SpaMedica Ltd

SpaMedica Hull

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

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

However:

- Staff did not always keep their mandatory training up-to-date.
- Staff did not always adhere to best practice when wearing personal protective equipment (PPE).
- Managers could not always keep the number of cancelled appointments to a minimum. They had the second highest number of cancelled appointments in the region in relation to this provider.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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

However:

- Staff did not always keep their mandatory training up-to-date. At the time of our inspection 76% of service staff had completed their mandatory training overall which did not meet the provider's 85% target. New starters impacted on these results.
- Staff did not always adhere to best practice when wearing personal protective equipment (PPE). We observed two clinical staff members wearing facemasks below their nose. One of these staff members was directly talking in close contact to a patient with the mask below their chin.
- At the time of our inspection the service's total staff turnover rate was 31%. This was above the provider target of 21% or less for 2022. The service used bank and agency staff to cover shortfalls.
- Managers could not always keep the number of cancelled appointments to a minimum due to staffing shortages. The service had 13 (16) cancelled appointments within 24 hours for the rolling three months up to 15 December 2021. This was the second highest number of cancelled appointment in the region.

Summary of findings

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Background to SpaMedica Hull

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

The service saw only NHS patients. Patients came mostly from Hull, East Yorkshire, North Yorkshire and also Lincolnshire.

The service's clinical services are provided over two floors. The service has a ground floor operating suite with one theatre providing cataract surgery and a discharge lounge. Their pre- and post-operative assessment areas were located on the first floor. The service did not treat children.

The service is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Surgical procedures

• Treatment of disease, disorder and injury

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

Ophthalmology consultants

Optometrists

Registered nurses

Healthcare technicians

Operating department staff

Administration staff

The registered manager had been in post since March 2021. This is the first time we have inspected and rated this service. We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 18 May 2022. To get to the heart of the patients' experience we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well led.

Summary of this inspection

How we carried out this inspection

The team that inspected the service comprised of one CQC inspector and one CQC assistant inspector. The inspection team was supported by an inspection manager. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

During the inspection we visited all areas of SpaMedica Hull. We spoke with 14 members of staff including regional and senior managers, the registered manager, nurses, doctors, optical technicians, optometrists and administrators. We observed the environment and care provided by patients and spoke with five patients, their families and carers. We reviewed ten patients' records; five at pre-assessment stage and five post-operatively. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans.

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

Outstanding practice

We found the following outstanding practice:

- We spoke to several staff about a serious incident at the service. All staff felt supported by the organisation and managers felt the team responded appropriately and went above and beyond to offer support. Managers offered psychological support to all staff and held multidisciplinary (MDT) debriefs for learning.
- The hospital manager had assembled 'welcome to work' induction packs for new starters on their first day with helpful information and a card signed by the whole team.
- The service recently introduced an out of work huddle without the hospital manager present (unless the staff wanted) every six weeks.
- The service ran accreditation evenings for local opticians to enable them to support patients post-operatively in the community.
- Feedback from people who used the service and those close to them was overwhelmingly positive about how staff treated people. The service conducted regular patient surveys. From 1 May 2021 to 31 May 2022 99.9% of patients from a sample of 3060 would recommend the service.

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 ensure staff adhere to best practice when wearing personal protective equipment (PPE). (Regulation 12)
- The service should ensure they meet provider targets for total staff turnover and sickness (loss time rates) along with completion of theatre total pain score summaries. (Regulation 12)

Summary of this inspection

- Managers should aim to keep the number of patient's cancelled appointments after admission to a minimum. For example, by reducing cancellation causes within their control such as booking errors. (Regulation 18)

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

Staff received mandatory training but at the time of our inspection 76% of service staff had completed and were up to date with their mandatory training overall. This rate did not meet the provider's 85% target.

Four staff members at the service had not completed mandatory training. Two staff member's mandatory training compliance had expired; one due to maternity leave. Another was a new starter in the week we requested the data and was progressing through training. The service had several new staff who joined in the few weeks before our inspection. Managers told us these staff were on course to complete all mandatory training as soon as possible.

The lowest mandatory training compliance rates for both clinical and non-clinical staff were practical manual handling, infection prevention control (IPC) and practical basic life support (BLS). Managers told us the three staff members yet to complete the IPC and BLS training only joined the service the week we requested the data. Moreover, the manual handling course had limited availability, but since inspection several staff had been able to book onto upcoming course dates. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was delivered through a combination of e-learning and face to face training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Senior managers told us all the service's healthcare professionals (HCPs) or registered staff were intermediate life support (ILS) trained and other non-clinical staff were basic life support (BLS) trained.

We reviewed mandatory training figures and found all eligible staff had completed their practical BLS course. The provider's policy outlined at least one ILS trained staff member must be onsite at all times. All other staff were BLS trained.

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

Good

Surgery

Senior managers told us they had clinic days and quieter times when staff could complete mandatory training modules. Leads tried not to make staff complete modules at home to better retain work life balance.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse.At the time of our inspection the service's overall safeguarding training compliance rate was 90%. The two staff members yet to complete this training only joined the service the week we requested the data. These staff were supervised and knew who to ask if they had any safeguarding concerns. Staff's safeguarding compliance training was included within their statutory mandatory training.

All staff were trained to at least safeguarding level two for adults and children. Service staff's safeguarding compliance training was included within their statutory mandatory training. Clinical and ophthalmic nursing staff told us all their safeguarding training was up to date.

Hospital managers were trained to level 3. Service staff could access a company safeguarding lead trained to level 4. The registered manager was the safeguarding lead for the hospital and was trained to level three for safeguarding adults and children.

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we asked had good understanding of safeguarding processes. All staff had access to the NHS safeguarding app on their PC desktops. Staff regularly made welfare checks on patients and would actively seek support from their local authority (LA) safeguarding team.

The service confirmed their staff had made three safeguarding referrals in the 12 months before our inspection. All three had a severity of 'no harm' and detailed actions staff had taken in response. Staff reported these referrals to their provider safeguarding team, local safeguarding authority, line manager and documented the incidents on their ophthalmic electronic patient record (EPR) system.

The provider had a robust safeguarding policy in place along with established referral routes to the LA and other external organisations. A staff member we asked gave the example of a time they escalated a safeguarding incident of alleged neglect to management about a patient.

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

Good

Surgery

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

Cleanliness, infection control and hygiene

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

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

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

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

The service generally performed well for cleanliness. We reviewed the service's latest monthly health and safety checklist audit completed by one of the porters on 25 April 2022. Any outstanding actions or equipment needing maintenance had been logged and hardware was sent back to head office for an update.

The service completed infection prevention and control (IPC) and hand hygiene audits. We reviewed this data which showed IPC scored 96.2% compliance in April 2022. This was scheduled to be carried out again in July 2022. The action plan from the April 2022 IPC audit showed medication boxes and leaflets were found in the pharmacy's medicine waste bins. In response managers sent an email reminder to all staff members to correctly dispose of medications.

The service's latest hand hygiene audit scored 100% compliance in February 2022 and was scheduled to be carried out again in May 2022.

The provider planned to introduce a modified technical cleaning audit based on the National Cleaning Standards 2021 but amended to ensure it was fit for their purpose. It covered all aspects of cleaning (from clinical and cleaning staff) in both the patient and staff areas. This tool was trialled and modified and would be rolled out by the regional facilities managers. The quarterly audit results would then be fed back to the hospital managers, infection prevention committee and to the board. Hospital managers/facilities were expected to undertake an action plan to rectify any failures and repeat audits monthly.

The provider planned an external assurance audit that involved facilities, area managers and hospital managers later in 2022.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Staff washed their hands and used hand gel between patients. We observed staff cleaning equipment after patient contact. All reusable equipment was decontaminated off site The service had a service level agreement (SLA) in place with an accredited decontamination service. Staff managed clean and dirty equipment well, with no cross contamination.

Good

Surgery

Staff we asked had a good understanding of infection prevention control (IPC) processes. Theatre staff had guidance displayed on wearing theatre attire and medical masks safely.

However, we observed staff members did not always use PPE correctly. For example we saw two clinical staff in the discharge area wearing masks below their nose. One of these staff members was directly talking in close contact to a patient with the mask below their chin. We saw one non-clinical staff member wearing a facemask below their nose.

Staff worked effectively to prevent, identify and treat post-surgery infections. The North East region's latest endophthalmitis infection (inflammation of the internal eye tissue) rate in December 2021 (Quarter 4) was 0.02%. The service's latest endophthalmitis rate was 0.31%.

The provider's latest North East regional post-operative uveitis rate was 4.12% in December 2021 (at the end of Quarter 4). Post-operative uveitis was a known common inflammatory reaction. The service's latest rate was 2.42% in April 2022. This rate had stayed below 2% for nine of the 12 months from May 2021 to April 2022.

Managers told us staff were cautious wherever a patient developed inflammatory post-operative symptoms. If they suspected endopthalmitis they would promptly assess and investigate patients as this was such a significant complication. Staff would send off and await negative pathology tests or diagnostic assessment to confirm cases were not endopthalmitis and downgrade the incident accordingly.

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

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

We reviewed the provider's policy for the management of Coronavirus. This was next due for review in March 2023 or upon change of national guidance. The policy was designed to provide clarity regarding the provider's management of COVID-19 and ensure they provided an environment and system of care which minimised risk of infection to patients, staff and visitors.

The provider's clinical governance meeting agenda included an infection prevention update / COVID-19 standing item. This reminded staff to follow guidance, policies and procedures in place, ensure visitors were testing for COVID-19, latest versions of their risk assessment tool and vaccine protection and efficacy updates as well as mandatory dose deadlines.

The service had an IPC link nurse who disseminated and managed any updates from the provider's IPC lead. We heard the provider's national IPC lead had recently become the lead for the North region. They had 30 years' experience within acute settings and were piloting a new cleaning audit tool to appoint the service and other locations a star rating.

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 design of the environment followed national guidance. The service had two receptions on the ground and first floors of the building. This kept the theatre and pre-assessment patient pathways separate. A patient lift was available for

patients who could not use the stairs. The reception areas were spacious with socially distanced chairs stating 'do not sit in this seat' where they were less than two metres apart. We saw the service had a bariatric wheelchair available in reception for patients if needed. The hospital manager told us these were for patients with walking difficulties but who could transfer independently.

A fire alarm test was performed on the day of our inspection. The service carried out weekly fire tests. We saw the service had planned routes in the event of fire and emergency evacuation. We reviewed the service's safe fire evacuation emergency plan from 25 February 2022. The service carried out annual fire drills and their last drill was on 21 September 2021. The drill sheet noted more practice was needed with training booked for December 2021. The service had 22 staff trained to be fire marshalls. The plan confirmed patient coordinators, porters and hospital managers were trained to use the fire panel.

Pre-assessment booths had screens either side and all chairs and screens could be wiped clean by staff. The booths had room for wheelchairs so patients could be assessed this way.

Patient lockers were designated alongside theatres and pre-assessment clinic lists. The porter told us they hand sanitised all the locker keys before and after use.

The service's discharge area was well equipped and the examination room had a slit lamp. Both these areas had two chairs, one for staff and one for the patient. Staff deep cleaned the chair between patients.

The building generators and the communication room was checked daily by one of the porters.

Staff carried out daily safety checks of specialist equipment. These were completed as per hospital policy. For example staff we asked were trained to use specialist equipment in the diagnostics room such as a retinal imaging device, a pentacam for anterior eye segment tomography and biometry equipment.

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

We reviewed the service's latest equipment and maintenance schedule. This included previous and scheduled annual dates to review all services and theatre air testing for clinical compliance.

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

The service maintained an endophthalmitis box onsite in case of an ophthalmic emergency. We saw staff had a checklist of contents to check monthly which encompassed their emergency procedures.

Within theatres most information was displayed on the walls, including where the vitrectomy packs were located. Sharps and needle stick procedures, wall lens loading processes and procedures and a list of lens choices with lens stock check along with current data were all well displayed on theatre walls. The provider had a sharps/needlestick injury process staff could clearly follow.

We saw reminder notices to theatre staff to wipe any crocs they wore with disinfectant wipes before entering or leaving theatre.

The service had enough suitable equipment to help them to safely care for patients. The theatre had an airflow system in place checked and maintained in line with hospital policy to maintain air quality. Any patients with a latex allergy would be seen first on the next day's surgery list after the airflow system had fully ventilated the environment.

The service had cubicles available for patients in the pre-operative ward. Staff informed us they did not care for or treat bariatric patients with a high body mass index (BMI) as per their clinical commissioning group (CCG) referral policy. The theatre beds had a weight limit restriction of 160 kilograms. Staff identified any patients who exceeded this weight limit at pre-assessment and referred them back to the trust. As a result the service had no hoists available.

At the time of our inspection we reviewed all the service's statutory and clinical compliance testing dates, none of which had expired. The service's portable appliance testing (PAT) was all in date. The hospital manager has oversight of PAT testing. Appliances had last been inspected and tested for electrical safety by an external contractor on 23 November 2021 to comply with the Electricity at Work Regulations 1989.

Staff disposed of clinical waste safely. Waste was separated with colour coded bags for general and clinical waste. Sharps bins were assembled correctly and not overfilled. These were disposed of in line with national guidance. Only designated clinical staff could access the clinical waste facilities area. The appropriate controls were in place for control of substances hazardous to health (COSHH). Staff we asked were aware of the COSHH Regulations 2002 procedure and described the process well. Cleaning equipment was stored securely in locked cupboards. Staff were reminded to write all removals in the COSHH folder.

The hospital manager told us if they had any problems with clinical waste they could make a phone call to facilities to clear any extra clinical waste usually within four hours.

Assessing and responding to patient risk

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

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

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

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

Good

Surgery

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

Ophthalmologists we asked understood this endophthalmitis protocol. They triaged patients out of hours, with a symptom-based transfer either to the centre or a neighbouring regional provider site. They would take samples from the eye in theatre and send them to a pre-assigned microbiology diagnostic centre.

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

We also reviewed the service's SOP for complex cataract listing. This referred to the management of complex cataract patients at their pre-assessment clinic appointment. This process allowed any patient with a greater risk (8%) of a posterior capsular rupture (PCR) to be identified at pre-assessment and listed on an appropriate complex cataract surgical list. The SOP identified other pathology considered as high risk for complication to be listed on a complex cataract list. The SOP included complex listing criteria for patients. Ophthalmic leads monitored the SOP for compliance in accordance with the provider's management of patients at pre-assessment policy.

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

Staff knew about and dealt with any specific risk issues (consider reporting sepsis, VTE, falls and pressure ulcers). Staff took patient's full medical history at pre assessment including allergies. From our observations and review of records, this was all completed, with appropriate actions taken. If a patient attended with a latex allergy, the theatre's air flow system ran overnight to rid the environment of any latex residue. The patient would be then first on the list for surgery the next day.

We reviewed the latest version (number 8) of the provider's pre-assessment (PAC) guidance. This alphabetically listed criteria clearly outlined how ophthalmologists should respond to any disease or condition patients had with onward pathways.

Service staff had access to a 24-hour clinical on-call service to which all patients were given contact information upon discharge. The on-call emergency team triaged patients in-house and consisted of a surgeon, optometrist, registered nurse and healthcare technician for diagnostic imaging if needed. The team could manage patients remotely or advise them to return to clinic urgently depending on the severity. All provider sites had regional nominated hospitals for follow up emergency work.

The service transferred patients with medical complications using 999. Patients with ophthalmic complications including a dropped nucleus (the **loss of a part or the whole lens nucleus to the vitreous cavity)** involved transfer to the provider's other regional sites for complex surgery. The service had no SLA for internal transfers as these were not to local NHS hospitals.

Good

Surgery

The service did not perform venous thromboembolism (VTE) assessments due to patient's average length of stay. The provider's patients had procedures under a local anaesthetic so they were mobile during their appointment.

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

In the event of a patient requiring an emergency transfer whilst undergoing care, this would be via a 999-emergency paramedic call and transfer. All registered health care professionals were at least resuscitation basic life support (BLS) trained. There was a resuscitation policy in place and the necessary resuscitation equipment, with regular mock scenarios practiced.

The service carried out at least bi-annual mock scenarios for responding to deteriorating patients using resuscitation crash trolleys. At the time of our inspection the last one was on 10 February 2021. A third party training provider resuscitation officer facilitated these scenarios.

We reviewed the provider's cardiopulmonary resuscitation of adults policy next due for review in May 2023 or when the UK resuscitation council guidance was amended. The policy stated 'SpaMedica has one escalation policy, which is a 999 call and transfer to an acute NHS Hospital.'

Nurse staffing

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

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

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

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

The service had enough nursing and support staff to keep patients safe. The service had established staffing levels for pre-assessment and theatre which we saw were in place.

The service's consultants and optometrists operated on 24-26 patients per day in one theatre. Their lists for YAG procedures contained 40 patients. These were average figures dependent on how long the surgeon had worked for the provider, clinical outcomes, and how comfortable the team and surgeon worked together. All surgeons new to the provider started on low daily patient numbers. For example, at first they would see eight patients each on a morning and afternoon list, or 16 per day.

Good

Surgery

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

The service had low and/or reducing vacancy rates. At the time of our inspection, the service had recently recruited to all their vacancies except one registered general nurse (RGN). One healthcare technician (HCT) had started at the service a week before our inspection, one RGN was starting the Monday after.

The service aimed to cover staff sickness and vacancies with staff from a neighbouring site if needed. Staff impact of changing sites was minimal as all provider hospital layouts and equipment were standardised.

The service did not meet the provider target for staff turnover rates. We reviewed the service's departmental turnover report for the period 1 May 2021 to 30 April 2022. Their total turnover for this 12-month period was 31%. This did not meet the provider target for 2022 of 21% or less. Their job roles with the highest turnover were reception and clinical. The registered manager was aware of the service's turnover rate and was taking action to address these issues.

The service did not have low and/or reducing sickness rates. Leads told us the service's main cause of staff sickness was the COVID-19 pandemic. The service would share their staff with a neighbouring provider site. We heard short notice staff absences were usually covered from the regional area's bank or agency staff.

We reviewed the service's absence rate using a lost time rate. This calculated staff's total hours of absence from 1 May 2021 to 30 April 2022. The service's lost time rate for this 12-month period was 3.4%. This did not meet the provider target for 2022 of 3% or less (excluding long-term sickness).

The service had high rates of bank and agency nurses. They used these staff to cover shortfalls. At the time of our inspection the hospital manager had recently recruited three bank scrub nurses. The service would not recruit agency nurses to work with the business directly as their purpose was for use if and when needed.

Managers limited their use of bank and agency staff and requested staff familiar with the service. They offered bank and agency staff long term bookings to ensure stability in the work force. One agency staff we spoke to had worked at the service for four years whilst rotating at different provider sites.

Managers made sure all bank and agency staff had a full induction and understood the service. The service engaged with the local agency for nursing staff and the hospital manager had recently appointed two registered general nurses (RGNs). They block booked agency nurses for approximately three months to ensure sign off all their competencies and retain skills by using them frequently. On the day of our inspection one agency nurse was running a visions clinic, the other was working in discharge having been signed off under the clinical lead nurse's supervision.

Medical staffing

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

Good

Surgery

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

Managers had quarterly meetings with the medical director to quality assure all surgeons' practice.

Records

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

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

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

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

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

We saw in the provider's quarterly clinical governance report up to 23 March 2022 the service had three patient incidents involving inaccurate details in their records. Managers had taken actions as a result such as amending these records at the time and incident reporting each. Managers discussed them with the staff involved as well as during morning huddles and sharing learning at hospital and area manager meetings.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had a medicines management policy in place with supporting procedures all staff could access. We reviewed the provider's latest medicines management policy next due for review in September 2022. The policy provided guidance to all staff who prescribed, administered, controlled, ordered, stored, dispensed or supplied medicines as part of their role. The area and hospital manager had responsibility for the cascade, receipt and understanding of the policy at site level to their teams.

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

technicians who recorded on the paper PSD record. We reviewed a PSD for cataract and VR theatre where the prescriber had to confirm they had considered each patient on the list on an individual basis as suitable to receive the listed medication. The form included space for the prescriber to detail patient's allergies information. For example, there was a prompt the prescriber should omit eye drops if the patient was allergic to iodine.

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

We reviewed the provider's PGDs for the administration of minims tropicamide 1% eye drops. This form included all patient details, tickboxes for staff to confirm patients met inclusion criteria and that no exclusion criteria applied. There was also a consent form for instillation. At the time of our inspection all the service's eligible clinical staff had completed their tropicamide PGD training. All nursing staff's competency was assessed after they watched a slideshow for information.

Staff told us medication checks were usually done through the dispensing sheet. At the time of our inspection the service did not operate a pre-labelled drops regime. This was introduced in June 2022. Staff put any unused medicines into the blue bin, added them on the register and indicated the reason for discarding.

Staff stored and managed all medicines and prescribing documents safely in line with the provider's policy. The medicines, in cupboards and fridges, were all within their expiry dates. The clinical fridge and storage room temperatures were monitored and recorded accurately, including the maximum and minimum ranges. The service's medicine fridges were linked to an uninterruptible power supply (UPS) system which kicked in if there was a power cut. The service had a digital temperature monitoring application that alerted when the temperature was out of range and would also provide accurate data about how long the temperature had been out of range. The manager told us this meant they could escalate accurate information to the pharmacy team in order to provide advice regarding any action to be taken.

The service stored medication to be available for patients who were identified as anxious prior to surgery. It was stored correctly, and records were completed for checking and administration. The service had a denaturing kit for Controlled Drugs (CD). CDs are certain medicines for which strict legal controls were needed as they may cause serious problems like dependence ('addiction') and harm if not used properly.

Staff reviewed patients' medicines and provided specific advice to patients and carers about their medicines. During discharge patients were given clear verbal instructions about the administration of their eye drops. They were also provided with written instructions and a table that they could use to record when they had administered the drops to help them follow the correct post-operative regime.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The provider's clinical governance meetings and reports included national safety alerts relevant to the service. For example, their 16 December 2022 meeting minutes included one regarding lucentis batch faulty plungers.

However, the service had four medicine incidents in the three months up to 2 December 2021. These four incident category sub-types were one drugs storage, one error in administering drug to patient, one error in dispensing medication and one prescribing error. Managers had shared lessons learned from these incident investigations. Lessons were discussed at huddles, hospital and area manager meetings and escalated company wide.

Good

Surgery

Incidents

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

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

Staff raised concerns and reported incidents clearly and near misses in line with provider policy. Staff told us they were encouraged to report incidents and felt confident to do so. They knew what incidents to report and how to report them. For example, we heard the recent example of one staff member slipping on the stairs. The service lay yellow edging on the stairs and employed a second porter in response so one porter helped and escorted patients on each floor.

We saw the provider's clinical governance report from 29 March 2022. This showed in the three months up to 23 March 2022 the service had 18 Covid-related incidents.

We reviewed the service's reported incident for the six months between 25 November 2021 and 25 May 2022. Staff reported one death and seven incidents with a severity of low harm in this period. These were all handled appropriately with any learning communicated.

Managers shared learning with their staff about never events and incidents that happened elsewhere. For example, senior managers outlined their actions in response to a never event at a different provider site in which the wrong lens was inserted in the eye. We saw the investigation learning detailed in the provider's clinical governance meeting minutes dated 16 December 2021.

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

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

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

Good

Surgery

Staff received feedback from investigation of incidents, both internal and external to the service. Senior management told us about a recent serious incident (SI) at another site .The SI's root cause analysis (RCA) found a number of recommendations .The provider had shared lessons learnt from this SI. For example, leads devised a standard operating procedure (SOP) in response, added an extra prompt on the WHO checklist and sticker prompt.

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

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

Are Surgery effective?

Good

We had not rated effective before. 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. For example, the service's cataract surgery checklist was adapted from the world health organisation's (WHO) surgical safety checklist. This checklist was first published in 2008 in order to increase the safety of patients undergoing surgery. We observed theatre staff during operative procedures adhering to this checklist.

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

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

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

The service carried out quarterly clinical audits that covered key topics. Any audits that were less than 95% compliant had actions identified, and the audit was repeated one month later. There was good compliance for the completion of these audits and actions plans were in place to address issues of poor compliance. We reviewed the service's latest clinical audit tool action plan for April 2022. This found three issues with clinical documentation. For example, staff did not record patient eye drop administration times on the pre-operative documentation. Managers sent reminder emails to all relevant staff members in response.

Good

Surgery

Nutrition and hydration

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

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

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

Staff captured any dietary requirements patients had on their admission form. Patients undergoing cataract surgery did not routinely require nutritional charts completing.

The service did not undergo nutrition and hydration audits as they only provided refreshments.

Pain relief

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

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

We reviewed the service's theatre total pain score summaries between May 2021 and April 2022. For 11 of these 12 months staff did not record 100% of pain scores. This did not meet their provider target of 100% completion. The month with the lowest compliance was September 2021 with 72.8%. Monthly compliance had improved since and achieved 100% completion in April 2022.

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

Patient outcomes

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

The service participated in relevant national clinical audits. The provider submitted data to the national ophthalmic database audit. Outcomes for patients were positive, consistent and exceeded expectations, such as national standards. We reviewed the service's infection rates for the last 12 months. The service's posterior capsular rupture (PCR) rate from 1 May 2021 to 30 April 2022 was 0.91%. At the time of our inspection the service's PCR which is an operative complication was 0.66% with two PCR cases during the period. These rates were both significantly better than the UK national average of 1.5%. However, they did not meet the provider target of 0.5% or less. We saw the service displayed a complication rate of 0.03% under an effective care noticeboard in the discharge waiting area.

The service monitored other outcomes such as visual acuity (VA) against the agreed driving standard (greater than 6/12 post-operatively). Their total VA outcomes in the 12 months from May 2021 to April 2022 was 97.42%. These outcomes were above the royal college of ophthalmology (RCOphth) benchmark standards.

Managers and staff used the results to improve patients' outcomes. The provider's medical director shared their infection rates dashboard information. The service benchmarked 100% of their data to monitor clinical outcomes. Outcomes were benchmarked across the organisation, as well as externally, that identified good practice and areas for support and focus.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. We reviewed the service's clinical audit outcomes for November 2021 and February 2022. For November the audit showed the service achieved a monthly total of 100% compliance in both laser safety and hand hygiene but 87.5% compliance in safeguarding and 66.7% compliance at daily safety huddles. This meant their total monthly compliance was 93.2%. For February compliance had improved to be 94.4% overall. Their lowest scoring metric for this month was clinical documentation with 93.9% compliance.

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

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

The service engaged with the private healthcare information network (PHIN) and collected and submitted data in accordance with legal requirements regulated by the competition markets authority (CMA). The provider submitted data to the national ophthalmic database (NODA). The service did not perform any private surgeries.

Senior managers carried out a national audit programme completed electronically and reviewed all themes and trends. They shared results and any follow up work at monthly clinical governance committee meetings.

We reviewed the service's monthly audit plan. This comprised age-related macular degeneration (AMD), clinical documentation, consent, daily safety huddle, hand hygiene, infection prevention, laser safety, medicine management – department and patient, safeguarding, surgical safety and urgent care.The service scored between averages of 88.9% for daily safety huddles and 100% in consent and hand hygiene from May 2021 to April 2022. Their total compliance score over these 12 months was 96%.

Staff completed audits quarterly. If the audit results fell below 95% a re-audit was needed a month later after a completed action plan.

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

Competent staff

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

Good

Surgery

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

At the time of our inspection staff at the service had a mix of experience which they felt worked well. For example eight staff were registered general nurses (RGN's) and one was an operating department practitioner (ODP).

The service had 70% of their staff who were trained fire wardens and five first aiders, many in the contact centre on the top floor who did a sweep down the floors. All the service's patient transport drivers were trained in life support and first aid.

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

The provider had a dedicated central educational team responsible for monitoring compliance with training and providing competency-based education sessions. There was a leadership programme for managers and staff completed competency training specific to their roles.

Managers gave all new staff a full induction tailored to their role before they started work. All staff including bank and agency did not practice in any role until assessed as competent. For example, new recruits' competences were signed off after they saw ten patients. Staff competences were rechecked every three years. The service's introduction percentage was monitored as part of theatre staff's first six months' probationary period. New staff's probation was reviewed at the end of their first, third and sixth month.

Managers told us the service's new staff were well orientated, given mentors and shadowing opportunities along with a competencies pack which they had to fully sign off including a patient journey for them to complete. Theatre staff could deploy 'hold the line' to pause and check if they had or found any issues. Nursing staff told us they were encouraged to raise concerns and had equal and respectful working relations with the ophthalmic surgeons.

All service staff completed both certified provider level and local inductions. Managers collated themes and trends from exit interviews to improve future staff's induction experience. New recruits to the service had an induction day online and face to face. Staff's platform for mandatory training (MT) was "Eye learn" and "Eye perform" for managers. MT was checked at one month, three months and six month intervals after they started in their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. Nine of 17 permanent staff (100% of those eligible) had completed their annual review in the two months before our inspection. The service held annual appraisals for all staff who completed their probationary periods with an additional mid-year check to give feedback and support on staff performance.

Provider bank staff did not receive an appraisal. However, the hospital manager told us their bank staff were happy to raise any issues/concerns through other channels. They had introduced 'return to work' interviews for bank staff after sickness and held monitor assessments. Bank staff felt managers were approachable so most issues could be resolved informally. Agency staff had appraisals via their agency.

One agency staff had just returned to work after a seven months absence for surgery and were retraining for their competencies.

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

Surgeon's clinical outcomes for the service were routinely reviewed by the provider's medical director (MD) who decided if/when surgeon numbers should increase. The MD used a RAG rated KPI tool to monitor all surgeon's practice and outcomes. Staff shared these at quarterly medical advisory committee (MAC) meetings, bi-monthly clinical governance meetings and operational meetings. We reviewed the provider's north east regional meeting slides from 10 March 2022. This showed the clinical outcomes and overall surgeon RAG ratings in posterior capsular rupture (PCR) rates, endopthalmitis and dropped nucleus for the region.

One surgeon who worked for the service and another site had an average PCR rate of 5.96% and monthly rate of 10.34% in December 2021. Managers had since addressed and improved this performance. For example, the surgeon had several observations with the quality lead and continued to be RAG rated by the medical director and monitored by the hospital manager.

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

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. To develop staff skills, the service planned to train healthcare technicians (HCTs) in undergoing discharge and YAG admission then further develop the training plan. For example, one senior HCT was undergoing this training in July 2022.

The hospital manager told us they previously had a staff team with many HCTs but now the team had more registered general nurses (RGNs) so they were covering more HCT skills. Nursing staff carried out vision tests and managers also planned to train nurses in retinal scans.

Staff were given protected time to complete any training needed.

Managers conducted 360 degree feedback for employees every few months.

Managers identified poor staff performance promptly and supported staff to improve. We asked managers how the service managed performance. They told us firstly conversations around performance with employees were added to their HR records. This information was then put onto their reporting system. Reporting system information was then forwarded to the provider's occupational health (OH) team or the employee undertook further training as required.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily 'start of the day' morning and debrief huddles were held in the hospital led by the clinical lead on the day to plan and review the day's activities collectively. All clinical and non-clinical staff on-shift attended including the hospital manager. Staff were given a patient list to run through and divide out tasks. Staff including surgeons shared any information around patients with

power of attorney or particular medication needs. The staff spoke to the optometrist when they arrived at work. At the morning huddles staff including the clinical lead and fire marshall raised any concerns, safety issues, disseminated incidents, discussed patient's transport, daily tasks and lists. For example, they shared any incorrect inputting of data at this meeting.

We reviewed the provider's daily safety huddle template. This covered any clinical, reception or transport concerns arising from the day's activity along with interpreter needs, OCT cover and theatre register scans. There was a safety debrief for staff to raise any issues or concerns and daily and weekly checks for staff to complete.

The service's end of the day debrief huddles were attended by optometrists where staff shared further feedback for opportunity. Staff told us about their MDT working between the optometrist and nurses. There was a theatre huddle at the start of each theatre list involving the entire team. The huddles were audited to check consistency and compliance. Staff we asked felt huddles were helpful as the agenda was very standardised.

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

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

Seven-day services

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

The service was open Monday to Friday and dependent on service demands, additional surgical lists could be planned for Saturdays.

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Good

Surgery

Service staff assessed capacity at each stage of the patient's assessment, before consenting for treatment with the optometrist. If staff had doubts around a patient's capacity, they had a dual consent process with their local clinical commissioning group (CCG).

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

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

Staff clearly recorded consent in the patients' records. The service audited this quarterly as part of its clinical documentation audit. There was a compliance rate of 100% most recently in April 2022 for collecting consent information as all patients consented prior to their treatment.

Staff did not always ensure patients consented to treatment based on all the information available. Before the procedure, patients received written information in the post. Staff obtained verbal and written consent from patients before providing care.

However, we reviewed the provider's last two quarterly clinical governance reports. They showed in the six months up to 7 March 2022 the service recorded three incidents involving incomplete consent in readiness for theatre.

Are Surgery caring?

Good

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

Compassionate care

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

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

The service's entrance foyer displayed a 'meet the team' pinboard with all staff photos so patients and visitors could familiarise themselves with names and faces.

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

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

Good

Surgery

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were discreet and responsive when caring for patients. They maintained patient's dignity and respect. For example, staff would not remove headscarves for patients who wore them until just before they entered theatre for surgery.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff provided reassurance and comfort to patients both in private consultations and during the surgical procedure. Staff were calm and supportive providing extra time to these patients. There was an option to have someone hold your hand in theatre if a patient was particularly nervous.

Staff explained options for support to patients early in their pathway. For patients with dementia, autism or LD staff allowed their family member or carer to stay with them right up to the point of entering theatre. Patients were provided with the organisation's "patient stories" DVD where previous patients described their experience to help relieve anxiety. Videos were also available on the organisation's website.

All staff we heard used their name and introduced themselves to patients then spoke and interacted with them positively.

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

Understanding and involvement of patients and those close to them

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

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

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

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

Patients gave positive feedback about the service. Feedback from people who used the service and those close to them was continually positive about how staff treated people. The service conducted regular patient surveys. 99.9% of patients from a sample of 3060 from 1 May 2021 to 31 May 2022 would recommend the service and felt reassured by the service and treatment provided.

Good

Surgery

We reviewed the service's patient satisfaction and nurse post-operative checks survey results from between 1 January and 1 May 2022. It showed from 1193 responses the service achieved a total of 99.9% with 100% satisfaction for all metrics except pain which scored 99.33% and reassure and recommend surgeon which both scored 99.92%.

The service achieved 99.91% patient satisfaction (those who strongly agree or agree) across all metrics from 2246 responses in the 12 months from May 2021 to April 2022. The overwhelming majority of patient comments within this timeframe were positive.

Patients we asked felt the booking process was simple and efficient.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

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

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

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

The service's business continuity plan cover had black and yellow signage for the benefit of patients with cataracts.

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

The service had optometrists who were accredited to provide post-operative care. Patients could choose to have their post-operative follow up with one of these services if it was more convenient.

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

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

Good

Surgery

Facilities and premises were appropriate for the services being delivered.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were two 'dementia champions' available at the hospital. These staff had undergone extra training to promote the needs of people living with dementia. We saw one of their names displayed under a 'proud to be dementia friendly' badge on a noticeboard.

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

The service had a hearing loop for patients, families or carers with a hearing impairment. There was a specific quiet area where staff could escort patients or they would use free clinic rooms for this purpose if requested. The service could accommodate patients, family or carers in wheelchairs. Staff we asked felt patients with disabilities were cared for and they took time to help them understand. For example, staff could access and use a clear face visor for hearing-impaired patients to lip read.

The service had information leaflets available in languages spoken by the patients and local community. The service had info leaflets for patients who wishes to complain in different languages. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service used two different organisations to book face to face or online interpreters for patients if needed. Their interpreter service was set up by the provider via the patient co-ordinators.

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

The service offered free transport to any patients who lived 10 miles or more from the hospital. Staff considered patient's safety by completing individual travel risk assessments. Drivers collected patients from their home with a phone call reminder the day before their expected time.

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

Access and flow

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

Good

Surgery

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

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service's average median waiting times for patients in the 12 months from May 2021 to April 2022 was 4.8 weeks. This meant 100% of patients referred directly to the service were seen within the 18 week referral to treatment time (RTT). Their lowest monthly average waiting time was 3.59 weeks in May 2021 and the highest was 5.67 weeks in September 2021. Managers confirmed the service had no patients that had previously been on waiting lists with another provider or delayed by COVID-19 pandemic related issues.

We saw the service displayed their current treatment waiting times. These were three weeks for cataract surgery and five weeks for YAG laser capsulotomy.

The service's pre-surgery waiting times were within 14 days of the pre-assessment. The service maintained a cancellations list so they had very few gaps as staff would contact people to attend sooner. The service had a small satellite bookings team onsite managed by their head office.

Theatre staff described examples of streamlined theatre processes to maximise patient flow/throughput. Saturdays were usually the catch up day for theatre staff to reduce the NHS backlog.

The service's pre-assessment clinic (PAC) and theatre utilisation rates were significantly above provider target averages. We reviewed these rates from 1 June 2021 to 31 May 2022. At the time of our inspection this averaged 87.89% for PAC over the 12 months compared to a provider average of 38.63% across all sites. The service's theatre rate averaged 92.16% compared to a provider average of 80.28%.

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

Managers could not always keep the number of cancelled appointments to a minimum. Cancellations at the service only occurred due to a change in surgeon availability. The service had reduced lists on three occasions but never cancelled full day lists.

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

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

We reviewed the service's did not attend (DNA) rate from May 2021 to April 2022. Their average DNA rate during these 12 months was 1.16%. However, this had risen slightly above 2% in November 2021 which had the highest monthly number of DNA appointments (17).

Good

Surgery

We reviewed the provider's clinical governance report on 16 December 2021 from the director of clinical services. The Yorkshire and North East region's slide showed the top five incident categories by site. The service had 13 (16) cancelled appointments within 24 hours for the rolling three months up to 15 December 2021. This was the second highest number of cancelled appointment in the region.

We followed this up with managers onsite who sent us data confirming in the three months from 15 July to 15 October 2021 they had a total of 14 cancelled treatments and five booking errors. The most common cause of cancelled treatment was health-related as the patient had hypertension which accounted for five cancelled treatments. The most common cause of booking error was delays or errors in communication between departments which accounted for three errors.

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

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

Learning from complaints and concerns

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

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

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

The hospital manager was aware of the service's latest complaints and gave us verbal summaries. All upheld complaints had an action plan including a timeline and lessons to be learnt if necessary. The service aimed to acknowledge all formal complaints within three days of receipt and respond to them within 20 working days. The provider monitored the effectiveness of this policy and audited it yearly with mandatory indicators before compiling an annual complaints report.

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

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed the last three complaints received by the service at the time of our inspection. Two were from December 2021 and one from February 2022. The service held follow up appointments and took prompt action for all three complaints. The lessons learned and outcome had been recorded where appropriate.

Good

Surgery

Staff could give examples of how they used patient feedback to improve daily practice. The service had revised their map and directions to the site in response to patient feedback before and after they made these changes to be clearer.

Are Surgery well-led?

Good

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

Leadership

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

Senior managers and staff told us regional hospital and area managers as well as clinical leads were readily available and supportive. The area manager with responsibility for five hospital sites within their region. Regional managers held once or twice weekly meetings which we heard were supportive and beneficial.

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

Leaders held regular staff meetings and staff told us they felt their views were heard and valued. The hospital manager ensured they were present and close at hand during huddles if staff needed them. They kept a communcations folder downstairs as lots of agency staff could not access email. The hospital manager could also print out information updates to staff if needed.

Staff told us that there was good local, regional and national leadership within the organisation.

Senior managers attended regional and national meetings with the senior leadership team (SLT) where they received updates, discussed governance and performance and shared learning. Senior managers told us they had recently created a management development programme in house to ‘grow their own’ and encourage their ambitious staff to progress.

We reviewed the service’s employee survey results from January 2022 relating to management completed by 14 staff members. Staff responses to many of the 80 questions were positive overall. For example, 64.29% of staff either agreed or strongly agreed that managers demonstrated strong leadership skills (

Vision and Strategy

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

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

Good

Surgery

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

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

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

Culture

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

Staff said they were very proud of the service they delivered and described their colleagues as supportive. All staff told us they had good working relationships with their colleagues.

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

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

Staff we asked felt the culture had improved once managers had addressed recruitment. They felt during staff changes the culture had varied. At the time of our inspection they had a good close-knit supportive team who worked closely together.

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

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

The hospital manager had introduced a staff 'star of the month' two months before our inspection to celebrate successes and achievement. At the time of our inspection one of the porters was awarded this accolade.

Provider staff could access an employee assistance programme (EAP) and numerous extra benefits through an online platform which provided free advice, guidance and counselling, along with wellbeing support. The provider had trained several staff to be mental health first aiders (MHFAs) and had an occupational health service available for staff if required.

Any staff could nominate other employees for a patient/office hero award each quarter to recognise somebody who goes above and beyond. The winner for each region was chosen by the area manager from the nominations and a further quarterly winner was then picked from the regional winners and both received shopping vouchers. At the end of the year a patient/office hero of the year was chosen and awarded a weekend break and an extra day's holiday.

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

The provider had regional employee forums for their hospitals and a head office forum for other support functions. All forums met quarterly to discuss any agenda items and deliver regional updates, and discuss any upcoming staff events/ engagement activities for the next quarter.

The provider aimed to improve staff engagement by promoting several events throughout the year. Examples include cultural events like Ramadan and Diwali to awareness days like cancer and children's charity coffee mornings and Christmas jumper day. Staff could also suggest events the provider had not previously covered.

Senior managers provided regular updates to hospital teams through department meetings, weekly e-mails and monthly newsletters. They aimed to maximise communication channels with their staff to be accessible.

The hospital had a freedom to speak up guardian forum representative onsite to raise and feedback any staff issues.

Governance

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

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

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

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

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

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

Good

Surgery

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

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

Management of risk, issues and performance

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

Service leads had a clear and effective process for identifying, recording and managing risk. The risks on risk registers were scored from one to 25, and rated on severity from 'none' to 'catastrophic'. The hospital and area managers reviewed all local risk registers routinely every month in accordance with the risk severity.

We reviewed the service's local risks at the time of our inspection. The service's highest rated risk related to the patient's use of the hospital staircase versus the lift where both a staff member and patient had fallen. This detailed patients' risk of slipping / fall on the stairs after treatment due to having dilating drops in eyes which causes blurred vision. This risk had been reviewed two days before our inspection. The service had controls in place such as assistance offered by hospital porter. Stairs were cleaned by contractors throughout the day ensuring no obstacles or signage was placed on floors if they were wet. We saw signage was in place for people not crossing on the stairs.

At the time of our inspection the service had five moderate level risks scored between four and six. These were all operational and related to the safety of patients, staff and the public from COVID-19 and issues with their electronic patient medical records system, service and business interruption from equipment failure and missing GP summaries, along with an information governance (IG) risk of breaching confidentiality from discussions being overheard by patients or visitors due to thin walls in some sections of the building.

All risks had been identified with control measures in place and review dates to help reduce any risk. The hospital manager had good oversight of the service's main risks and summarised the top three on their latest risk register with actions taken. For example, they had installed TVs to play music on digital radio stations in response to the IG risk. These acted as audio barriers to prevent private conversations being overheard between different areas. Managers told us they also implemented shared learning from other sites about falls and near misses. They explained staff were trained to use the Evac-u chair for patients in the event of a fire or the lift breaking down. Their facilities reporting service and managers could all be quickly contacted.

We reviewed the provider's COVID-19 situations decision making guidance last updated on 5 April 2022 by the IPC lead. This advised staff what to do if they had COVID-19 symptoms or were COVID positive, actions needed, work arrangement for patient and non-patient facing staff and any financial support available.

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

Good

Surgery

We reviewed the provider's operations board report for March 2022. It included a RAG rated chart highlighting the service's Red rated risk as one of two sites in the North region. We followed this up with managers who confirmed this related to recruitment. By the time of our inspection they had taken all necessary actions.

The service had a business continuity plan that reflected actions to take in response to untoward events effecting service delivery such as IT issues or severe weather. The plan included actions to support business continuity, recovery and resumption along with critical and non-critical activities and lists of relevant contacts.

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

Regional senior managers completed a monthly CQC self-assessment tool based on our key lines of enquiry (KLOEs) for the service. The tool's outcomes were reviewed at their provider-level clinical governance meetings. The service achieved a total monthly score of 83.1% in February 2022. However, this was the lowest score out of 36 provider sites who submitted results.

We saw the service had completed the audit tool monthly from May 2021 to April 2022, except for December 2021. They achieved total monthly scores of between 75.93% in September 2021 and 95.41% in April 2022 respectively. Their highest total compliance by domain was 100% in caring for all 11 months and their lowest compliance was 80.99% in well led.

The service displayed their latest audit results from April 2022 in surgical safety, infection prevention, safeguarding, daily safety huddle, consent, medicine management of the patient and medicine management department. All scored 100% except infection prevention with 96.2% and medicine management department with 97.1%.

Information Management

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

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

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

The provider submitted 100% of their PCR data to the RCOphth NODA, and also submitted 90.7% of the service's post operative visual acuity outcomes.

At the time of our inspection the service's PCR funnel plot adjusted for case mix was 0.39%.

Good

Surgery

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

The service had an internal contact system to readily access any other provider numbers.

Engagement

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

Staff feedback was encouraged through staff surveys and forums where concerns could be escalated to senior leaders. We heard the example of a senior HCT moving pre-operative machines around to streamline the patient journey who could now just turn around in their seat.

An annual staff survey was undertaken every February. Senior managers analysed and collated results to address any areas of concern. The Head of People lead presented these along with actions to address any areas for improvement at the senior manager's briefing. The organisation had a timeline of activities responding to employee feedback to celebrate what they did well and how they could improve. At the time of our inspection the service planned to feedback to teams their timeline of delivering these activities by the end of the week. Staff forums also captured feedback and measured how they performed.

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

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

The service held an onsite recruitment evening in October 2021. One bank staff joined as a result who the hospital manager supported to trial leaving clinical practice after 20 years.

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

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

Learning, continuous improvement and innovation

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

The provider had four digital dry labs throughout England and pop up dry labs that enabled ophthalmology trainees to learn and practice cataract surgery. The dry labs were also used by surgeons to perfect techniques and practice using the providers standard instruments.

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

Good

Surgery

The service planned to join a study day on 17 June with Hull University with staff from other provider sites and ophthalmic surgeons worldwide. The service linked in with a local ophthalmic service to recycle prescription glasses to send to developing countries charity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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