explain procedures to patients.
- Consultants led and made decisions on care and treatment based on clinical evidence. This ensured consultants avoided discriminating against patients on the grounds of age, gender, disability and sexual orientation.
- Use of digital health technology was limited and the service did not use any applications, telephone medicine clinics or NHS access systems for imaging. However, the service operated an electronic management system for appointments and invoicing through third party software on a remote server.
- The hospital had procedures to ensure patients with complex needs, including those subject to the Mental Health Act (MHS) were treated at the local NHS trust, which was better equipped to treat those patients. Therefore, the hospital did not treat patients subject to the Mental Health Act.

Pain relief

- The service did not monitor the effectiveness of pain relief against national standards in pain management. We observed consultants asking patients about levels of pain in clinics however, they did not document this information or use pain scores in patient records. Consultants used anaesthetic eye drops prior to any investigations during clinics.

Nutrition and hydration

- Staff offered patients drinks while waiting for appointments. The service asked patients, through surveys, what they thought about the quality of drinks offered. We observed there was a coffee machine and water dispensing machine in the waiting area.

Patient outcomes

- Consultants completed outcome forms at the end of every clinic. All records we viewed had completed

outcome forms attached. The hospital did not audit patient outcome forms. Therefore, the hospital was not in a position to measure how effective their service was and use the information to make improvements.
- The hospital did not have a comprehensive programme of clinical audits because in some specialities the number of patients was too small.

Competent staff

- It was hospital policy staff received an annual appraisal to review performance development. Data from the hospital showed 100% of administrative staff have had received appraisals in the current appraisal year so far (July 2016 to Jun 2017). We saw examples of comprehensive appraisal forms, which covered progress and opportunities for staff development going forward. Staff received guidance on their appraisals through invitation letters. We did not see any completed appraisal forms during the inspection.
- The hospital did not have competency frameworks for staff. This meant managers could not assess the competency of their staff undertaking their duties. It also hindered managers in terms of identifying strengths or development opportunities.
- Staff who were new to the hospital said they had received support from managers and colleagues in the form of training and shadowing when they started their employment. However, all staff we spoke with said managers had not set them any development goals or held regular meetings during their first six months in the role. This meant the hospital could not assure the inspection team managers were identifying staff learning and development needs.
- The hospital told us staff had one to ones with line managers on a monthly basis as part of ongoing support to staff. However, all staff we spoke said they did not receive regular one to ones. One to one meetings occurred on an ad hoc basis when required.
- The hospital had policies and procedures regarding consultants practising privileges. The hospital expected consultant anaesthetists, ophthalmologists to provide copies of their regular appraisal, training and development, professional registration and indemnity on an annual basis. Consultants informed the hospital immediately if they were under evaluation or investigation at any time. The hospital reviewed fitness to practice monthly for all consultants.
- The service had procedures for managing poor performance. The hospital used the medical advisory committee (MAC) meetings to discuss poor performance .should it be necessary to do so..
- The hospital ensured consultants working under practising privileges carried out treatments and procedures they were skilled and competent in. For example all consultants employed had skills and experience in a range of eye conditions and performed similar work in a local NHS trust.

Multidisciplinary working

- Consultants referred complex patients to NHS providers. In particular consultants referred patients with eye cancer to the local NHS multidisciplinary team meeting. The meeting consisted of a range of consultants from across the area to discuss complex cases.
- When patients were discharged from the service we saw in patient records consultants informed the relevant organisations and individuals involved in their care. For example, we saw letters to GPs and optometrists informing them of procedures undertaken and next steps in care.
- The hospital had an agreement with another independent health provider to provide pathology services.

Access to information

- Staff had all the information necessary to deliver care and treatment. We observed the hospital had process to make patient records available in a timely and accessible way. Consultants could communicate with NHS departments and colleagues to gain updates and information regarding the care and treatment of both NHS and private patients. Administrative staff had electronic systems to manage and coordinate appointment bookings.
- Consultants had appropriate procedures to share information with other providers when patients moved between services. Consultants used a range of methods including telephone, email, letter and fax to ensure other providers had access to information about patients.
- The hospital had electronic procedures to ensure medical records generated by staff holding practising

privileges were available to staff (or other providers). Staff scanned paper records onto an electronic system used by other NHS providers. A third party organisation based at the hospital provided this service.
- Consultants communicated with GPs primarily by letter. Where urgent contact with GPs was required consultants telephoned GPs directly. Consultants dictated letters to hospital administrative staff who typed the letters the same or following day. The hospital did not audit or review the timeliness of letters sent to GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with understood their roles and responsibilities with regards to consent. We observed the hospital had forms and procedures to document patient consent to treatment. We saw in all patient records consent forms were present, signed and dated. The hospital did not audit the quality of the consent process.
- Staff told us patients who may lack capacity to make an informed decision about their care were extremely rare. Staff identified any issues at the pre-appointment or first appointment stage. Consultants would make any considerations at this stage. We found staff to have a variable understanding of the Mental Capacity Act and Deprivation standards although this was part of mandatory training.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good**

Compassionate care

- Both private and NHS patients received feedback forms after they attended clinics. We reviewed patient feedback data for the period January 2017 to March 2017. Data showed 99% of patients in January 2017 and 100% in February and March 2017 would recommend the services provided at the hospital. Data from the hospital for July 2017 showed 94% of all patients who returned surveys would recommend services provided at the hospital. The hospital did not provide data for April 2017 to June 2017.
- The NHS Friends and Family Test (FFT) give every patient the opportunity to feed back on the quality of services. The outpatient service collected FFT data for the NHS contracted cataract service. We reviewed the FFT results for the period April 2017 and July 2017 and saw between 93% and 99% of patients were likely or extremely likely to recommend the service. The hospital had an 11 - 15% response rate between April and June 2017. In July, the patient response rate increased to 45%.
- During our inspection, we spoke with nine patients and three relatives. All 12 individuals we spoke with were positive about their experience at the hospital. All patients and relatives described staff as friendly, compassionate and supportive. The majority of patients spoke about having positive relationships and caring interactions with staff.
- Staff we spoke with described their passion for providing good patient care and building relationships with long-term patients. Staff were respectful and allowed patients plenty of time for discussion and questions. We saw many positive and friendly interactions between staff and patients. Staff talked to patients in a familiar manner and asking about family members.
- Staff displayed a supportive attitude to patients and put their needs first. All staff enquired whether patients wanted a drink and were comfortable. Consultants used encouragement and praised patients who had received successful treatment. We observed consultants encouraging and supporting patients during clinics, especially during eye examinations. Patients we spoke with all said they felt staff were caring and staff were quick to meet their care needs.
- Staff ensured they respected patient privacy. Staff closed consulting room doors during clinics and avoided any patient-related conversations in public areas. Reception staff kept patient records faced down on the reception desk to avoid other patients or members of the public seeing patient details. Staff we spoke with knew their responsibilities in terms of maintaining patient privacy and dignity.
- Consultants asked patients about pain levels and demonstrated a sympathetic approach. Patients said staff were compassionate and sensitive towards their pain levels and therefore they felt reassured.
- Staff said they offered patients the opportunity to have a chaperone. We did not observe staff offering patients a chaperone at any point during the inspection. The

hospital did not have posters advertising chaperones in waiting areas or clinic rooms. We raised this with managers at the hospital. The hospital responded by ensuring they displayed chaperone posters in reception, waiting areas and consulting rooms.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a way, which enabled patients to understand what was happening about their care and treatment. We consultants telling patients what tests they were undertaking and why they were necessary. They explained to patients in simple terms any complicated or technical terms. Consultants gave patients plenty of time to ask questions and checked with patients they had understood what consultants told them.
- All patients we spoke with said they consultants gave them enough time during clinics to ask questions and find out more information. Patients and relatives said they felt involved and informed about their care and treatment.
- All staff understood patient's personal commitments and we saw examples of staff attempting to fit appointments around patient lifestyles and commitments such as work or children.
- Patients knew who to contact if they were worried or had further questions. Staff provided patients with phone numbers they could call during the day and out of hours. All patients we spoke with said they were either confident they could call someone or had already used the phone number if they had concerns.
- Staff had appropriate and sensitive discussions with self-funding patients regarding cost of treatment. Staff provided patients with treatment options including any attached costs. Staff conducted conversations in private and away from waiting areas.

Emotional support

- Staff understood the impact care, treatment or the condition had on patient wellbeing and on those close to them, both emotionally and socially. We saw in all our observations consultants discussing the impact of their condition on everyday life such as driving or reading. Consultants handled this in a sympathetic and considerate manner.
- We observed a consultant giving a patient unexpected bad news. The consultant gave the patient time and opportunity to ask questions. The consultant reassured the patient and provided the patient with timely access to further scans at another provider.
- We observed consultants empowering patients to support and manage their own health. Consultants provided patients with information regarding using eye drops but in addition encouraged patients to make lifestyle changes such smoking less because of the impact it had on the eyes.
- All patients we spoke with said they were involved in their care and treatment. Consultants provided patients choices in terms of next steps. Consulted provided patients with the positive and negative impacts on any option of treatment and care.
- We saw staff providing information leaflets to patients and observed them explaining their treatment and ongoing care. Consultants also used visual aids and images to explain how the treatment would work and what would happen.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The service offered clinics at a variety of times throughout the day, evenings and weekends to fit in with local people's needs. Managers said they listened to patients, who often relied on family to bring them for their appointments. The majority of patients required assistance with transport due to issues with their eye sight. Therefore they offered most of the appointments during evenings and Saturdays when most people found it easier to get assistance with transport. The service offered daytime clinics to patient who preferred them.
- The environment was bright and spacious and waiting rooms had comfortable seating and refreshments. We observed there were appropriate facilities for disabled access including ramps and a lift.

- Managers at the hospital told us in order to improve access, outpatient services delivered clinics on the ground floor and reduced the number of heavy doors opting for lighter weight fire doors for older and frailer patients.
- The hospital had a car park. However, during busy periods the car park was full and difficult to access. Data from the hospital showed much of the negative feedback about the service related to car parking. However, the hospital was situated next to a residential street and therefore on-street parking was available to patients.

Access and flow

- There were 4,002 outpatient total attendances in the reporting period Apr 2016 to March 2017. Of these, 81% were NHS funded and 19% were private or self-funded patients.
- All patients had timely access to care and treatment. All patients we spoke with complimented the speed in which they received an appointment. We saw examples of patients self-referring to the hospital due to the ease and speed in which they could access the service. Where patients needed urgent treatment or scans we saw consultants could refer them quickly into other services.
- Appointment times were flexible and outpatient services offered most patients a range of clinic appointments including evenings and weekends. However, commissioning arrangements meant the hospital did not offer NHS patients choices in appointments. The hospital provide dthe commissioner with appointment slots and the commissioner allocated NHS appointments. The hospital provided the clinic slots and staff working for the commissioner allocated appointments. However, where outpatient services had gaps or late cancellations hospital staff contacted patients to see if they wished to have their appointment sooner.
- Consultants prioritised patients who needed urgent appointments. Consultants booked patients into clinics regardless of whether all appointment slots were full. While this meant some patients had to wait longer for their appointment it meant consultants could see patients with urgent needs quickly.
- NHS cataract patients did not have long waiting list times. The hospital monitored the referral to treatment times (RTT) for NHS patients. In 2017 patients had to wait nine to ten weeks for surgery. Data from the July hospital and commissioner operational meeting minutes showed RTT wait times had reduced in June to 20.6 days for first appointment.
- The service had an out of hours telephone advice service operated on a rota system, which transferred telephone calls to the duty consultant. This enabled patients to seek advice outside of clinic hours.
- Consultants had the responsibility of setting their own clinic dates. This meant no clinics ran during consultant leave reducing the possibility of cancelling clinics. Staff added consultant leave to the electronic system meaning administrative staff knew when clinics could not take place.
- The hospital monitored clinic cancellation data. Between April 2016 and April 2017, data from the hospital showed 578 cancelled appointments. The majority were patient cancellations (342). Thirty appointment cancellations were due to the hospital or consultant cancelling the appointments.
- Outpatient services had procedures for patients who did not attend (DNA) clinic appointments. Procedures differed slightly for NHS and private patients because a third party organisation referred NHS patients in to the service. We saw the electronic systems alerted staff regarding any history of a patient consistently not attending appointments. In all cases consultants contacted GPs informing them the patient had not attended. Staff attempted to contact patients by telephone or letter asking them to make another appointment. For NHS patents, if they did not attend consultants referred the patient back to their GP.
- We observed some patients waited long periods, sometimes over an hour for their appointment and subsequent treatment or procedure. The hospital tried to minimise this by staggering appointment times. Patients not requiring treatment (for example consultations and follow ups) did not have to wait as long. Urgent and priority patients were also seen quickly. We saw the hospital allocated specifc amounts of time for follow up and new patients to ensure patients could be seen on time.

Meeting people's individual needs

- Due to the referral criteria outpatient services did not normally see patients with complex needs including patients with learning disabilities or those living with

dementia. The hospital referred patients with complex needs back to NHS services who were more equipped to care for those patients. This also included bariatric patients.

- Outpatient services did not have materials available in other languages for patients whose first language was not English. This included pre-appointment information. The service required patients to fill out forms prior to their arrival, which could cause issues for non-English speaking patients.
- Signage in the hospital was small and difficult for patients with visual impairments to see. It did not meet the standard of black print on a yellow background for visually impaired people. We discussed this with the hospital and they arranged for a local representative group for people with visual impairments to advise them about the signage.
- Staff could access translation services through a third party provider for NHS patients. This service was not accessible for private patients therefore consultants used other members of staff, including cleaning staff, or patient relatives to act as translators. This meant at times, staff asked people without clinical experience or knowledge to relay clinical information to patients.
- Outpatient services did not have the full range of written materials available in large print for patients with visual impairments.
- The service had a portable hearing loop which patients used and could take around the building with them.
- Staff gave us examples of when they had taken into account of patient's culture and religion. For example, staff turned a consulting room into a prayer room for a patient.
- The hospital had made reasonable adjustments so disabled patients could access services on an equal basis to others. The hospital had numerous disabled toilets with fixed hand rails, disabled access ramps and a lift to access any clinics operating on the first floor of the hospital. When staff knew a patient with mobility issues or a disability was attending clinics staff made arrangements to see patients on the ground floor if clinic capacity allowed.

Learning from complaints and concerns

- The majority of patients using the service said they knew how to make a complaint and had no issues raising concerns. The hospital had information for patients on how to complain for NHS and private patients.
- The majority of staff we spoke with said managers and consultants did not share learning from complaints. One member of staff gave us an example of a complaint shared by managers. Staff could not tell us any examples of where things had changed because of a patient complaint.
- For more information on complaints and concerns, please refer to the surgery report.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership and culture of service

- We observed there was strong clinical leadership within the outpatient service. The daily clinical activity and development was consultant led. A practice manager led the operational elements of outpatient activity including the management of administrative staff.
- Leaders generally understood the challenges to good quality care and knew how to address them. For example, leaders knew the service had become busier and more space was required. Therefore, leaders had plans to expand the hospital to create more clinic space.
- Leaders encouraged open and supportive relationships between staff. In turn staff said they felt supported by their managers and leaders. We observed positive relationships between all staff designations. Leaders were visible and staff said they could approach any of the leadership team if they had concerns.
- The majority of staff said openness, independent thinking and suggestions for improvement was encouraged. The majority of staff said they felt comfortable raising ideas and suggestions. Staff said they felt respected and valued.
- We saw staff committed to a culture of patient centred care. All staff we spoke with were committed to providing patients the best possible experience and care within the hospital.

- For more information on leadership, please refer to the surgery core service report.

Vision and strategy for this core service

- The hospital had a clear vision supported by a mission statement. The vision was to be the centre of excellence for eye care in the East Midlands providing urgent care within 24 hours wherever possible. The mission statement referred to a high quality service, achieving exceptional standards, using state of the art equipment.
- The hospital had a business plan dated October 2016. The business plan set out the basic information, roles and responsibilities for running the service. The business plan had a strengths, weaknesses, opportunities and threats (SWOT) analysis.
- However, there was no long or medium term strategy or action plan underpinning the business plan, vision and mission statement. This meant there were no action plans or strategic milestones supporting their mission and vision. Therefore, leaders could not judge or monitor progress against where they wanted to be.
- The majority of staff we spoke with did not know about a strategy or vision for the service. However, staff could tell us about key service developments including the hospital expansion and the purchase of new equipment.

Governance, risk management and quality measurement

- The hospital had a basic management structure to support the day to day running of the hospital. A medical director had overall oversight supported by the practice manager, who acted as line manager to outpatient administrative and reception staff.
- Outpatient services conducted some audits to ensure staff met national guidelines and standards including hand hygiene and patient records. The hospital had also commissioned an independent infection control audit in February 2017.
- Outpatient services collected performance information for NHS patients as part of ongoing contract arrangements. The hospital had set up regular meetings with the commissioner to discuss performance and capacity. The minutes showed the service was not meeting contractual targets or and did not know about required service capacity.
- However, the service did not collect or discuss performance data for private patients. We saw from minutes of governance meetings managers discussed patient feedback, complaints, risk and incidents in terms of risk and quality measurement.
- Managers held administrative team meetings and discussed elements of risk and quality for example ensuring case notes were tracked and clinical waste emptied regularly. However, managers did not specifically discuss outpatient performance or formally recognise and record risks. We reviewed three sets of minutes between December 2016 and July 2017 and saw no ongoing review of actions identified or managers ensuring staff had implemented actions.
- For more information on governance, risk management and quality measurement please refer to the surgery report.

Public and staff engagement

- The service used feedback questionnaires to obtain patient feedback from both NHS and self-funding patients. The service provided pre-paid envelopes to encourage patients to respond. We saw staff discussed patient feedback with commissioners and identified actions such as providing a wider range of food and refreshments post treatment. Data from the July 2017 meeting with commissioners showed feedback rates had reduced from 15% to 11% between May 2017 and June 2017. The commissioned target was 25%.
- The service said they used patient's views to shape services. They installed a larger waiting area, different seating, installed portable hearing loops and provided alternative refreshments in response to patient feedback.
- As part of the patient feedback questionnaire the hospital had a 'staff mention or message for the team' section. This allowed patients to specifically mention specific staff members or team which managers then relayed to staff. Staff said they appreciated the positive feedback and all comments from staff.
- Staff had the opportunity to discuss suggestions and areas for improvement during pre-arranged team meetings. Managers engaged staff on a one to one and via staff surveys. Staff said they could have informal discussions at any time with their managers and other

leaders. At the time of the inspection the practice manager was processing and analysing the results of the staff survey. There had not been a staff survey for 2016.

- It was not clear from talking to staff how regular team meetings should have been. However, we saw evidence of three team meetings between December 2016 and July 2017. Therefore we could not be sure staff had regular opportunities to formally discuss suggestions, learning from complaints and incidents, or hear about business objectives regularly.

Innovation, improvement and sustainability

- The service was keen to innovate and bought the most recent diagnostic equipment with the best accuracy, in order to give patients the best treatment. The service is planning to install a corneal laser and the setting up and specialists would undertake calibration. Leaders continued to research the best types of equipment and treatment available.
- Staff were focused on continually improving the quality of care. All staff we spoke with at all levels were keen to look at how they could improve through the inspection process and through best practice. Leaders were responsive to the inspection team feedback and implemented changes quickly.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure patient records are left secure at all times
- The provider must ensure that there are procedures in place to ensure the proper management of medicines.The provider must ensure patient records are recorded in line with General Medical Council (GMC) standards for example, are legible, signed, dated and complete.
- The provider must ensure there is a robust system in place to record, manage and mitigate ongoing risk
- The provider must ensure that there is a sepsis policy in place with sepsis toolkit and related training
- The provider must ensure that they put effective medicines management arrangements in place
- The provider must ensure that they have arrangements to prove that directors conform to the Fit and Proper Persons regulation.

Action the provider SHOULD take to improve

- The provider should hold regular staff team meetings to ensure staff are engaged and informed with regards to strategic direction, incidents, complaints, performance and risk.
- The provider should work towards implementing staff competency frameworks to ensure staff know their roles, responsibilities and identify areas for development.
- The provider should continue to improve written information and materials (including signage) for people with visual impairments.
- The provider should consider using professional translation services for private non-English speaking patients.
- The provider should train staff in the Duty of Candour regulation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors The provider did not have information readily on file to prove that its directors were Fit and Proper Persons. The provider emailed and said they had implemented their policy. The provider emailed their FPPR policy and signed declarations by all directors. However, the hospital did not originally have everything on file.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have guidance or training about Female Genital Mutilation. (FGM). This aspect of safeguarding was not included in the Child or Adult Protection Policy and these policies did not conform to the Intercollegiate guidance.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2) b The hospital's arrangements for managing risk were incomplete and lacked oversight. There was a risk register for NHS cataract work but not for private practice. There was a lack of oversight of the complete range of organisation risks. There was no sepsis policy in place or sepsis toolkit to support staff.

This section is primarily information for the provider

Requirement notices

The hospital did not manage risk relating to medications effectively. Use of prescription pads was not consecutive or auditable. During our unannounced inspection we found a red bag with emergency medications unlocked on top of a trolley in the recovery room where patients were not always supervised. Not all items were in date and stock control and checking arrangements wer inconsistent.

17 (2) c Not all records were not properly maintained in accordance with GMC guidance or complete. Total- 26 records- 11 unsigned, incomplete or illegible. Records were not always stored correctly.