SpaMedica Ltd

SpaMedica Bradford

Inspection report

Eccleshill ISTC
Harrogate Road
Bradford
BD10 0EP
Tel: 01618380870

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

Ratings

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

Summary of findings

Overall summary

We had never inspected this service before. We rated it as good because:

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

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

• Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

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

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

However;

• Staff did not always keep their mandatory training up-to-date. Managers did not always alert staff when they needed to update their training.

• Staff did not always adhere to best practice when wearing personal protective equipment (PPE). The service could not always dispose of clinical waste safely.

• Managers could not always keep the number of cancelled appointments to a minimum.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We had not inspected this service before. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients. They supported patients to make decisions about their care, and had access to good information. Key services were available six days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. However: • Staff did not always keep their mandatory training up-to-date. At the time of our inspection 73% of

Summary of findings

service staff had completed their mandatory training overall which did not meet the provider's 85% target. Staff sickness and new starters impacted on these results.

• Managers did not always alert staff when they needed to update their training. For example, 13 staff had not started their practical manual handling training and nine staff had not started their dementia champions training.

• Staff did not always adhere to best practice when wearing personal protective equipment (PPE). We observed one clinical and two non-clinical staff members wearing facemasks below their nose.

• Clinical staff did not always introduce themselves fully or clearly explain their role. We observed one junior optometrist at pre-assessment only introducing themselves to a patient by name without giving their role or wider context. This meant less verbal or cognitive patients could be potentially confused or unclear about their care and treatment options.

• The service could not always dispose of clinical waste safely. They had some periods of non-collection leading to overflowing of general and clinical waste bins.

• At the time of our inspection the service's total turnover rate was 26%. This was above the provider target of 21% or less for 2022. Ten staff had left the service within the last year, six of which were clinical and two optometrists.

• Managers could not always keep the number of cancelled appointments to a minimum due to staffing shortages. In the six months from September 2021 to February 2022 the service cancelled a total of 53 patient appointments after admission. 25 of these were for clinical reasons, 24 were by the provider and four were by patients.

Summary of findings

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Summary of this inspection

Background to SpaMedica Bradford

SpaMedica Bradford is operated by SpaMedica Ltd. The service offers cataract surgery and yttrium-aluminium-garnet laser (YAG) capsulotomy services for NHS patients. YAG capsulotomy is a special laser treatment used to improve your vision after cataract surgery.

In the 12 months before our inspection between March 2021 and February 2022 the service had performed 3,807 operations.

The service's clinical services are provided on the ground floor. The service has an operating suite with one theatre providing cataract surgery, pre- and post-operative assessment areas including a discharge lounge. The service did not treat children.

The service is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Surgical procedures

• Treatment of disease, disorder and injury

The service is managed by a registered manager supported by an ophthalmic team which consists of:

Ophthalmology consultants

Optometrists

Registered nurses

Healthcare technicians

Operating department staff

Administration staff

At the time of our inspection the registered manager was new in post having started on 4 April 2022. This is the first time we have inspected and rated this service. We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 31 March and 27 April 2022. To get to the heart of the patients' experience we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well led.

The main service provided by this hospital was surgery.

Summary of this inspection

How we carried out this inspection

The team that inspected the service comprised of one CQC inspector, one CQC assistant inspector and a specialist advisor with expertise in eye surgery. The inspection team was supported by an inspection manager. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

During the inspection we visited all areas of SpaMedica Bradford. We spoke with 15 members of staff including regional and senior managers, the registered manager, nurses, doctors, optical technicians, optometrists and administrators. We observed the environment and care provided by patients and spoke with two patients. We reviewed ten patients' records; five at pre-assessment stage and five post-operatively. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans.

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

Outstanding practice

We found the following outstanding practice:

• We found staff knowledge and awareness extended beyond the scope and responsibilities of their roles. For example, one of the location's two portering staff demonstrated extensive knowledge about services provided.

• The service ran accreditation evenings for local opticians to enable them to support patients post-operatively in the community.

• The service achieved over 99.49% patient satisfaction across all metrics from 1,765 responses within a six-month period. The overwhelming majority of patient comments were positive.

• Senior managers told us the service had hosted a first-year student studying an undergraduate nursing degree at the local university. The placement took place in January and February 2022 and lasted seven weeks. The new hospital manager planned to agree future student placement dates and learning opportunities to roll out to other provider sites.

• The service was peer reviewed as the first of 21 Spamedica sites in 2021. The hospital manager visited another provider site and completed a focused peer review and validation process with the area manager. The managers then devised an action plan and shared outcomes nationwide to encourage standardisation and best practice.

• Regional senior managers completed a monthly CQC self-assessment tool for the service based on our key lines of enquiry (KLOEs). Outcomes were reviewed at their provider-level clinical governance meetings. They achieved a total monthly score of 98.3%. This was the fourth highest score out of 36 provider sites who submitted results.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

We had not rated safe before. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Staff received mandatory training but did not keep this up-to-date. At the time of our inspection 73% of service staff had completed and were up to date with their mandatory training (MT) overall. 24% of lesson assignments comprising 76 courses had not been started by staff. Staff sickness and new starters impacted on these results which did not meet the provider's 85% target.

We reviewed these figures which were broken down based on 26 staff users' module completion rates. The service's highest top three compliance rates by training course were workplace bullying which 21 users had completed, statutory and MT and sex discrimination which 19 users had completed for both.

However, the service's top three lowest compliance rates by training course were practical manual handling with only 24% compliance which 13 staff had not started, 'dementia champions' with only 31% compliance which nine staff had not started. Infection prevention control (IPC) had 68% compliance which six staff had not started. This meant we could not ensure staff were always sufficiently trained to carry out their roles properly.

Managers monitored mandatory training but did not always alert staff when they needed to update their training. We reviewed MT figures and found all 13 eligible staff had completed their practical basic life support (BLS) course. However, two of seven eligible staff had not started their resus council intermediate life support (ILS) course. We followed this up with managers who were aware of gaps in staff training. The provider's policy outlined at least one ILS trained staff member must be onsite at all times and as such felt there was no risk to patients. All other staff were BLS trained.

The service had an electronic system that notified staff of training required which linked with staff electronic calendars so they could see when face to face training was to be completed.

Good

Surgery

Senior managers told us they had clinic days and quieter times when staff could complete MT modules. Leads tried not to make staff complete modules at home to better retain work life balance. However, one healthcare technician told us due to staffing issues they struggled to complete MT. They were not given protected or allocated time to complete MT so sometimes had to do this during their lunch break.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. At the time of our inspection the service's overall safeguarding training compliance rate was 95%. Service staff's safeguarding compliance training was included within their statutory mandatory training. Clinical and ophthalmic nursing staff told us all their safeguarding training was up to date.

Hospital managers were trained to level 3. Service staff could access a company safeguarding lead trained to level 4. At the time of our inspection the area manager who started on 4 March 2022 was the safeguarding lead for the hospital.

The clinical director and clinical governance lead were national safeguarding leads within the organisation trained to safeguarding level four, staff could access support and advice if required. At the time of our inspection the clinical director was training for safeguarding level five.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us about specific patient concerns that they had identified and escalated appropriately. The computer system had an easy to access safeguarding icon linking to details to swiftly report concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we asked had good understanding of safeguarding processes. All staff had access to the NHS safeguarding app on their PC desktops. Senior managers told us safeguarding referral incidents relating to social deprivation were the service's most common. Staff regularly made welfare checks on patients and would actively seek support from their local authority (LA) safeguarding team.

The service confirmed their staff had not made any safeguarding referrals in the last year before our inspection.

The provider had a robust safeguarding policy in place along with established referral routes to the LA and other external organisations.

The service demonstrated safe recruitment procedures and employment checks. Staff had disclosure and barring service (DBS) checks before starting work. These checks support employers to prevent unsuitable people from working with vulnerable patients.

The hospital had a chaperoning policy which staff knew how to access. There were notices in patient areas advising patients that they were entitled to have a chaperone present for consultations, examinations and surgery.

Good

Surgery

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. They kept equipment and the premises visibly clean. Staff used equipment and control measures but did not always protect patients, themselves and others from infection.

Staff had access to an up to date infection control policy to help control infection risk. We reviewed the provider's policy for infection prevention last issued March 2021. This policy's purpose was to ensure compliance with national policy and guidance. Relevant amendments had been made by the provider's infection prevention lead nurse.

Additional protocols were in place in response to the COVID-19 pandemic. There were visible adaptations for the arrival of staff, patients and visitors at the hospital to limit the risk of cross infection, for example temperature checks upon arrival.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated all areas were cleaned regularly in line with hospital policy. Porters did a daily walkaround sweep of all areas very early in the morning to ensure cleanliness and all systems were working. Managers completed documented spot check inspections for cleanliness.

The service generally performed well for cleanliness. (make reference to PLACE scores where present). We reviewed the service's monthly health and safety checklist audit completed by the former hospital manager on 15 February 2022. This showed an overall score of 94.87% with no actions for improvement.

However, there were six flagged items. For example, a fire door was damaged and still outstanding awaiting repair completion which the manager had chased. At the time of the audit this meant the fire doors only stayed shut when locked which was an ongoing issue with NHS procurement services.

The service completed infection prevention and control and hand hygiene audits. We reviewed this data which showed IPC scored 100% compliance in January 2022. This was scheduled to be carried out again in April 2022. The service's latest hand hygiene audit scored 100% compliance in March 2022 and was scheduled to be carried out again in June 2022.

The provider planned an external assurance audit that involved facilities, area managers and hospital managers later in 2022. The audit would include external persons such as a clinical commissioning group (CCG) representative, external organisation or patient group to provide assurance of the process, our cleanliness in the patient facing hospital areas and how the environment feels for patients.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff washed their hands and used hand gel between patients. We observed staff cleaning equipment after patient contact. All reusable equipment was decontaminated off site. The service had a service level agreement (SLA) in place with an accredited decontamination service. Staff managed clean and dirty equipment well, with no cross contamination.

Staff we asked had a good understanding of infection prevention control (IPC) processes. Theatre staff had guidance displayed on wearing theatre attire and medical masks safely. However, we observed one clinical and two non-clinical staff members using PPE incorrectly by wearing facemasks below their nose.

Staff worked effectively to prevent, identify and treat post-surgery infections. The service's endophthalmitis infection (inflammation of the internal eye tissue) rate was zero and no cases were reviewed in the 12 months before our inspection.

Good

Surgery

The provider clinical governance meeting minutes included any infection updates. For example, after some sites had issues with water pseudomonas and legionella, staff were reminded to be aware and ensure they raised any concerns.

At the time of our inspection the service had recently stopped checking the temperatures of all staff, patients and visitors at the front door on 14 March as per the latest Covid-19 guidance. However, staff still adhered to PPE policy and symptom checked patients at their pre-assessment and on the day of their appointment.

All patients were asked to undergo a Covid-19 lateral flow test (LFT) on the morning of their surgery.

We reviewed the provider's policy for the management of Coronavirus. This was next due for review in March 2023 or upon change of national guidance.

The service had an IPC link nurse who disseminated and managed any updates from the provider's IPC lead. We heard the provider's national IPC lead had recently become the lead for the North region.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, staff could not always manage clinical waste well.

The design of the environment followed national guidance.

The location had challenges related to sharing a building with another independent health hospital. We found a lack of signage and there was not always clear division of which provider was responsible for certain areas. The Director of Clinical Services told us this was one of the top three risks on their local risk register. Managers had controls in place for this risk which they deemed adequate. However, this was not one of the service's top risks as its risk severity level was low.

Managers told us they had mitigated the risk by maintaining a close working relationship with the new registered manager (RM) of the other hospital, their Estates and Facilities as well as domestic housekeeping teams onsite. Staff accompanied patients at every stage of their pathway. This meant there was no risk patients access the other provider's hospital. All the service's clinical doors were locked where staff needed swipe card access. On the day of our inspection the theatre entry and exit door did not auto-lock so a theatre staff member stood beside it to lock manually during patient procedures. Managers promptly reported this to their building contractor to fix and raised an incident report.

The service's reception was spaceous with socially distanced chairs stating 'do not sit in this seat' where they were less than two metres apart. We saw the service had two spare wheelchairs with signage not to remove these from the reception.

A fire alarm test was performed on the day of our inspection. The service carried out weekly fire tests and we reviewed the March 2022 log which included any extra comments/observations around door issues.

We saw the service had three planned routes in the event of fire and emergency evacuation. The service's fire warden/marshall confirmed their last evacuation procedure was in 2021.

The service's discharge area was well equipped and the discharge room had a slit lamp. This area only had one chair but the porter told us they could fetch another if required. Staff deep cleaned the chair between patients.

We saw recent flood damage led to a ceiling leak to one of the corridor toilets. This was taped off in the process of being repaired. We noticed this issue was highlighted as one of six flagged items from the service's monthly health and safety checklist audit on 15 February 2022. This meant at the time of our inspection ten weeks later this flagged item had still not been actioned. Managers told us staff had contacted the contractor who was scheduled to attend. They also reported to NHS property services after their recent toilet refurbishment.

Staff carried out daily safety checks of specialist equipment. These were completed as per hospital policy.

There was a regular maintenance programme in place for specialist equipment. An external maintenance provider attended the clinic to service and safety check equipment. All the equipment checked had been serviced and safety checked within the required timeframe.

There was resuscitation equipment available for use in a patient emergency. The service had two resuscitation/crash trolleys readily accessible, one in the main theatre and another in the pre-assessment corridor. Staff completed daily checks of stock and tamper prevention seals were fitted to each trolley.

The service had enough suitable equipment to help them to safely care for patients. The theatre had an airflow system in place checked and maintained in line with hospital policy to maintain air quality.

On the day of our inspection theatre staff were undertaking a stock take. The senior administrator had responsibility for consumables such as checking expiry dates.

At the time of our inspection we reviewed all the service's statutory and clinical compliance testing dates, none of which had expired. The service's portable appliance testing (PAT) was all in date.

Staff could not always dispose of clinical waste safely. The service shared clinical waste facilities with the building's other surgical hospital. Only designated clinical staff could access this area. We saw sharps bins were assembled correctly and not overfilled. These were disposed of in line with national guidance. The appropriate controls were in place for control of substances hazardous to health (COSHH). Staff we asked were aware of the COSHH regulations 2002 procedure and described the process well. Cleaning equipment was stored securely in locked cupboards.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. All patients referred to the service attended a pre assessment appointment. Risk assessments were carried out for patients which included falls, mobility/they could lie flat, dementia and anxiety.

The service used an adapted "five steps to safer surgery" World Health Organisation (WHO) surgical safety checklist. Theatre staff completed safety checks before, during and after surgery. WHO check list compliance was audited quarterly and the latest audit achieved 100% compliance in January 2022 against the threshold of 95%.

Patients at higher risk of infection were identified during pre-assessment and alternative after care treatment was put in place to reduce the risk of infection. The national clinical director of services reviewed all clinical outcomes.

Good

Surgery

We reviewed the service's latest SOPs. SOPs included those for theate staff's management of endophthalmitis. Endophthalmitis is a severe inflammation of the anterior and/or posterior chambers of the eye. Service staff were required to treat this emergency within one hour of diagnosis as each stage was time critical.

The service would undertake thorough investigations into the possible sources of inflammation for any isolated cases, with any necessary lessons learnt. Staff would raise an incident report and commence a root cause analysis (RCA) as well as notifying the infection prevention control (IPC) lead within 24 hours. The service also had a post-operative endophthalmitis flowchart with clear steps staff could follow.

Ophthalmologists we asked understood this endophthalmitis protocol.

Staff identified patients with complex cataracts via a risk stratification process at the pre-assessment stage. These patients were added to a complex waiting list and treated at a neighbouring provider site.

We reviewed the service's latest policy for the management and reporting of clinical risks, incidents and near misses next due for review in January 2024. This policy's purpose was to strengthen the provider's clinical risk management framework, further embed risk management at a corporate and local level and ensure appropriate escalation of clinical risks, incidents and near misses through the organisation to the board.

Staff knew about and dealt with any specific risk issues (consider reporting sepsis, VTE, falls and pressure ulcers). Staff took patient's full medical history at pre assessment including allergies. From our observations and review of records, this was all completed, with appropriate actions taken.

Service staff had access to a 24-hour clinical on-call service to which all patients were given contact information upon discharge. All provider sites had regional nominated hospitals for follow up emergency work.

The service transferred patients with medical complications using 999.

Staff shared key information to keep patients safe when handing over their care to others. Staff collated all information on the electronic patient record (EPR) and produced discharge letters as patients were discharged from care back to their referring community optometrist or GP as appropriate.

The service carried out at least bi-annual mock scenarios for responding to deteriorating patients using resuscitation crash trolleys. At the time of our inspection the last one was on 3 March 2021. A third party training provider resuscitation officer facilitated these scenarios.

In the event of a patient requiring an emergency transfer whilst undergoing care, this would be via a 999-emergency paramedic call and transfer. We reviewed the provider's cardiopulmonary resuscitation of adults policy next due for review in May 2023 or when the UK resuscitation council guidance was amended. The policy stated *'SpaMedica has one escalation policy, which is a 999 call and transfer to an acute NHS Hospital.'*

However, as 13 service staff had not started their MT in practical manual handling MT we could not always ensure staff were trained to sufficiently follow the moving and handling section of this policy.

Good

Surgery

Nurse staffing

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

Managers accurately calculated and reviewed the number and grade of nurses and ancilliary staff needed for each shift in accordance with national guidance. The service had a standard staffing model in place which was regularly reviewed. The service held weekly activity meetings to assess and plan in line with activity.

The provider held a company wide weekly activity meeting which reviewed staffing in line with their safe clinical staffing policy. Hospital managers met at least weekly to discuss cross-site staffing cover. Senior managers told us they were good at providing cover. The service could access a regional advanced nurse practitioner, but no specialist nurses worked at the location.

Managers could adjust staffing levels daily according to the needs of patients. Hospital managers liaised across the region to support and plan staffing.

The service had enough nursing and support staff to keep patients safe. The service had established staffing levels for pre-assessment and theatre.

The number of actual nurses and healthcare technicians matched the planned numbers. The organisation had agreed minimum staffing for the hospital and could only proceed when the standard of skill-mix was confirmed. Staff we asked confirmed this. They told us if a full team was not available then a theatre list would be cancelled or adjusted, although this very rarely happened.

Managers told us the service's latest data showed two lists were adjusted in the 12 months before our inspection. One related to severe weather conditions where the surgeon and three team members could not attend site and the second related to a surgeon being unwell at short notice. Both lists were rescheduled.

The service had low and/or reducing vacancy rates. At the time of our inspection the service had one outstanding vacancy.

The service did not have low turnover rates. We reviewed the service' departmental turnover report for the period 1 April 2021 to 31 March 2022. Their total turnover was 26%. This did not meet the provider target for 2022 of 21% or less. Ten staff had left the service within the last year, six of which were clinical and two optometrists. Managers told us salaries impacted recruitment efforts as they had nearby competitors but sought to offer would-be staff more opportunities for progression. The service did not have low sickness rates. We reviewed the service's absence rate using a lost time rate. This calculated staff's total hours of absence from 1 April 2021 to 31 March 2022. The service's lost time rate for the year before our inspection was 3.52%. This did not meet the provider target for 2022 of 3% or less (excluding long-term sickness).

The service had low rates of bank and agency nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service. They offered bank and agency staff long term bookings to ensure stability in the work force. Managers made sure all bank and agency staff had a full induction and understood the service. We heard short notice staff absences were usually covered from the regional area's bank or agency staff.

Good

Surgery

Medical staffing

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

The service had enough medical staff to keep patients safe. All ophthalmic surgeons worked for the service under practising privileges. These were reviewed by the medical director The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.

Records

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

Patient notes were comprehensive and all staff could access them easily. The service used a mixture of electronic and paper based notes. The service used electronic patient records (EPR) on mostly an ophthalmic specialised system. Staff collected and stored patient details on the organisation's electronic records system. This included information following pre-assessment, theatre, discharge and post-operative care.

Staff maintained paper records for consent, demographics, biometry information copies, outcome forms and referrals. All scans could be viewed electronically. Biometry scans could be viewed electronically as well as printing of hard copies if required at the hospital.

The service conducted quarterly clinical documentations audits. Their latest audit results achieved 97.2% compliance for February 2022. The service repeated any audit which scored under 95% the month after. There was an action plan in place to improve compliance. We reviewed records for ten patients and found they had been completed correctly.

Records were stored securely. We found patient notes were stored within a room with cabinets and locks.

However, we saw in the provider's quarterly clinical governance report up to 23 March 2022 the service had three patient incidents involving inaccurate details in their records.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had a medicines management policy in place with supporting procedures all staff could access. We reviewed the provider's latest medicines management policy next due for review in September 2022 which was comprehensive.

Staff completed medicines records accurately and kept them up-to-date. The service used topical and local anaesthesia to the eye only. Drops were prescribed using patient specific directions (PSD). These were administered by health care technicians with appropriate training, who recorded on the paper PSD.

The service also had patient group directions (PGDs) in place. A PGD is a written instruction that includes the administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The service had PGDs available for the management of clinical conditions such as corneal oedema and uveitis.

Staff stored and managed all medicines and prescribing documents safely in line with the provider's policy. The medicines, in cupboards and fridges, were all within their expiry dates. The clinical fridge and storage room temperatures were monitored and recorded accurately, including the maximum and minimum ranges.

The service stored diazepam to be available for patients who were identified as anxious prior to surgery. It was stored correctly, and records were completed for checking and administration.

Staff reviewed patients' medicines and provided specific advice to patients and carers about their medicines. During discharge patients were given clear verbal and written instructions about the administration of their eye drops.

The service had systems to ensure staff knew about safety alerts and incidents. The provider's clinical governance meetings and reports included national safety alerts relevant to the service. We saw the service had one incident under the category 'error in dispensing medication' in the three months up to 2 December 2021. The provider's medicines management committee had requested all staff complete governance actions in response.

We reviewed the service staff's medicines management awareness training compliance. At the time of our inspection this was 76% overall, as 19 of 26 staff users had completed the course. This did not meet the provider target of 85%.

Incidents

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

Staff knew what incidents to report and how to report them. Incidents and near misses were recorded on an electronic reporting system. All service staff including non-clinical could raise and report incidents. Staff we asked described clear reporting lines up to senior management level. The provider's clinical governance leads oversaw every level or type of clinical incident reported. They shared any trends through the provider's committee meeting structure. Any significant learning was included in the provider's monthly newsletter to all staff.

Staff raised concerns and reported incidents clearly and near misses in line with provider policy. Staff told us they were encouraged to report incidents and felt confident to do so. They knew what incidents to report and how to report them.

We reviewed the service's reported incident for the six months between 4 October 2021 and 3 April 2022. Staff reported no severe or moderate harm incidents reported in this period as all were graded as low or nil harm.

We saw quarterly clinical governance reports showing the service had the highest number of incidents in their Yorkshire and North East region under the category 'cancelled treatments within 24 hours' for the three months up to 15 December 2021 (14) and 23 March 2022 (23).

The group chief executive provided a weekly update which shared learning from incidents. Immediate learning was shared at the daily staff huddle attended by all staff at the beginning of each day. The provider distributed a 'sharing learnings' bulletin yearly. We reviewed the latest bulletin from March 2022. This was a summary of themes and key learnings from key significant clinical incidents causing harm and near misses across the organisation in the past 12 months. It was shared with hospital and area managers monthly who cascaded through their teams to support and promote shared learning.

Good

Surgery

The clinical lead sent incident copies and weekly updates to the team by email. There was also a monthly 'sharing lessons learnt' newsletter issued by the director of clinical services detailing any themes and learnings from significant clinical incidents.

However, service leads and staff had not undertaken training to understand human factors that underpinned the delivery of safer patient care.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The provider had a duty of candour policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person). We reviewed a recent example of a duty of candour letter from August 2021 which was open and transparent.

Staff received feedback from investigation of incidents, both internal and external to the service. Senior management told us about a recent serious incident (SI) at another site. The SI's root cause analysis (RCA) identified the reasons leading to the incident. The provider had shared lessons learnt from this SI adding additional checks and balances to the procedure to improve safety.

The provider held significant incidents lessons learnt summaries for regular company wide sharing.

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

Are Surgery effective?

Outstanding ☆

We had not rated effective before. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, the service's cataract surgery checklist was adapted from the world health organisation's (WHO) surgical safety checklist. This checklist was first published in 2008 in order to increase the safety of patients undergoing surgery. We observed theatre staff during operative procedures adhering to this checklist.

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

All staff could access policies and standard operating procedures in place to support practice on the organisation's intranet. Staff we asked were well sighted on all relevant policies. They could access these through the Netconsent system. They received update notifications to policies and procedures when logging in to the systems. The iLearn system also flagged any changes to staff.

Good

Surgery

Compliance with relevant guidelines was monitored through governance processes. The service had systems to ensure policies, standard operating procedures and clinical pathways were up to date and reflected national guidance.

The service carried out quarterly clinical audits that covered key topics. Any audits that were less than 95% compliant had actions identified, and the audit was repeated one month later. There was good compliance for the completion of these audits and actions plans were in place to address issues of poor compliance.

Nutrition and hydration

Staff gave patients enough to drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Water dispensers were available in waiting areas that patients could use. Hot drinks were available from a machine.

Staff offered patients a drink and biscuits whilst they were waiting for their appointment. Healthcare technicians (HCTs) understood their role entailed escorting patients after surgery and offering them hot drinks. If a patient's surgery was delayed staff offered them sandwiches. Staff captured any dietary requirements patients had on their admission form. Most patients only attended the hospital for a short period, therefore food was not routinely provided.

Pain relief

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

Staff assessed patients' pain and comfort throughout their procedure. Staff prescribed, administered and recorded pain relief accurately. They gave pain relief in line with individual needs and best practice. Staff documented pain scores on the recording system and controlled pain with painkillers such as paracetamol. Staff we asked used and had a good understanding of pain scoring charts. They asked patients if they were comfortable and recorded scores on the electronic medical records system and their clinical notes.

Patients were provided with a leaflet which gave advice on expected symptoms post-surgery and how to treat any pain they might have.

Patient outcomes

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

The service participated in relevant national clinical audits. The provider submitted data to the national ophthalmic database audit. Outcomes for patients were positive, consistent and exceeded expectations, such as national standards. We reviewed the service's infection rates for the last 12 months. At the time of our inspection the service's posterior capsular rupture (PCR) rate which is an operative complication was 0.66% but reduced to 0.46% by the time of our second inspection visit. This met the provider target of 0.5% or less. This was also significantly better than the UK national average of 1.5%.

The service monitored other outcomes such as visual acuity against the agreed driving standard (greater than 6/12). These were above the royal college of ophthalmology (RCOphth) benchmark standards for all four years 2018-2021.

Managers and staff used the results to improve patients' outcomes. Outcomes were benchmarked across the organisation, as well as externally, that identified good practice and areas for support and focus.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. We reviewed the service's clinical audit outcomes from November 2021 and February 2022. It showed the service achieved a monthly total of 99.6% and 97.3% compliance respectively after completing the laser safety and clinical documentation modules.

The service collated and reviewed comparative complication and infection rates for individual surgeons. Any issues were addressed immediately.

The service engaged with the private healthcare information network (PHIN) and collected and submitted data in accordance with legal requirements regulated by the competition markets authority (CMA). The provider submitted data to the national ophthalmic database (NODA).

We reviewed the service's monthly audit plan. This comprised age-related macular degeneration (AMD), clinical documentation, consent, daily safety huddle, hand hygiene, infection prevention, laser safety, medicine management – department and patient, safeguarding, surgical safety and urgent care. The service scored between averages of 96.1% (medicine management – department) and 100% (infection prevention) in all areas for the seven months from August 2021 to February 2022.

The service offered an accreditation scheme to their local community optometrists.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service maintained a skills matrix that indicated staff who had been trained and deemed competent for certain roles and responsibilities. Newly appointed surgeons had a period of supervised practice under a lead surgeon.

We found staff knowledge and awareness extended beyond the scope and responsibilities of their roles. For example, one of the location's two portering staff demonstrated extensive knowledge about services provided. All the service's patient transport drivers were trained in life support and enhanced first aid.

Any community optometrists referring to and from the service had to undergo an accreditation session before being signed off to provide patient follow up or aftercare.

Managers gave all new staff a full induction tailored to their role before they started work. Staff did not practice in any role until assessed as competent. For example, new recruits' competences were signed off after they saw ten patients. Staff competences were rechecked every three years. The service's introduction percentage for theatre staff between March 2021 and February 2022 was 99.82 and 99.96%.

All service staff completed both certified provider level and local inductions. New recruits to the service had an induction day online and face to face. Staff's platform for mandatory training (MT) was "iLearn" and "iPerform" for managers. MT was checked at four weeks, one month, three months and six month intervals after they started in their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. 100% of staff had an appraisal in the previous 12 months. The appraisal was followed up with a six month review.

Provider bank staff did not have an appraisal. One bank staff member we spoke to was happy to raise any issues they had informally or ad-hoc with senior management. They were given monthly supervision from their previous hospital manager until they left in February 2022.

Senior managers told us the service had hosted a first year student studying an undergraduate nursing degree at the local university. The placement took place in January and February 2022 and lasted seven weeks. The placement was a first for the provider and formed the first stage of a pilot to assess the suitability of our services for student nursing placements. The new hospital manager planned to agree future student placement dates and learning opportunities to roll out to other provider sites.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Team members were only considered 'in the numbers' once they were deemed competent to ensure clinical quality and patient care was of the highest standard.

Surgeon's clinical outcomes for the service were routinely reviewed by the provider's medical director (MD) who decided if/when surgeon numbers should increase. The MD used a RAG rated KPI tool to monitor all surgeon's practice and outcomes. Staff shared these at quarterly medical advisory committee (MAC) meetings, bi-monthly clinical governance meetings and operational meetings.

The service monitored quarterly comparative complications, infection rates and patient bedside manner for surgeons using a red, amber, green (RAG) rating tool.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. To develop staff skills, the service planned to train HCTs in undergoing discharge and YAG admission then further develop the training plan.

Managers told us they conducted 360 degree feedback for employees every few months.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. We asked senior managers how the service managed performance. They told us firstly they held conversations around performance with employees. These notes were added to their HR records reporting system and the employee undertook further training as required.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily 'start of the day' morning and debrief huddles were held in the hospital led by the clinical lead to plan and review the day's activities collectively. At the morning huddles staff including the fire marshall raised any concerns, safety issues, disseminated incidents, discussed patient's transport, daily tasks and lists. They shared any incorrect inputting of data at this meeting. The morning huddles were not attended by any clinical staff as they were not a multidisciplinary team (MDT) meeting.

Good

Surgery

The service's end of the day debrief huddles were attended by optometrists where staff shared further feedback. Staff told us about their MDT working between the optometrist and nurses.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service networked with other provider sites regionally. The hospital managers had their own national meetings to benchmark, share ideas and good practice. There was effective working between all staff at the location with good teamwork. The service worked well with external stakeholders including commissioners and GPs as well as private optometry services.

The service ran accreditation evenings for local opticians to enable them to support patients post-operatively in the community.

Seven-day services

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

The service was open Monday to Saturday and dependent on the demands for the service, additional surgical lists could be planned for the weekends.

There was an emergency helpline available 24 hours a day, seven days a week. Patients were informed verbally about the helpline and in writing in their discharge information. An on-call team were available to provide advice for patients when required.

The national call centre was staffed from 8am to 6pm Monday to Saturday.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The organisation had a consent policy within review date and included guidance staff could follow. The provider had a mental capacity and deprivation of liberty (DOL) policy available to all staff via a policy management software library which held all the provider's policies and procedures.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service had a two-stage consent process by obtaining written consent at pre-assessment which was re-confirmed on the day of the procedure by the surgeon.

Staff clearly recorded consent in the patients' records. The service audited this as part of its clinical documentation audit. There was a compliance rate of 100% for collecting consent information as all patients consented prior to their treatment.

Staff ensured patients consented to treatment based on all the information available. Before the procedure, patients received written information by post. Staff obtained verbal and written consent from patients before providing care.

Are Surgery caring?

Good

Surgery

Good

We had not rated caring before. We rated it as good.

Compassionate care

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

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff made special efforts to help patients. Patients we asked said staff treated them well and with kindness. Staff interacted with patients and saw that they were kind and caring. All staff introduced themselves at each stage of a procedure and were observed asking the patients questions about how they were tolerating treatments throughout.

Staff followed policy to keep patient care and treatment confidential. Discussions with patients took place in consulting rooms to ensure privacy and confidentiality.

Staff understood and respected the individual needs of each patient. They showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs and patients living with dementia.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff we asked showed good understanding of cultural/religious differences, specifically within the local population. One non-clinical staff member gave the example of de-escalating an incident where a patient made xenophobic remarks.

Staff were discreet and responsive when caring for patients. They maintained patient's dignity and respect. For example, staff would not remove headscarves for patients who wore them until just before they entered theatre for surgery.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided reassurance and comfort to patients both in private consultations and during the surgical procedure. Staff were calm and supportive providing extra time to these patients. There was an option to have someone hold your hand in theatre if a patient was particularly nervous.

Patients were provided with the organisation's "patient stories" DVD where previous patients described their experience to help relieve anxiety. Videos were also available on the organisation's website.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Due to the COVID-19 pandemic for some patients their appointment at the hospital was the first time they had left their homes.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

Good

Surgery

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff respected patient choices and delivered their care with an individualised person-centred approach.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients told us that they received information in a manner that they understood before and after the procedure. If an appointment or procedure was taking longer than planned, administrative staff telephoned waiting relatives to keep them updated to appease any potential concerns.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff captured and recorded patient feedback after every visit including pre-assessment clinic and post-operatively via a discharge questionnaire before patients left the facility. Staff also gave patients a postcard with details on how to give feedback on the NHS platforms in the patient's pharmacy bag.

Patients gave positive feedback about the service. Feedback from people who used the service and those close to them was continually positive about how staff treated people. The service conducted regular patient surveys. 100% of patients would recommend the service and felt reassured by the service and treatment provided.

We reviewed the service's patient satisfaction and nurse post-operative checks survey results from between 1 October 2021 and 31 March 2022. It showed from 1,765 responses the service achieved over 99.49% satisfaction for all metrics except one. The overwhelming majority of patient comments within this six month timeframe were positive.

Are Surgery responsive?

Good

We had not rated responsive before. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. The service worked closely with the local clinical commissioning groups (CCG's) and planned and developed services to meet the needs of the local population. The service offered surgical eye services to NHS patients working within CCG contracts. Patients were referred by their GP or optometrist.

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

We heard the example of the provider's medical director trialling a uveitis pilot at the service as ethnicities among the local population were at higher risk from this condition. Uveitis was caused by swelling of the uvea in the coloured portion of the eyes. This trial was successful and had since been rolled out to other regional and provider sites.

Good

Surgery

Managers monitored and took action to minimise missed appointments. Managers were keen not to keep patients waiting for appointments so actively contacted patients when slots became unexpectedly available.

The service had systems to help care for patients in need of additional support or specialist intervention. All cases were elective, and patients were pre-assessed before surgery. Patients with specific needs such as learning disabilities, mental capacity or physical disabilities were identified at pre assessment. Patients whose more complex needs could not be met by the service were referred on to a provider that could safely meet their specific requirements.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were two 'dementia champions' available at the hospital. These staff had undergone extra training to promote the needs of people living with dementia.

Staff understood and applied the policy on meeting the information and understood the communication needs of patients with a disability or sensory loss. The service was designed to meet the needs of patients living with dementia. Information leaflets were available in large print. The service offered cataract surgery patients a post-operative information booklet and eye drop timetable. This included a timeline of information from patient's first day of surgery, frequently asked questions, do's and don'ts, emergency contact numbers and feedback and complaints advice and information.

The service had a hearing loop for patients, families or carers with a hearing impairment. There was no specific quiet area but staff could escort patients into unused clinic rooms for this purpose if they requested. The service could accommodate patients, family or carers in wheelchairs. Staff we asked felt patients with disabilities were well cared for and staff took time to help them understand. For example, staff would pull down their mask for patients who needed to lipread.

However, we observed one junior optometrist at pre-assessment only introducing themselves to a patient by name without giving their role or wider context. This meant less verbal or cognitive patients could be potentially confused or unclear about their care and treatment options.

The service had information leaflets available in languages spoken by the patients and local community. The service had info leaflets for patients who wishes to complain in different languages. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service used two different organisations to book face to face or online interpreters for patients if needed. We observed theatre and non-clinical staff communicating via an interpreter on behalf of patients.

To be suitable for surgery patients needed to be able to lie flat and still for 15 minutes. Many patients were anxious about this so the trolley test was devised. At the assessment stage, patients were given the opportunity to lie on a bed and were timed to check their suitability. This quick and simple test, alleviated patient anxiety and helped to prevent cancellations.

Free patient transport was offered between a 10 to 30 mile range of the hospital. Staff considered patient's safety by completing individual travel risk assessments. Drivers collected patients from their home with a phone call reminder the day before their expected time.

Good

Surgery

Patients were offered an appointment within a couple of weeks from the date of their optical assessment. Staff would readily accommodate if people needed to defer appointments due to holidays, work commitments or religious festivals.

Access and flow

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

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

We reviewed the provider's latest patient access policy last reviewed in October 2019.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service's average median waiting times for patients in the 10 months from March 2021 to January 2022 was 5.71 weeks. This meant 100% of patients referred directly to the service were seen within the 18 week referral to treatment time (RTT). Managers confirmed the service had no patients that had previously been on waiting lists with another provider or delayed by Covid-19 pandemic related issues.

We reviewed the service's pre-assessment clinic (PAC) and theatre utilisation rates. At the time of our inspection this was 87.3% for PAC compared to a provider average of 38.63% across all sites. The service's theatre rate was 87.98% compared to a provider average of 80.28%.

Managers and staff worked to make sure patients did not stay longer than they needed to. There were processes in place to ensure that patients were seen and treated in a timely manner.

Managers could not always keep the number of cancelled appointments to a minimum. Following confirmation of their appointment, patients were sent out written details of their appointment and what to expect, this was then followed up by a telephone call reminder 48 hours prior to their attendance.

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

We reviewed the service's number of patient appointments cancelled after admission from September 2021 to February 2022. In these six months the service cancelled a total of 53 patient appointments. 25 of these were for clinical reasons, 24 were by the provider and four were by patients. Managers confirmed these 53 cancelled appointments included one full theatre list due to adverse weather conditions. Staff treated all patients on this list within the same month by adding an extra theatre list to their schedule. 25 patient cancellations were due to general health reasons such as patients on a current course of antibiotics, with open wounds and/or high blood pressure.

When patients had their treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. If the service had to cancel a patient, they were brought back within one week. If theatre staff could not perform the surgery at the service, they tried to transfer the patient to alternative sites.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. In the discharge room a registered nurse provided the patient with discharge information and guidance both verbally and in writing.

Good

Surgery

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service had a complaints policy and clearly displayed information about how to raise a concern in patient areas. Patient complaints procedure leaflets were available in reception areas advising patients of how they could provide feedback or submit a complaint by email, phone or post. Patients could speak to a receptionist or contact the provider's chief operating officer.

Staff understood the policy on complaints and knew how to handle them. We reviewed the providers' latest policy for complaints next due for review in April 2023. The policy's scope and detail mentioned the need to be open and transparent adhering to the duty of candour.

In the 12 months before our inspection the service received six complaints. There were no themes identified from the complaints.

All upheld complaints had an action plan including a timeline and lessons to be learnt if necessary. The service aimed to acknowledge all formal complaints within three days of receipt and respond to them within 20 working days.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The provider held complaints training around process and ownership which included a section on incident reporting database improvements such as expanding login access for complaints, the use of "actions tab" and database requests for reminder alerts in complaints.

Managers investigated complaints and identified themes. We reviewed one of the service's recent complaint acknowledgement and response letters from the hospital manager in January 2022 which covered all of the patient's concerns.

Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed the last three complaints received by the service at the time of our inspection. All were from January 2022. The hospital manager investigated the actions taken and shared lessons learnt in response to all these complaints, two of which were given by verbal feedback.

Staff could give examples of how they used patient feedback to improve daily practice. For example, staff had fitted bright yellow and black highlighting signage to help patients with impaired vision. The service had also increased their non-clinical workforce from one to two porters who worked alternate shifts. This ensured patients were routinely escorted from arrival to departure, and throughout their visit.

Are Surgery well-led?

Good

We had not rated well-led before. We rated it as good.

Good

Surgery

Leadership

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

The service had no hospital manager for the two months before our inspection, after the last hospital manager left in mid-February 2022. However, senior managers and staff told us other hospital and area managers as well as clinical leads had been readily available and supportive during this time. The area manager had acted as the service's interim hospital and line manager for all staff. The service's new hospital manager started their role on 4 April 2022 and was previously a training registered practitioner within the organisation.

There was a clear management structure with defined lines of responsibility and accountability.

Staff told us that there was good local, regional and national leadership within the organisation. Leaders were well respected, approachable and supportive. For example, non-clinical staff we asked said their last hospital manager was very approachable and dealt with issues quickly. Leaders were passionate about the service and worked well with staff to deliver the best possible outcome for their patients.

Leaders held regular staff meetings and staff told us they felt their views were heard and valued.

Senior managers attended regional and national meetings with the senior leadership team (SLT) where they received updates, discussed governance and performance and shared learning.

Senior managers told us they had recently created a management development programme in house to 'grow their own' and encourage their ambitious staff to progress.

However, we reviewed the service's employee survey results from January 2022 relating to management completed by nine staff. Staff responses to many of the 80 statement questions were neutral overall with similar numbers agreeing or disagreeing.

Vision and Strategy

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

The organisation's vision and strategic objectives were 'every patient, every time. no excuses, no exceptions'. They focused on various objectives to achieve and improve. Visions and values displayed on the staff notice board were safety, integrity, kindness and transparency.

The organisation's values were included in the induction for all staff and available on the organisation's website.

The organisation's strategic overview focused on growth, quality, leadership, governance and developing the infrastructure. The provider's board members met weekly to review progress against the strategy.

Staff were committed to upholding the vision and values and managers spoke openly about the corporate strategic aims.

Good

Surgery

Culture

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

Staff said they were very proud of the service they delivered and described their colleagues as supportive. All staff told us they had good working relationships with their colleagues. For example, one porter said they felt like an important part of the organisation.

Staff were patient focused, and the culture was focused on the needs and experiences of people who used the services. Several members of staff told us they were proud of the care they gave to patients and told us they felt the service was patient centred. We observed positive working relationships and engagement with patients.

Staff described the service's open door policy in raising any incidents or concerns. They felt very happy and valued working for the provider.

All the service's policies and procedures we reviewed included an equality impact assessment section and screening tool. These sections outlined the provider's statutory responsibility under the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005 and the Equality Act 2006. The provider identified and addressed any adverse impact related to staff's protected characteristics. The service met the national WRES reporting requirements in requesting ethnicity details from their staff.

The organisation had an incentive reward scheme, a recognition scheme and during certain months, provided snacks to staff as a thank you. There was a 'going home' checklist that suggested staff completed actions such as 'took a moment to think about the day', thought about things that had gone well and then advised staff switched their attention to home and recharging after work.

Provider staff could access an employee assistance programme (EAP) and numerous extra benefits through an online platform which provided free advice, guidance and counselling, along with wellbeing support. However, in the service's last employee survey from January 2022 all nine staff who responded had never accessed the EAP through the provider benefits online platform (Q39).

The provider had trained several staff to be mental health first aiders and had an occupational health service available for staff if required. However in the service's last employee survey from January 2022, six of nine staff who responded were unaware who the mental first aiders were or how to contact them (Q41).

The service provided lateral flow test (LFT) devices to all staff for twice weekly testing. Managers carried out Covid-19 risk assessments on all staff. The provider offered all service staff a free flu vaccine, which could be arranged through their manager.

Any service staff could nominate other employees for a patient/office hero award each quarter to recognise somebody who goes above and beyond. At the end of the year a patient/office hero of the year was chosen and awarded a weekend break and an extra day's holiday.

The service offered staff peer to peer recognition through pre-printed cards to acknowledge and celebrate great work. They also had a length of service recognition scheme to celebrate staff commitment. Staff received cards signed by the executive team, certificates and gift vouchers depending on their length of service.

The provider aimed to improve staff engagement by promoting several events throughout the year. Examples include cultural events like Ramadan, Diwali and Christmas jumper day to awareness days like cancer and children's charity coffee mornings. Staff could also suggest events the provider had not previously covered. One non-clinical staff member had suggested introducing team 'away days' which had been fed back to the senior leadership team (SLT) for consideration.

Senior managers provided regular updates to hospital teams through department meetings, weekly e-mails and monthly newsletters. They aimed to maximise communication channels with their staff to be accessible. Senior managers could be contacted by any staff and area managers/people business partners maintained a regular presence at the service.

An annual staff survey was undertaken every February. At the time of our inspection senior managers were analysing and collating results to address any areas of concern. The organisation had a timeline of activities responding to employee feedback to celebrate what they did well and how they could improve. There were staff forums to also capture feedback and measure how they performed.

Governance

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

There was an effective governance structure, processes and systems of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

There was a medical advisory committee (MAC) which met quarterly with responsibility for surgeon performance and surgery specific matters. The service monitored individual consultant files, checking registration with the General Medical Council (GMC), professional indemnity and appraisals. The MAC reviewed the monitoring processes with a responsible officer on the MAC.

A clinical governance meeting was held bimonthly. We reviewed the last three sets of meeting minutes and saw they were well attended by the representatives from the SLT, hospital managers and clinical leads. Agenda items included clinical governance, quality, risk, compliance and audit. All levels of governance and management worked effectively together.

The provider's clinical governance meeting minutes from 16 December 2022 stated the service recently had lots of cancelled treatments caused by staff shortages.

We followed this up with the service who shared their summary of patient surgery cancellations within 24 hours between 15 July and 15 December 2021. During this six-month period there was a total of 21 patient cancellations within 24 hours of treatment which was 0.13 % of the total activity. The most common reason given was the surgeon rescheduling surgery for eight of these 21 cancellations. Another six patients of the 21 were cancelled by the clinical team due to various issues.

However, only one of the 21 reasons given were related to staffing; the surgeon and three staff were unable to attend due to severe weather conditions so the surgery was rescheduled. This meant clinical governance meeting minutes were inaccurate and overstated the service's staffing shortages.

At the time of our inspection the provider clinical governance team were reviewing clinical audit questions to be more based on previous outcomes and learning. In 2022/23 the provider planned greater focus on audit action plans for sites with lower scores and requested line graph data to monitor improving and/or deteriorating trends.

Significant incidents and themes were reported and discussed at the organisation's national clinical governance and clinical effectiveness bimonthly meetings, medical advisory and health and safety committees.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits were completed monthly, quarterly and annually as per the providers audit schedule. Results were monitored by the local, regional and national management team. Results were shared at relevant meetings including the hospital team meetings and clinical governance meetings.

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

The provider planned to continue governance culture growth in 2022 with support to consistently complete audits and the "so what" aspect of action planning, monitoring and improving practice, sharing learning. At the time of our inspection the provider' governance team were expanding and applying for a clinical governance lead for the South.

Management of risk, issues and performance

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

Service leads had a clear and effective process for identifying, recording and managing risk. The risk registers were rated on severity from 'none' to 'catastrophic'. The hospital and area managers reviewed all local risk registers routinely every month in accordance with the risk severity. We reviewed the service's local risks at the time of our inspection. The service's highest rated risk related to inadequate staffing which they felt was insufficient to cover activity levels and caused reliance on agency staff.

Risks had been identified with control measures in place and review dates to help reduce any risk.

For example, the service had recruiting in place, use of familiar agency staff, staff working overtime and the hospital manager covering gaps in clinical activity where possible in response to their inadequate staffing risk.

The provider's latest infection prevention policy section 10 stated '*The hospital manager is responsible for ensuring the correct and safe disposal of clinical waste'*. The service included clinical waste issues as a risk on their local risk register under the environmental impact risk type. At the time of our inspection this risk severity level was moderate. This detailed the risk of contractors not fulfilling their contract or staff not complying with standard operating procedures (SOPs). Variation in theatre activity made it unpredictable to ensure there was always sufficient clinical waste capacity. The other surgical hospital provider sometimes over-spilled their clinical waste into the service's bins.

Managers told us in response they had emailed a request to the other provider and landlord who shared the building on 24 April. The service proposed their own separate waste stream within the compound. We followed this up and request an update after our inspection. The area manager confirmed their email had triggered the waste provider company to schedule an assessment to meet the hospital manager onsite to review the clinical waste area and gain a quote for a separate waste stream. The service were awaiting this on 24 May.

We reviewed the service's monthly health and safety checklist audit completed by the former hospital manager on 15 February 2022. This showed the service had some periods of non-collection leading to overflowing of general and clinical waste bins. The manager had escalated this to the building's waste collection contractor.

Good

Surgery

Senior managers were committed to providing quality care for patients. Surgical performance was monitored quarterly using a dashboard that included outcomes of surgery and bedside manner on a red, amber, green (RAG) rated system. Consultants who operated at the location were rated green.

We reviewed the provider's operations board report for March 2022. It included a RAG rated chart highlighting the service's need to address legacy issues around team culture. The report advised stronger leadership to ensure staff felt more supported. We asked managers about these issues who acknowledged there used to be some division and communications issues between service departments. They had worked to improve this through chat-based workspaces online for both theatre and clinic staff where everyone could contribute, feel heard and listen.

The company collated patient outcomes and submitted data to national audit to benchmark their performance against other service providers. The data provided showed that they met or exceeded the performance targets for all indicators. In addition, the senior team planned services and used resources effectively to ensure they met referral to treatment times which were much better than the national average.

The service was peer reviewed as the first of 21 sites in 2021 where a hospital manager visited another provider site and completed a focused peer review and validation process with the area manager. The managers then devised an action plan and shared outcomes nationwide to encourage standardisation and best practice. This bi-annual peer review programme was restarting in May 2022.

Regional senior managers completed a monthly CQC self-assessment tool based on our key lines of enquiry (KLOEs) for the service. The tool's outcomes were reviewed at their provider-level clinical governance meetings. We saw the service had completed the audit tool for November 2021. They achieved a total monthly score of 98.3%. Their score was fourth highest out of 36 provider sites who submitted results.

However, in February 2022 the service was the only site which didn't submit their CQC audit tool results due to their hospital and area manager's departure. Senior managers provided support to the new hospital manager to achieve the March 2022 submission.

Information Management

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

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

The service submitted 100% of their data to benchmark and monitor their clinical outcomes nationally. For example, they submitted data to the national ophthalmology database (NOD) clinical audit to measure their performance rates against other similar services in the sector. NOD is run by the royal college of ophthalmologists (RCOphth) which measures the outcomes of cataract surgery and includes a new age-related macular degeneration (AMD) audit to protect patient safety and professional standards.

SpaMedica had invested significantly in their IT infrastructure to improve the accessibility of patient records and the performance of both the central contact centre and the administration team. This had also included a staff intranet and development of their website to improve the resources and information available to staff and patients.

Good

Surgery

The service had a poor local network for WiFi or internet access onsite with potential loss of access to essential systems. This was due to their shared occupation of the building. However, managers had controls in place which they deemed adequate to mitigate this risk on their local risk register.

Engagement

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

Staff feedback was encouraged through staff surveys and forums where concerns could be escalated to senior leaders.

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

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

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

The provider conducted a patient feedback programme, which included feedback for patient booklets. SpaMedica booklets were adapted as a result of this engagement with patients to improve how information was shared.

We saw the area manager who was interim hospital manager for the service invited any staff feedback in an email dated 22 March 2022. We heard staff responses to this email focused on their needs to upskill and learn new competencies. Managers had responded by drawing on all resources to invest in helping service staff develop. Other staff felt colleagues used to be more sociable so the area manager made themselves and tried to make other staff available more informally.

Learning, continuous improvement and innovation

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

We heard about some recent ongoing research projects trailed at the service and subsequently rolled out. The medical director had carried out research into how social deprivation and ethnicity impacts cataract surgery outcomes and post-operative care. This was presented at ophthalmic conferences and was published in a national journal for the medical profession.

The service had implemented a point of care finger prick testing of international normalised ratio (INR) at all SpaMedica sites. Patients did not need to go to the warfarin clinic or require a district nurse to check their INR seven days prior to surgery (as per RCOPhth). This reduced the burden on the NHS and streamlined the pathway for the patients.