

Independent Health Group Limited

Independent Health Group Limited

Inspection report

Independent Health Group Head Office
8 The Office Village, Bath Business Park
Bath
BA2 8SG
Tel: 03330100362
www.ihg.org.uk

Date of inspection visit: 04 April 2022, 14 April 2022,
19 April 2022
Date of publication: 08/09/2022

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

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive to people's needs?

Good 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

We have not previously inspected this service. We rated it as outstanding because:

- The service had enough staff to provide innovative, holistic care for patients that kept them safe and promoted wellbeing beyond their clinical need. Staff had extensive training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided care and treatment that went above and beyond expectations and that was holistic by nature.
- Managers monitored the effectiveness of the service through a programme of continual, ambitious auditing and benchmarking. They made sure staff were competent by providing an extensive programme of continual professional development.
- Staff worked well together for the benefit of patients and used a wide range of multidisciplinary opportunities to explore opportunities for improved care. Staff advised patients on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week and staff sought an expansion of some services where this would improve patient outcomes.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. This approach was fully embedded in all aspects of care. Staff provided individualised emotional support to patients, families and carers and adapted care delivery based on individual needs.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. The service aimed to reduce waiting times for NHS patients and prioritised those who had already exceeded national maximum waiting times.
- Leaders ran services well using reliable information systems and supported staff to develop their skills through a programme of engagement. Staff understood the service's vision and values, applied them in their work, and used provider standards to challenge the status quo. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and creating a working environment that promoted innovation and development. Staff were clear about their roles and accountabilities. The service engaged meaningfully with patients and the community to plan and manage services and all staff were committed to improving services through research and exploration of new evidence-based practice.

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Outpatients

Outstanding



We have not previously inspected this service. We rated it as outstanding because:

- There was a strong culture of safety and staff worked within least-risk care frameworks.
- Care and minor procedures reduced waiting times for patients and meant they could be seen at convenient community locations.
- Patient outcome monitoring was embedded in the service and demonstrated consistently good outcomes for patients.
- Outpatients operated in a culture of learning and multidisciplinary working that meant patients received care from professionals with up to date experience.
- The average referral to treatment time was 4.8 weeks and no patients had breached the maximum 12 week wait.
- Staff openly engaged with patients and it was common practice to use feedback for changes and improvements.
- Care was compassionate and individualised, and staff took the time to listen to patients.

However:

- A variety of factors meant there had been delays to issuing clinic letters within the provider's seven day standard.

Outpatients operated separately from surgery but shared governance, leadership, and elements of other core processes. Where arrangements were the same, we have reported findings in the surgery section.

Surgery

Outstanding



We had not previously inspected this service. We rated it as outstanding because:

- Staff demonstrated a good track record of infection prevention and control standards, including low rates of surgical site infections.
- Safeguarding processes were comprehensive and reflected the geographically-spread nature of the service.

Summary of findings

- Safety systems and operating procedures were appropriate to the nature of the service, such as providing clinic care from rented premises of other providers. Patients received safe care as a result.
 - Medicines management focused on ensuring essential items were always available, including during a national shortage.
 - Care was demonstrably evidence-based, and the service actively monitored changes in national standards and guidance to ensure practice was up to date.
 - The service performed well in relation to access and flow. Unplanned readmission rates were consistently low, cancellation rates were very low, and staff offered flexibility to meet individual needs. Capacity planning was focused on reducing waiting times for patients.
 - Staff adapted the service to meet the needs of people living with mental health challenges, including learning disabilities.
 - Clinical governance processes were tailored to the service and the needs of patients. The senior team was integrated, collaborative, and worked with colleagues across health economies to coordinate care.
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Summary of findings

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Summary of this inspection

Background to Independent Health Group Limited

The Independent Health Group Limited delivers surgical and outpatient services. The name of the provider and the registered location are the same.

The service was registered to provide regulated activities in 2018 and this was our first inspection. There was a registered manager in place.

The service provides clinical care to NHS patients from rented clinical space in 12 GP practices across England. The organisation provides staff, records, and some equipment. Each clinical site has its own arrangements with the building operator with regards to areas such as cleaning, storage, and emergency procedures.

The organisation provides both surgical and outpatient services for hernia, cataracts, vasectomy, hand, and podiatric surgery

In the 12 months leading to our inspection, the provider carried out 10,570 spells of patient care. This included pre-assessments, operations, outpatient visits, and follow-ups.

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

How we carried out this inspection

We carried out a series of short-notice announced inspection days of the service on 4 April 2022, 14 April 2022, and 19 April 2022 using our comprehensive methodology.

To inspect and rate surgery and outpatients, as well as governance and safety arrangements, we carried out three days of activity. These included a clinical site inspection at a GP practice in Chippenham for surgery, a clinical site inspection at a GP practice in Swindon for outpatients, and a day speaking with the head office team. GP practices are inspected, regulated, and rated separately and our report does not include any judgements of their services.

At the time of our inspection the provider operated from 12 sites. Our approach was therefore a sample and we supplemented this by asking the provider to submit data and other evidence to us of their standards and practices.

A lead inspector and a specialist advisor carried out the surgery inspection. A lead inspector carried out the outpatients inspection and head office interviews.

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:

Summary of this inspection

- Staff were empowered and worked well together to deliver a highly personalised, responsive service. This included on-demand and short-notice reviews following clinical procedures that exceeded usual expectations of care.
- Governance structures and strategies were stretching and embedded into all aspects of care. They demonstrably contributed to safer care and better outcomes.
- There was a culture of continual learning and development. This included at clinic level where consultants supported healthcare assistants to develop and at senior level where staff continually sought development opportunities for colleagues at all levels.
- The senior team had a demonstrable focus on equality for staff and patients. They assessed each policy and work process to ensure services were as accessible as possible and benchmarked policies and standard operating procedures against equality frameworks.
- The provider had a persistent, demonstrable focus on quality improvement and clinical effectiveness. They were research active and used national and international benchmarking to ensure the latest standards of practice.
- The audit programme was substantial and was based on a review of national audits to identify those of most use.
- The senior team maintained a demonstrable focus on reducing pressure on NHS services and reducing waiting times for patients through flexible working and new partnerships.

Areas for improvement

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










Action the service SHOULD take to improve:

- The service should establish more frequent opportunities for staff to meet each other for developmental and professional purposes.
- The service should continue to improve clinic outcome letter times in outpatients.






Our findings

Overview of ratings

Our ratings for this location are:

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

Outpatients

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

Are Outpatients safe?

Good 

We have not previously inspected this service.

We rated it as good.

For mandatory training, safeguarding, cleanliness, environment, records, medicines, and incidents, see surgery.

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 knew about and dealt with any specific risk issues. Staff demonstrated a clear understanding of specific risks to minor surgery in GP outpatient settings. They used consistent, appropriate risk assessment measures to reduce such risks. These were effective based on the safe track record of the service.

Podiatry staff carried out minor surgery procedures in the outpatient clinic. They used an appropriate checklist system to ensure each member of staff had a designated role. Staff documented key times, such as tourniquet on and off times, and used a tracing system for consumables.

Staff ensured patients had someone to take them home after minor surgery and encouraged them to avoid work for an appropriate period to help the wound heal.

Staffing

All outpatient services were led by consultants or senior doctors with healthcare assistant and nurse support.

Three matrons led on clinical specialties and geographic areas. In outpatients, one matron was responsible for podiatry across all areas.



Outpatients

Are Outpatients effective?

Inspected but not rated



We have not previously inspected this service.

We do not currently rate effective for outpatients.

For evidence-based practice, see surgery.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Consultants liaised with patients' GPs for post-operative pain relief and provided referrals for patients who found it difficult to manage oral analgesics.

Staff used a verbal assessment scale to help understand each patient's level of pain.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Consultants prescribed pain relief for the first 24 hours following all surgical interventions to reduce the impact of breakthrough pain and improve recovery.

Staff in each specialism audited pain relief on a monthly basis with patients. In the previous four months, staff recorded pain scores for 90% of patients. In the same period, 89% of podiatry patients said interoperative and postoperative pain had been managed well.

Patient outcomes

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

Outcomes for patients were positive, consistent and met expectations, such as national standards. Consultants asked patients to define their best outcome from treatment and reported these as individual patient-reported outcome measures (PROMs). For example, during our site visit the consultant asked a patient, "What do you hope for?" and then tailored the assessment and advice to their individual needs.

Staff used information from the audits to improve care and treatment. For example, consultants changed the equipment they used during treatment for bunions to better manage pain in the 24 hours post surgery. They implemented this change as a result of audit outcomes and feedback from patients.



Outpatients

Staff provided patients with appropriate medical consumables to take home after a procedure, such as sterile dressings after minor surgery. They provided specific follow-up information such as who to contact if they had a concern or query at any given time.

Consultants prescribed exercise regimes to patients to help them recover from minor surgery and to improve long-term outcomes for on-going health problems. During our observations, staff asked patients to show them how they were doing their excises and provided interactive feedback to make sure the activities were useful.

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.

Managers supported staff to develop through yearly, constructive appraisals of their work. Consultants said they were happy with the supervision options and said they could request a supervision from the medical director at any time.

We observed a culture of learning and development during consultants and treatment. For example, the podiatry team saw patients with a wide range of different needs and the consultant proactively coached their healthcare assistant colleague during treatments.

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 worked across health care disciplines and with other agencies when required to care for patients. Consultants arranged onward referral to biomechanics for walking assessment and fitting for orthopaedic shoe inserts and physiotherapy, including ultrasound.

Staff organised joint lists for patients with complex needs. Consultants had good working relationships with colleagues in regional NHS services and referred patients where treatment was needed out of their scope of practice, including for urgent intervention.

Staff actively sought opportunities for new multidisciplinary working. They had secured new equipment for plantar plate surgery and additional professional input to schedule joint lists.

Matrons worked with GP practices to delegate high-dose vitamin D provision to patients after minor podiatric surgery. This helped to strengthen bones during recovery.

Seven-day services

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

Health promotion

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



Outpatients

The service had relevant information promoting healthy lifestyles and support in patient areas. Staff provided clinical services from rented spaces in GP practices and patients used shared facilities such as waiting rooms and toilets. GP practices displayed local health promotion campaign material in these locations, such as signposting to domestic violence and sexual health services. Staff displayed information in their own clinic areas relating to smoking cessation, living well, and alcohol reduction.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Consultants encouraged patients to reflect on their exercise and lifestyle choices and worked with them to make changes that could improve treatment outcomes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consultants followed a three-step consent process as part of minor surgery planning. This involved discussing alternatives, preferences, and risks to help the patient make an informed choice.

Staff confirmed consent in detail with each patient and included details relating to allergies and medicines. They asked for consent before carrying out a physical examination and explained what they were doing and why.

Are Outpatients caring?



We have not previously inspected this service.

We rated it as outstanding.

Compassionate care

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

Patients said staff treated them well and with kindness. One patient told us, "This didn't feel like minor surgery, it was more like a coffee morning with friends!"

Patients provided consistently positive feedback in surveys. One patient noted, "Everyone in the IHG has looked after me so well from start to finish. I cannot thank them enough." Another patient wrote, "Staff very friendly and supportive through the whole procedure so thank you."

Emotional support



Outpatients

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

Staff had a genuinely caring, holistic and supportive approach to each patient's needs. They took time to understand each individual's personal circumstances and how their medical condition was impacting their daily lives. Staff showed empathy and worked with patients to reduce the impact on their lives, such as by finding ways for a patient to safely return to the gym.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed the consultant confirmed the reason for the patient's appointment, discussed their recent clinical notes, and discussed the plan for the appointment.

During our clinical site visit, staff asked patients for feedback during procedures to identify how they were feeling. As many patients did not have a confirmed diagnosis and consultants worked to establish the medical problem, they delivered interactive sessions to fully understand each person's symptoms. This reflected a deep, holistic approach to care that was above and beyond usual expectations.

Staff explained to each patient what to do after minor surgery or their appointment. For example, they told them what to expect in the coming hours and days and when and how to seek help. Staff went the extra mile to make sure patients understood this by providing guidance tailored to their circumstances.

Consultants used an ultrasound machine to help diagnose podiatric conditions. During our observation the consultant turned the screen towards the patient and explained what they could see and what the problem was. The consultant explained how the ultrasound had picked up an issue a previous hospital scan had not and used language matched to the patient's level of understanding.

Are Outpatients responsive?

Good



We have not previously inspected this service.

We rated it as good.

For learning from complaints and concerns, see surgery.

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.



Outpatients

The service had systems to help care for patients in need of additional support or specialist intervention. The matron and consultant post-operative on-call system worked well in practice. For example, one patient experienced an unusual side effect at home after a minor procedure. They called the provider who arranged for an immediate return to the clinic. The consultant carried out a full review of the patient's condition and adjusted their treatment and medicine as a result.

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.

During our clinical site visit, staff checked if each patient was comfortable and offered to adjust the temperature.

Consultants provided specific, individual advice for each patient about changes to daily routines that would help improve their health or reduce pain. For example, during one observation a consultant showed a patient how to tie their shoelaces differently, which would provide them with more support.

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.

Staff led mixed clinics that included first consultations, on-going reviews, and minor surgery.

In the previous 12 months, no patients waited longer than 12 weeks for outpatient treatment from the time of referral. The average referral to treatment (RTT) time was 4.8 weeks. In 100% of cases the provider saw patients referred for a nerve conduction study within six weeks. This fully met the time to treatment target.

The provider standard was to issue a clinic letter within seven days of each appointment. At the time of our inspection, average compliance was 57% against a target of 100%. Delays to letters were caused by administration staff shortages following the pandemic, clinical delays caused by sickness amongst consultants, and the inauguration of a new service, which opened to full capacity, and caused a short-term delay to letters.

Staff automatically assigned patients to an outpatient follow-up clinic on confirmation of a surgery date. This ensured continuation of care.

Staff could book follow-up appointments at the time of a consultant for some clinics. They offered patients flexibility to meet their preferences.

Podiatric consultants accepted referrals from local podiatry services and GPs. If onward referrals were required, consultants referred patients to regional orthopaedic clinics.

Are Outpatients well-led?

Outstanding 

Outpatients






Outstanding 

We have not previously inspected this service.

We rated it as outstanding.

Please see surgery.

Surgery

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

Are Surgery safe?

Good 

We have not previously inspected this service.

We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Each individual was required to maintain up to 11 mandatory modules depending on their role. At the time of our inspection, 90% of staff were fully up to date, which met the provider's target of the same percentage.

The mandatory training was comprehensive and met the needs of patients and staff. Required training was role-dependent and included modules such as infection prevention and control, moving and handling, and data security. All modules were appropriate for the settings in which staff worked. For example, all staff undertook a standard fire safety module. The provider supplemented this with local safety procedures at individual clinical sites.

Clinical staff completed a wide range of mandatory training including awareness of autism and dementia. Consultants worked with referrers to ensure surgical treatment was safe and appropriate.

Managers monitored mandatory training and alerted staff when they needed to update their training. The senior team had developed a tracking system that considered the wide range of working arrangements reflected amongst the staffing team. This was good practice with a fragmented workforce, many of whom also worked substantively for NHS services. The system meant senior staff reduced duplication of training where an individual held the same certification with their main employer.

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.



Surgery

Staff received training specific for their role on how to recognise and report abuse. Staff completed training in adults and children safeguarding to a level commensurate with their role. For example, administration staff completed training to level one and clinical staff completed training to levels two or three. The provider's safeguarding lead maintained training to level four. At the time of our inspection, 97% of staff were up to date. This was significantly better than the provider's 90% target.

The service required all staff to complete UK government 'Prevent' training, which aimed to identify and report evidence of extremism, as a safeguarding measure. At the time of our inspection, 92% of staff were up to date.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The duty matron was the first point of contact for safeguarding referrals and coordinated contact with local services.

Cleanliness, infection control and hygiene

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

Clinical areas we inspected were clean and had suitable furnishings which were clean and well-maintained.

The service performed consistently well for cleanliness. Matrons undertook a rolling programme of infection prevention and control (IPC) audits, including hand hygiene to monitor adherence to Association for Perioperative Practice guidance. An audit in March 2022 found 59% compliance, with a need for improvement in pre-surgery scrub techniques. The result indicated the audit process was working to highlight substandard practice and the matron worked with the team involved to return their practice to compliance.

Staff used the aseptic non-touch technique (ANTT) as part of IPC routines. Posters were displayed in staff areas to guide best practice.

Staff used records to identify how well the service prevented infections. Staff monitored and reported clinic-acquired infections, including Methicillin-resistant *Staphylococcus aureus* (MRSA), and *Clostridium difficile* (*C. Diff*). In the previous 12 months there had been no infections, reflecting consistently high standards of practice.

Staff followed infection control principles including the use of personal protective equipment (PPE). IPC was a mandatory part of training for all staff. Overall, 82% of staff were up to date with training, which was lower than the provider's target of 90%. This was an average and reflected 100% completion of IPC level one and 64% of IPC level 2.

Staff cleaned equipment after patient contact and this provider was the only user of clinical spaces in GP practices. This enabled the local team to keep track of cleaning schedules.

Staff worked effectively to prevent, identify and treat surgical site infections. In the previous 12 months, the service reported 18 surgical site infections (SSIs). This reflected a very low incidence rate of 0.6%. The senior team used an investigation process that reflected the geographically spread nature of the service. For example, they reviewed local practices at the specific location to identify opportunities for learning then shared these across the clinical site network.



Surgery

Staff used an electronic monitoring tool to record and track infection-related incidents, including SSIs. This enabled all staff who worked for the service to access records and reports.

Environment and equipment

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

The provider rented clinical space from other services, most often GP practices. During their contract, clinical space and equipment was reserved solely for the provider's team. This meant staff had assurance equipment was reliably available and they maintained oversight of maintenance and stock.

Staff underwent local fire safety inductions for each clinical site from which they worked. This was in addition to the provider's standard fire safety training and meant staff safely adapted to different work environments.

Staff used an adapted version of the NHS National Patient Safety Agency National Cleaning Standards (NCS) to audit clinical environments. While building operators were responsible for overarching maintenance and structure, the provider audited specific environmental standards to ensure environments were fit for purpose. In the previous three months audits found 99% compliance with NCS standards.

The design of clinical environments followed national guidance. Staff delivered clinical care from GP practices compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 and 00/10 in relation to clinical environment design and infection control in the clinical environment.

Staff followed Control of Substances Hazardous to Health (COSHH) Regulations. They stored chemicals securely and maintained up to date safety information on each item.

The service was fully compliant with DHSC Health Technical Memorandum (HTM) 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste.

Spill kits were stored in key locations and included equipment to help staff contain bodily fluid spills and other similar risks.

Staff carried out daily safety checks of specialist equipment. A designated member of staff at each site was responsible for stock control and arranging maintenance. Healthcare assistants (HCAs) managed the tracing system for surgical equipment, including tracking of single-use items.

Each clinic had emergency resuscitation equipment including an automatic external defibrillator (AED), airway support equipment and anaphylaxis rescue medicine. Staff displayed directional signs to help them locate emergency equipment quickly. This enabled staff who worked across different clinical sites to remain up to date.

The service had enough suitable equipment to help them to safely care for patients. We looked at a sample of five items of clinical equipment during our inspection. Each item had a service sticker attached that showed the equipment had been serviced and was safe for use. The service managed equipment maintenance and service through contracts with NHS and private providers. The senior team maintained a central log of equipment at each clinical site and arranged maintenance, service, and capital replacement in advance. Staff at each site had an urgent escalation pathway to secure support in the event of equipment failure.



Surgery

Staff disposed of clinical waste safely and in line with HTM 07/01 (2013) in relation to the safe management and disposal of healthcare waste.

Assessing and responding to patient risk

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

Staff used the national early warning scores (NEWS2) tool throughout each procedure to identify deteriorating patients and escalate their care.

The provider had a protocol to support the safe transfer of patients in a medical emergency. Staff treated patients who were medically stable, and the transfer protocol was good practice in the event a patient unexpectedly deteriorated. In the previous 12 months, staff arranged the transfer of one patient to an NHS emergency department during treatment. The transfer demonstrated adherence to the provider's policy.

Staff used a three point ID check with each patient before treatment. This reflected national good practice in line with NHS standards.

Staff used the World Health Organisation (WHO) surgical safety checklist to prepare and carry out treatments safely. The senior team monitored completion of the checklists through documentation and observational audits. In the previous 12 months, staff achieved 99% compliance.

Staff completed risk assessments for each patient and reviewed them regularly, including after any incident. Risk assessments helped staff to make sure patients were medically fit for surgery.

Staff knew about and dealt with any specific risk issues. They carried out a risk assessment for venous thromboembolism (VTE) for each patient at the pre-assessment stage and audited completion. In the previous 12 months, 100% of patients had a VTE risk assessment. In the same period staff reported one case of organisation-acquired thrombosis and carried out a review to identify opportunities for improved practice.

Staff completed life support training to a level commensurate with their role. Theatre practitioners and podiatric clinicians completed immediate life support (ILS) training and local anaesthetic toxicity training. Other clinical staff completed basic life support (BLS) training. At the time of our inspection, 90% of staff were up to date, which met the provider's target. Surgeons and consultants held advanced life support (ALS) training with their substantive NHS trust..

Surgery teams established specific roles in the event of a patient emergency prior to each operation. Each surgical list had an ILS-trained practitioner as part of the team.

The service facilitated access to out of hours mental health liaison and specialist mental health support if needed after surgery. Staff maintained up to date knowledge of local procedures to be used in the event a patient needed help. This was comprehensive process that reflected the range of different areas in which the service operated.

Staff arranged onward referral for psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Consultants delayed treatment for patients who presented with mental health needs or for whom they had capacity and consent concerns. This reflected the provider's policies and working ethos to prevent inappropriate



Surgery

treatment to patients with unmet mental health needs. The patient records system was the same as that used by GP practices, which meant consultants could identify known concerns or risks to patients. This worked well in practice and staff demonstrated rapid action when a surgeon contacted the quality and governance team to raise a concern about a patient's suicide risk to ensure nothing had been missed.

Staff shared key information to keep patients safe when handing over their care to others. They acted on urgent findings in test results to keep people safe and ensure they received the right care. This included where consultants had referred patients to other services for tests, such as a hernia ultrasound or a foot X-ray. The patient pathway coordinators provided a rapid response service in such circumstances. For example, a recent instance showed a patient had a previously undiagnosed fracture after a consultant had referred them for an X-ray. The booker and referring consultant secured the patient an appointment at an appropriate clinic within 24 hours.

The patient pathway team were trained to escalate urgent concerns to clinicians. The provider trained this team in handling urgent needs to ensure patients who called the service after a procedure had rapid access to an appropriate level of support.

Most clinical staff were trained as chaperones and the bookings team arranged this in advance. Posters were on display in clinical areas that explained how to request a chaperone. Staff did not carry out chaperone duties unless they had up to date training.

The medical director described an ethos of safety throughout the service and worked with practice managers in GP sites to ensure local procedures were embedded.

Staffing

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

The service had enough nursing and support staff to keep patients safe. A range of 78 clinical and non-clinical staff provided clinical services. The provider employed two consultants and 17 consultants and surgeons worked under practising privilege (PP) arrangements. One consultant and two GPs with specialist training working under PP arrangements provided carpal tunnel and trigger finger treatment. Senior theatre practitioners, theatre practitioners, and healthcare assistants (HCAs) supported consultants and nurses in specific clinics. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Patient care was pre-planned, which meant the service knew in advance how many staff were needed. Nurses and HCAs worked across clinical specialties in line with their training and professional interests.

The service had low and/or reducing vacancy rates. 6% range 0-13 In the previous 12 months the service an average 6% vacancy rate and a turnover rate of 2%. During this period the service had a 2% sickness rate. The nature of the workforce meant the service was flexible in filling short term gaps.

The operational manager and matrons planned staffing in advance based on planned treatment and standard operating procedures. For example, typical staffing for hernia operations was one consultant, two registered nurses or operating department practitioners, and one HCA. The service planned lists so that only one person was seen at once and appointments were spread out to allow for extended procedures or complications.



Surgery

Three matrons took a lead of a cluster of clinical specialties and a geographic area. For example, one matron led on pre- and post-operative assessments and ophthalmology in a defined area.

The provider maintained a record of each clinician's medical indemnity insurance, designated body, annual appraisal, and Disclosure Barring Service (DBS) status. The provider required clinical staff to undergo a new DBS check every three years. The service was in full compliance with this measure at the time of our inspection.

Managers made sure GPs and consultants working under PP arrangements had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends and patients knew how to contact them. On-call consultants had access to patient records through the provider's head office.

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. In most clinics, staff used the same electronic patient records system as local GP practices and hospitals. This meant systems were integrated and when patients transferred between teams, there were no delays in staff accessing their records. The service managed patient records under service level agreements with each clinical commissioning group (CCG) under which they practiced. This established the process for consent, shared access, and storage frameworks. The system enabled staff to retrospectively access records, such as in the event of a clinical investigation or complaint.

Records were stored securely. The electronic system was encrypted and provided restricted access. The system operator maintained a failsafe back-up that enabled staff to access records in the event of an IT failure.

The service benchmarked standards of shared clinical documentation against the Professional Record Standards Body. This established the content and timeliness of transfer of care documentation and helped the service to maintain coordinated systems.

Consultants dictated clinical letters and referrals immediately after an appointment. The provider had established a standard operating procedure to ensure the process was consistent between consultants. This reflected good practice and mitigated the risk of staff working under practising privileges who usually worked to different standards.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff performed surgery under local anaesthetic for patients considered to be clinically very low risk for complications. This meant medicines stored on site were minimal. Surgeons performed hernia operations using local anaesthetics in line with national guidance.

Staff reviewed each patient's medicines and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date. Staff stored medicines in each clinic in a locked cupboard with restricted access. They documented weekly stock control checks and temperature checks to ensure this did not exceed the manufacturer's limits.



Surgery

Staff stored and managed all medicines and prescribing documents safely. Each clinical location had established rules for storage and staff adhered to each.

Staff followed national practice to check patients had the correct medicines. Consultants prescribed post-operative antibiotics for patients as needed.

Staff learned from safety alerts and incidents to improve practice. In the previous 12 months, staff reported 10 medicines-related incidents and one delayed safety alert implementation. None of the incidents resulted in patient harm.

The senior team had responded to local medicine shortages by changing the stock management system. This reduced the risk of an interruption to surgical services.

A medicines management group reviewed medicines optimisation and management. A pharmacist and matron supported this group and the most recent minutes reflected work to maintain consistent standards of practice that were in line with national best practice.

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, including near misses, in line with provider policy. In the previous 12 months staff reported 130 incidents, of which 80% were clinical in nature.

The service had no never events or serious incidents. The senior team reviewed incidents to identify harm or potential harm to patients. Of those reports, 89% resulted in no harm or was a near miss and 11% resulted in low harm.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The provider had a duty of candour threshold trigger, which the medical director used to implement the process if an incident had resulted in harm. There had been no such incidents since 2019 and previous evidence indicated the provider followed best practice.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, GP practice managers shared local incident reports with the provider team where these were relevant to the environment, staff, and patients.

Staff met to discuss feedback and look at improvements to patient care. Various committees had oversight of incidents relevant to their area of work. For example, the health, safety, and wellbeing committee reviewed health and safety incidents and an IT and information governance committee reviewed related incidents or IT failures.

The senior team recorded incidents that occurred as a result of an omission or event from a third party supplier or operator. As staff provided care across a wide range of clinical environments, this system enabled the senior team to manage external issues that impacted the service. For example, there had been three third-party IT failures in March 2022 that presented a potential risk of confidentiality breach. The information governance team worked with the provider to identify joint learning. From March 2022, the team scored IT incidents using the Information Commissioner's Office (ICO) framework. This provided greater assurance of security impact.



Surgery

Staff implemented improved practices as a result of learning from incidents. For example, one incident highlighted that GP referrals did not include patient body mass index (BMI). However, some surgery could not safely be carried out on patients with a BMI of 35 or over and one patient had their procedure cancelled on the day due to this. As a result, staff introduced new referral guidance and documentation.

There was evidence that changes had been made as a result of feedback. For example, the senior team worked closely with local laboratories to make sure required microbiology was available.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations if this was appropriate.

The senior team monitored NHS England safety alerts and reviewed them to identify relevance to the service. They documented these as part of safety management processes and communicated with relevant staff across the organisation.

Are Surgery effective?

Good



We have not previously inspected this service

We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were available remotely and staff accessed these from each location. The provider used an electronic system to keep staff up to date and the head of quality and governance kept track of which staff had updated their knowledge.

The quality and governance team monitored updates to national guidance on a monthly basis. They used a system of action plans to ensure the most appropriate team reviewed updates and applied them to policies and standard operation procedures. For example, in March 2022, the National Institute for Health and Care Excellence (NICE) issued nine national updates of relevance to this service. Staff acted quickly to ensure these were applied to current standards, which meant patients received care using the most up to date guidance.

Surgeons carried out hernia operations under local anaesthetic as a faster alternative to more common general anaesthetic procedures. They used national and international best practice guidance on which to base standards.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.



Surgery

Patients waiting to have surgery were not left nil by mouth for long periods. Patients typically starved for no more than two hours before a procedure, which was in line with national standards for local anaesthetic. Staff carried out procedures using local anaesthetic and patients did not need clinical nutritional monitoring.

Consultants referred patients to specialist support from staff such as dietitians and speech and language therapists when needed. The service was integrated into regional health teams and consultants could refer patients to the full range of NHS services.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Patients told us staff had explained possible pain during their procedure and encouraged them to ask for additional pain relief if needed. Three patients we spoke with said they had no pain during their procedure, and they felt staff managed analgesia well.

Consultants prescribed post-operative pain relief as needed and advised patients on how to manage expected pain. Staff used a numeric pain relief score system with patients in postoperative recovery. Scores of eight or higher triggered an incident response and staff carried out a review of the patient's care as a result. Staff reviewed monitoring outcomes during clinical review meetings to contribute to effective care standards.

Staff in each specialism audited pain relief on a monthly basis. In the previous four months 100% of cataract and hand surgery patients said interoperative and postoperative pain had been managed well. In the previous 12 months, 99% of hernia surgery patients said pain had been well managed.

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. Matrons took a lead role in audits and other senior staff supported specific programmes. A rolling programme of 40 audits was underway for 2022 in line with national priorities. Staff had established frameworks for additional audits and could implement them if they would demonstrably drive good patient outcomes.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service used patient-reported outcome measures (PROMs) in each clinical specialty. They contributed to the elective surgery national PROMS audit, NHS Digital audits, and the Royal College of Ophthalmologists National Ophthalmology Audit. This reflected the service's comprehensive approach to care benchmarking.

The service measured PROMs using a sample of monthly patients and identifying the number of patients who agreed or disagreed with key outcome statements. Results were consistently good. In 2021, hernia patients reported 99% achievement against PROM measures. In 2022, hand surgery patients reported 89% and vasectomy patients 100%. Managers and staff used the results to improve patients' outcomes. For example, they worked with hand surgery patients to ensure they more clearly understand expected outcomes.



Surgery

The service had a low risk of readmission. In the previous 12 months, seven patients (0.2%) had an emergency readmission to hospital within 30 days of a procedure. In the same period, three patients were readmitted to the provider's theatre on the same day as their procedure.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. A team had implemented an audit review programme to check each audit delivered tangible outcomes. This was part of a culture of continuous reflection and improvement.

Managers used information from audits to improve care and treatment. Staff used a standard operating procedure for the vasectomy pathway to adhere to the time-specific follow-up actions needed to ensure success of the surgery. This ensured staff coordinated timings between the laboratory and patients to test post-surgical semen samples as the primary measure of success. Staff worked with patients where sample results indicated surgery had not been fully successful and provided continuing care within national guidance. The most recent outcome data for vasectomy services related to procedures undertaken in 2021. In this period, the service had a 100% success rate of patients who fully completed the care pathway.

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 provider used a skill-based, comprehensive competency framework to assess all staff when they joined the service and used this in subsequent reviews. They tailored the framework to individual job roles, such as the patient administration team. Staff completed a self-reflection followed by work with one of five competency assessments, which checked their level of achievement.

Managers gave all new staff a full induction tailored to their role before they started work. This included staff working under practising privileges or other temporary arrangements. The provider had an up to date standard operating procedure that included arrangements to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection 84% of staff were up to date with appraisals. The provider established an appraisal system for consultants working under practising privileges. This ensured everyone completed an annual appraisal with their responsible officer and registered this with their designated body. The medical director supplemented this with an appraisal specific to the provider. This process reflected best practice and meant the provider was assured of each consultant's good standing and competence. At the time of our inspection all consultants were up to date with their appraisals.

Managers supported staff to develop through regular, constructive clinical supervision of their work. The provider had developed a supervision system to reflect the nature of the workforce, that involved tailored approaches for staff roles and groups. For example, matrons carried out group supervisions of registered nurses who worked substantively in NHS services. This helped ensure staff were up to date with provider-specific processes and support without duplicating supervisory processes.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The organisation distributed meeting information to all staff and encouraged their engagement. This helped maintain consistency between staff on different contracts.



Surgery

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Salaried staff completed an annual performance development review with their line manager. At the time of our inspection, 71% of staff were up to date. This was lower than the provider's target of 90% and reflected recovery from the pandemic and a sharp increase in demand on capacity.

Managers made sure staff received any specialist training for their role. For example, consultants had developed and implemented British Hernia Society learning sessions to help colleagues upskill and improve competency.

The senior team had a flexible approach to staff development as part of a strategy to develop the service, support career progress for individual staff, and address recruitment challenges. For example, healthcare assistants completed clinical competency training to support patient admission and discharge. This released scrub nurses to focus on more complex clinical tasks and improve patient flow and capacity. Senior surgeons supported associate specialist to progress to consultant level through a team-based process of development.

Clinicians led team debriefs following each session to maintain good standards of teamwork.

Clinicians attended quarterly clinical review groups with others in their specialty to review clinical outcomes such as surgical site infection rates and pain score results.

Multidisciplinary working

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. The service accepted referrals from a range of different clinicians and consultants worked with them to coordinate procedures.

Staff worked across health care disciplines and with other agencies when required to care for patients. Where consultants referred patients to their original doctor or to an onward professional, they identified the least restrictive options available for their care needs.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Each clinical location had local escalation pathways and staff could provide referrals based on level of urgency.

Consultants provided onward referral for general anaesthetic, such as for cataracts, where local anaesthetic surgery was not deemed to be clinically appropriate.

Patient feedback reflected a high level of satisfaction with the provider's approach to joint working with other organisations.

Staff worked across different clinical commissioning group (CCG) boundaries, which meant different restrictions on some services. For example, some laboratories and microbiologists would decline some blood sample requests while others would approve them. Different CCGs would also approve the cost of treatment while others would not. As staff worked across different CCGs, they developed an understanding of these differences and worked with colleagues to ensure patients received the best care.



Surgery

Seven-day services

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

The service operated according to demand and capacity with clinics scheduled in advance. This included weekend services

The operating consultant or GP remained on call until 9.30pm on the day of each procedure and from 8am to 6.30pm on the day after the procedure.

Patient pathway coordinators provided a point of contact for patients and referrers during extended hours and had access to information on local services if a patient needed unexpected support.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in each local area.

Staff provided patients with tailored post-operative advice relating to their lifestyle. For example, they asked patients about their usual daily activities and exercises and provided a specific plan of how and when they could resume these activities.

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. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff used a capacity and consent policy to make reasonable adjustments to care.

Staff made sure patients consented to treatment based on all the information available. Surgeons carried out initial consent during the pre-assessment stage of the treatment pathway. This was followed by the national standard of a 14-day cooling off period. Surgeons carried out further consent on the day of the procedure to ensure they understood any further risks or complications for the patient.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.

The service based capacity and consent policies and practices on NICE guidance. The service was in the process of reviewing all care and treatment policies to check their adherence with NICE national guidance 195 (NG195) in relation to the principles of shared decision-making. This formed part of the provider's broad focus on equality and equitable access to treatment.



Surgery

Are Surgery caring?



We have not previously inspected this service.

We rated it as outstanding.

Compassionate care

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

The provider used the NHS Friends and Family Test (FFT) to measure patient experience. Feedback from patients, those close to them, and stakeholders, was continually positive. The service achieved consistently high standards of feedback with significant sample sizes that reflected an ethos of staff working to 'go the extra mile' and exceed expectations. The most recent 12-month results represented an 85% response rate with a 98% recommendation rate. The service scrutinised the narrative comments of patients who said they would not recommend the service and found high levels of satisfaction, suggesting errors in the completion of the forms.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. One patient noted in feedback, "I felt the surgeon cared and took extra effort to ease me through the process."

Staff demonstrated a consistent, visible person-centred culture that reflected their motivation to promote dignity and exceptional care, which we saw was embedded in all aspects of care planning and delivery. Patients said staff treated them well and with kindness. Patients reported consistently good standards of staff care. One patient noted in feedback, "Treatment was life changing."

Staff followed the provider's policy to keep patient care and treatment confidential. This included appropriate use of shared digital information services, with which staff were well trained and competent.

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They recognised emotional and social needs as being as important as physical needs and took time to discuss these with patients.

Staff routinely involved carers on request from the patient or where additional support was needed. For example, staff enabled carers to join the patient in the admission room and discussed post-operative details and medicine instructions with carers. Staff provided numerous examples of how they worked with support workers and other carers to help facilitate the most appropriate standard of care.



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. This formed part of an intentional process to make partners and those close to them active partners in their care. Administration staff and patient pathway coordinators completed training to help support patients who contacted them with anxieties and worries about a procedure. Staff demonstrated a clear understanding of the key issues patients often had and said usually providing time for them to talk resolved their concerns. Nursing staff, including matrons, worked with patients to help them understand planned procedures where they had substantial anxiety.

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. They were committed to working in partnership towards the best possible outcomes and empowered patients to speak up about their wishes and needs. We observed this standard of practice in all of our observations.

The service gathered narratives from patients as part of a programme of feedback and engagement. Patients reported consistently good standards of practice. One patient said, "I felt comfortable from the moment I walked through the door. And I still feel like this now, everyone has been so friendly and helpful." Another patient said, "The entire team were extremely friendly. They were reassuring and gave me the all clear."

Staff had introduced more in depth pre-treatment counselling and risk-benefit discussions for patients on a vasectomy pathway. They met with patient's partners on request and addressed their anxieties to make sure the operation was an appropriate choice for their needs and desired outcomes. Staff recognised the need for patients to have access to support networks and specialist information to make the most informed decisions about their care. They worked with local services to signpost patients appropriately.

During the pandemic, the provider suspended services for five months. During this period a dedicated team maintained contact with patients who were in the clinical pathway to help alleviate worry and anxiety about delays. This team worked with NHS clinicians to prioritise patients with the greatest need to undergo surgery at the earliest opportunity.

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 as part of a consistent, substantial focus on promoting independence. During our observations staff gave each patient time to ask questions. They gave patients tailored information as they wanted about the procedure and the equipment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Two patients we spoke with said staff communication had been very good. One patient said they knew exactly what to expect on the day of treatment because staff had explained everything to them in advance.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback indicated patients felt genuinely cared for, which reflected our observations.



Surgery

Staff supported patients to make informed decisions about their care. One patient said the consultant had explained everything at their pre-assessment appointment and this helped them make the decision to proceed with the surgery. Another noted, “Having surgery, I was put at ease - explained the procedure well, all questions answered.”

Staff provided patients with detailed post-operative information. This included how to manage their wound, how they could safely bathe, and potential side effects to expect.

Staff made sure patients had answers to their questions before they left the clinic. For example, one patient had a specific query about a type of prescribed medicine they usually took and whether this was safe to take with their post-operative pain medicine. The consultant took the time to check British National Formulary (BNF) guidance and then provided the patient with guidance and signposting for a follow-up the next week. We asked staff about this approach and one individual said, “We want patients to be prepared and informed.”

The service asked patients about their interaction with staff as part of outcome measures. In the most recent audit, 99% of vasectomy patients said surgeons, nursing staff, and administration staff were helpful. In the same period, 100% of hernia patients said their surgeon had listened to them and gave them the opportunity to talk and 100% hand op patients chance to talk and felt the surgeon understood them.

A senior manager or executive carried out a ‘15 steps challenge’ in each clinic location on a rotating monthly basis. The team used this activity to measure areas of a caring approach to patients. For example, the manager checked if staff introduced themselves by name, measured the positivity of staff communication, and established levels of service for patients with additional needs. This process demonstrated consistently high standards of caring practice. For example, in one example the manager noted they had observed staff show an anxious patient how a surgical gauze would be applied, which helped to demystify a procedure and help the patient relax.

Are Surgery responsive?

Good



We have not previously inspected this service.

We rated it as good.

Service delivery to meet the needs of 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 people. They worked across health economies of each area in which they operated and made sure planned provision met regional needs.

Facilities and premises were appropriate for the services being delivered. All clinical sites had step-free access, and toilet facilities for those with additional needs.

Patients could access emergency support 24 hours a day 7 days a week and staff signposted them as needed. Staff maintained an up to date understanding of processes related to mental health provision, including local provision across clinical sites.



Surgery

The service had systems to help care for patients in need of additional support or specialist intervention. For example, the service had provided treatment for patients as part of standard commissioned pathways including those living with a learning disability and Parkinson's disease.

Managers monitored and took action to minimise missed appointments. After referral to the service, a patient pathway coordinator worked with each patient to schedule surgery at a date convenient for them. Both patients we spoke with said they were happy with the range of options offered to them and both had surgery completed within 14 weeks of their initial referral.

Managers ensured patients who did not attend (DNA) appointments were contacted. The patient pathway team followed up with each individual and considered if service adjustments would support attendance. Staff recognised themes in DNAs and found these most often occurred in the vasectomy service when patients experienced conflict with securing time off work. The team was planning the introduction of a text message reminder service to help remind patients to get in touch if they needed to change an appointment.

The service relieved pressure on NHS services by offering pre-operative and post-operative treatment that reduced reliance on other local services.

Staff provided patients with post-operative care information based on their individual needs. This included pictorial guidance on exercises to help speed recovery, information on where to obtain support, and how to manage prescribed medicine, the removal of stitches and wound care.

Patients who had cataract surgery required extended recovery advice and monitoring. Staff provided this through a post-operative schedule with specific patient-led actions and follow-up appointments at key stages. Staff provided patients with printed and digital information to help them manage the recovery period effectively and prompt them to seek help if they experienced an unplanned symptom.

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. Referring clinicians highlight such needs and consultants worked with them to establish safe surgical protocols.

Each clinical specialty had exclusion criteria based on the standard operating procedure for surgical services. The service worked with referring trusts and doctors to build consistent understanding of referral processes and reduce the number of inappropriate referrals.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss or those living with a mental health need or learning disability.

The service had information available in languages spoken by the patients and local community and printed this for patients on request. The service was planning to improve this further by providing digital translated material through QR code or barcode links.



Surgery

The patient pathway booking team arranged interpreters in advance if this information was indicated on the referral form. This team offered patients interpretation services at the point of booking and staff could obtain immediate telephone interpretation from any clinical site using the provider's central contract. Staff did not allow friends or relatives to translate for patients, which reflected good safeguarding practice.

The nursing team carried out a post-operative call to each patient to check on their recovery and provide any guidance or advice requested.

Patients waited in a discharge room after their procedure so that staff could observe them for any unexpected reactions. Staff provided a drink and snack after each procedure and patients had time to fully recover before leaving the site.

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.

Staff in a dedicated patient referral centre managed access and flow and ensured service level agreements with CCGs were met.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service provided surgery on 18 week pathways. This was a standard NHS measure and meant all patients should have their surgery completed within 18 weeks of referral. As all patients were treated on NHS pathways, the provider worked with referring services and trusts to ensure waiting lists were managed.

The senior team audited referral to treatment times (RTTs) as a performance measure. In the previous 12 months, the service achieved an 88% 18-week completion rate. This was slightly lower than the provider's 92% target and reflected patients who chose to select later appointment dates for personal reasons and patients who were referred to the service after they had already breached an 18 week wait. No patients breached a 52-week RTT in the previous 12 months.

Managers worked to keep the number of cancelled appointments to a minimum. In the previous 12 months, the service cancelled 1% of operations for non-clinical reasons. This reflected 33 individual procedures and the provider rescheduled all of these within 28 days.

Staff planned patients' discharge carefully, particularly for those with mental health and social care needs. The service had a good track record in relation to discharge summaries. In the previous 12 months, consultants provided 99% of discharge summaries to referring clinicians within 24 hours of treatment.

A dedicated administration team, including patient pathway coordinators, facilitated the patient journey from referral to discharge. This team ensured clinicians reviewed referrals in a timely manner and diagnostic report turnaround times were in line with targets.

Staff offered patients flexibility in the choice of clinic location even if this was outside of their local area. This helped to reduce DNA rates because people could more easily arrange care around their other commitments.



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. Complaints in the service were very rare. In the previous 12 months, the service received one formal complaint and three concerns. Staff had fully resolved all four issues within the timeframe in the provider's policy.

The service displayed information about how to raise a concern in patient areas. Staff displayed complaints posters in clinic rooms and information was available on the provider's website. During our clinical site inspection, we saw the complaints policy was clearly branded with the provider's name and demonstrably separate from the GP practice complaints procedure.

Staff understood the policy on complaints and knew how to handle them. Staff were trained to resolve minor issues at the time they were raised and help patients access the formal process if the issue could not be resolved.

Managers investigated the single formal complaint and resolved this within the provider's policy timelines. They shared the outcome with the wider team and reviewed the issue to identify opportunities for learning.

Are Surgery well-led?



We have not previously inspected this service.

We rated it as outstanding.

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.

Leadership roles were clearly defined. The chief executive officer (CEO) led the organisation, supported by the executive management team. The medical director was a consultant surgeon and provided clinical leadership liaison with consultants. The head of quality and governance was the registered manager and had good oversight and assurance relating to the daily running of the service. The patient administration manager and the operations and performance manager led the patient pathway and other critical support teams. Leaders at all levels were compassionate, inclusive and effective in driving capacity and capability towards exceptional, sustainable care.

Staff spoke positively about leadership and line management. They described leaders as approachable and said they could request meetings on demand.

Leaders were demonstrably involved in operational and strategic work and staff knew their roles and responsibilities. They had worked throughout the pandemic to ensure staff were supported with wellbeing and care needs and maintained positive relationships with counterparts across NHS services.



Surgery

The senior team promoted leadership development pathways and encouraged staff to progress through opportunities. While clinical services were geographically fragmented, the leadership structure ensured staff were well supported and the service operated within dependable frameworks. Leaders worked to a comprehensive, evidence-based strategy that ensured the sustainability of the service through deep understanding of issues, challenges, and priorities.

Vision and Strategy

The service had a stretching, ambitious 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 provider's vision focused on quality care in community settings. This was underpinned with three core values relating to putting the patient first, delivering excellence through continuous improvement, and a focus on teamwork. The provider embedded the vision and values into all aspects of recruitment, supervisions, and training and applied them equally to all staff regardless of their contract or how often they worked for the service.

Strategic plans reflected local and regional health economies in which services were delivered. The senior team demonstrated commitment to collaboration with community partners to drive success and evidence in the strategy.

The provider's strategy had a significant focus on patient engagement, including a patient engagement framework for 2022/23. This ensured strategic plans were fully integrated with patient care. The framework guided staff at all levels to put the patient voice at all aspects of care and non-clinical operations. The framework incorporated a highly effective aspect of 'co-production', which refers to collaborative work between staff and patients to improve care and outcomes. Initial work within this strategy included reviews of clinical services by patients with staff to identify opportunities for environmental and pathway improvements.

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 had a demonstrable focus on the provision of equitable services that adhered to the principles of the Equality Act 2010. The registered manager said this was part of a culture in the service in which staff were challenged with "How do we do it?" rather than "Can we do it?" Staff reflected this ethos during our discussions, and it was evident they were fully invested in equitable care. This represented an inspiring shared purpose established by the provider, which resulted in high levels of staff motivation and satisfaction.

Staff spoke highly of the culture and organisation and said they were proud of their achievements and the difference the service made to people's health. The provider had an established whistleblowing policy and all staff we spoke with knew how and when to access this.

Staff told us they never felt pressured to deliver more appointments than was safe. This meant the service helped to reduce waiting times without reducing quality and safety.



Surgery

The senior team recognised the risks involved operating clinical services with a geographically-spread team of staff who worked under a range of different contracts. To facilitate good cohesion and working relationships, the provider arranged training and other opportunities in groups. For example, they scheduled different professional groups to attend practical training together. This helped staff to form good teamwork practices in emergency scenarios.

An equality and diversity lead worked across the organisation to build positive working relationships and support new ideas to improve the working environment.

The CEO led periodic 'open house' events, to which they invited all staff. This was an open forum in which staff could openly talk about issues and ideas. The senior team organised similar events for specific staff groups, such as a nurse team day, as a tool to check staff wellbeing and to gather useful feedback on the service. The human resources director described how important it was to ensure staff were listened to and to make it easy for everyone to stay connected. This reflected a consistent focus on cross-team collaboration. Staff across all functions said they understood how their work contributed to quality and sustainability of care.

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.

The service provided care to NHS patients under subcontracts with clinical commissioning groups (CCGs). While the provider had its own governance and clinical governance processes, the senior team recognised the need to work within CCG frameworks.

The integrated governance committee was responsible for implementation and monitoring of the practising privileges policy, which ensured consultants worked safely and to the provider's standards. The policy was comprehensive and established a framework of national guidance and professional standards within which consultants were to deliver care, such as that issued by the General Medical Council.

The provider developed an audit programme based on a review of all key national clinical audits used in similar clinical specialties. The team reviewed 105 national audits to establish the most useful combination for this service, which resulted in a rolling programme of 40 audits.

The provider maintained an operations handbook in each clinic to help staff troubleshoot local issues such as IT or Wi-Fi failures or challenges in working with contractors, such as the pathology service. The handbook guided staff to specific contacts in the provider, such as the head of operations for problems in running clinics and the Freedom to Speak Up Guardian for confidential discussions.

Meeting minutes indicated appropriate staff consistently attended key meetings and tracked actions to ensure service monitoring and improvement measures were kept on track. This reflected a well-established, proactive governance system.

The medical director and director of human resources were responsible for clinicians working under practising privileges, including monitoring appraisals and changes to practice registration.



Surgery

The medical director led quarterly specialty review meetings with clinical staff from each specialty. The review meetings carried out the usual functions of a medical advisory committee and considered updates to best practice and impact on the service. Clinicians were highly engaged in the work of the provider and offered proactive guidance and updates tailored to the nature of the service.

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.

The senior team was demonstrably focused on best practice performance and the effective use of risk management systems to drive a highly functional organisation.

The leadership and operations team prepared a monthly integrated performance report (IPR) as the core element of clinical governance, quality assurance, risk, and performance management. The IPR provided easy-to-read visual tracking of a wide range of data such as infection control issues, incidents, complaints, and patient outcomes. The tool meant the senior team had access to comprehensive, high quality data that helped them respond to trends and risks.

The senior team was working to improve the quality dashboard to provide a joined up overview of all areas of the business with aggregated performance data and quality metrics to support clinical staff. This reflected a considerable focus on ensuring governance processes had a material impact on clinical care.

The risk and incident management group maintained a service-wide risk register that included clinical and corporate risks. At the time of our inspection there were 11 active risks including one risk that had been active for over 12 months. The team assessed two risks as being at a very high level, relating to IT and a senior post vacancy, respectively.

Staff used quarterly clinical review meetings to monitor patient outcomes in each speciality. This ensured senior teams maintained an up to date understanding of patients' perception of their own care.

All core operational services, such as IT and bookings, were available to staff whenever a clinic was in operation.

The medical director and quality team led quarterly clinical review meetings and used these as a quality assurance mechanism to identify good outcomes. An accountable emergency officer led plans to address interruptions to the service.

The senior team maintained risk assessments specific to each clinical site. This ensured services were consistent and within national standards. For example, one site had a damaged floor in a theatre area and another needed attention to its air handling unit. Individual risk assessments meant the senior team could effectively resolve local issues as they occurred.

The provider had a persistent, demonstrable focus on quality improvement and clinical effectiveness. For example, the service routinely assessed hernia outcomes using a standard national tool. In 2021, the quality team identified a potential opportunity to change the outcomes measure and contribute to more useful national database auditing. The team was in the process of carrying out a gap analysis and comparison study with national and international hernia services to identify if a change of reporting would benefit patients.



Surgery

The medical director carried out an annual clinical performance review with each consultant. This supplemented appraisals and considered the individual's level of activity, their surgical procedure rate, and measures such as patient feedback. The process established internal benchmarks for practice that provided detailed understanding of standards.

The senior team went above and beyond national requirements to monitor outcomes and risk. For example, the types of surgery offered did not require contribution to national surgical site infection monitoring. However, the service adopted this process as a measure of best practice.

The service prioritised good governance processes as a tool to ensure care was safe. They used an operational reporting and assurance framework to identify opportunities to improve efficiency and reduce duplication in governance processes.

Risk management systems reflected the nature of the service. For example, staff relied on the senior team at each GP practice to ensure clinical environments and infrastructure were well maintained. A risk assessment found one practice did not have adequate verification checks in place to ensure air handling units complied with national standards. In response, the service implemented a new system to work with local practices on environmental safety checks to jointly ensure standards were at the highest level possible.

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.

Data security awareness and information governance was part of mandatory training for all staff and reflected best practice. At the time of our inspection, 84% of staff were up to date, which was lower than the provider's 90% target.

In the previous 12 months, staff reported 27 incidents relating to information management. The senior team worked with the external IT provider to identify themes amongst the reports and found challenges in IT access from some clinical sites caused by variable internet access. The senior team worked with local GP practices and the IT provider to improve infrastructure. The provider worked with IT services that were accredited to national and international standards.

Information management roles were clearly defined and reflected the complexity of delivering services across multiple sites with different IT structures. Information governance represented the provider's commitment to proactive system-wide improvements in data management. The finance director was the senior information risk owner and the medical director was the Caldicott Guardian, which provided risk assurance to the provider.

Information management governance systems functioned well and helped to highlight opportunities for improvement. The integrated governance and business committee found areas of duplication in reports produced internally and externally. In response, the service was reviewing all reporting functions to identify how these could be streamlined and make the organisation more efficient.

The provider had data sharing agreements with relevant organisations to ensure the safe management and sharing of patient records between organisations.

The service had a representative on the NHS Digital cybersecurity group and worked with East of England information governance services to share and coordinate data improvements.



Surgery

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.

The service used the NHS Friends and Family Test (FFT) as a key part of engagement and service measurement. Staff encouraged patients to provide feedback and the service achieved a consistently high response rate, which averaged 82% in the previous 12 months. In this period over 99% of patients said they would recommend the service.

The service delivered care solely to NHS patients. All signage and printed material, such as appointment letters, were co-branded with the NHS logo. Staff made sure patients understood who was delivering their care at the point of booking. This reflected good practice in ensuring patients understood who was delivering their care and who they were communicating with.

There was consistently high levels of constructive, meaningful engagement with a broad range of stakeholders. The senior team included patient and stakeholder feedback in the IPR and used this to measure the level of useful engagement in any given month. Feedback was consistently good. For example, one recent comment was, “They [provider] put the patient at the top of everything they do. The administration team are brilliant, the governance structure is good, and staff are terrific.”

The senior team had introduced a new patient engagement strategy, which was part of wider quality assurance work, to contribute in a more structured way to governance and assurance processes.

The senior team carried out a rolling programme of site visits to provide a visible presence to staff and encourage consistent engagement. The provider introduced staff forums as an engaging tool to gather feedback on plans and facilitate consistent communication.

The senior team reviewed the induction process through feedback from staff recently recruited as part of work to ensure the engagement strategy was working well. Overall feedback was positive, and the senior team acted on feedback that new staff would like more opportunities to meet colleagues who worked from different sites.

The provider used the annual NHS staff survey to understand how staff felt working there. The senior team acted on detail in this survey, such as by improving access to promotion and career development.

The 2021 staff survey reflected a positive working culture in which staff felt proud to work for the organisation, felt respected, and were committed to patient care. In all outcome measures most staff reported good experiences working with the provider. The senior team tracked improvements from the previous survey and identified opportunities for improvement.

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 through a fully embedded approach to improvement.

The senior team rewarded innovation and developed a systematic, proactive approach to sustainability. They developed apprenticeship pathways in the operations, administration, human resources, and finance teams and offered these opportunities to people in the local area seeking professional development.



Surgery

The service continually monitored established ways of doing things to identify opportunities for improvement. For example, the senior team was in the process of digitising the risk management and governance system to improve the quality of reporting and management. This process would establish a safety culture data collection to act as a baseline that would enable staff to identify any outliers in incident trends.

The service had a consistent track record in patient engagement and sample sizes of feedback and audits were high, with up to 93% of all cases in some specialties in the previous 12 months. The senior team was exploring options to interact with patients digitally in ways that would add value to services and the patient experience. The team was preparing a paper on this and would present it to colleagues to identify new opportunities.

The senior team maintained a demonstrable focus on reducing pressure on NHS services and reducing waiting times for patients through flexible working and new partnerships. For example, during the pandemic, the service extended the use of a cataract theatre to an NHS service that had suspended procedures. This helped reduce waiting times for patients with urgent need. In this period the service increased surgical slots to support an acute trust with extensive waiting times for patients.

The senior team monitored local health economies and worked with Clinical Commissioning Groups (CCGs) to identify how the service could support regional sustainability and transformation plans. This helped the senior team to target service development to meet specific geographic needs.

Staff valued the use of research to drive innovation in care and service operations. The hernia team presented at the annual European Hernia Society meeting to demonstrate the effectiveness of carrying out hernia operations under local anaesthetic. Of the hernia operations in the previous 12 months, 99% would more usually have been carried out under general anaesthetic and the team used this to show they reduced pressure on NHS acute services. A consultant was in the process of extending this work through a long-term study to assess the impact of hernia operations in a community, local anaesthetic setting.