Community Health and Eyecare Limited

Northampton Surgical Cataract Centre & Endoscopy Services

Inspection report

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

Ratings

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

Summary of findings

Overall summary

This is the first time we have rated this service. We rated it as outstanding 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. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.

- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and supported them to make decisions about their care.

- There was a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

- People's individual needs and preferences were central to the delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs. People could access services and appointments in a way and at a time that suited them. The service made it easy for people to give feedback and used the learning from complaints and concerns as an opportunity for improvement.

- 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:

- The service had some clinical areas with no hand wash basins and this was not in line with national guidance. This had already been identified by the provider and actions had been put in place to mitigate risk.

- The service did not maintain a written explanation of gaps in employment history for all staff, as is required by regulations to ensure safe recruitment practices.

- Policies did not always have a review date or refer to national guidance. This had already been identified by the provider and a policy review process was underway.

- There was not always evidence that risks on the risk register had been regularly reviewed and updated.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Outstanding ☆	This is the first time we have rated this service. We rated it as outstanding overall. We rated caring and responsive as outstanding. We rated safe, effective, and well-led as good. Please refer to overall summary above.
Outpatients	Outstanding ☆	This is the first time we have rated this service. We rated it as outstanding overall. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated caring and responsive as outstanding. We rated safe and well-led as good. We do not rate effective for outpatient services.

Summary of findings

Contents

Summary of this inspection

Background to Northampton Surgical Cataract Centre & Endoscopy Services

Northampton Surgical Cataract Centre & Endoscopy Services is operated by Community Health and Eyecare Limited. It is an independent health provider delivering cataract surgery and ophthalmic consultations.

The service had performed 704 cataract surgeries and carried out 1,969 outpatient appointments between April 2022-June 2023.

The service also provides YAG (Yttrium Aluminium Garnet) capsulotomy, which is a type of laser eye surgery that is used to treat a specific complication of cataract surgery known as posterior capsule opacification. This problem is caused by development of frosting from new cells forming behind a lens implant after cataract surgery and occurs in around 10% of people.

Eye care and treatment is provided for NHS patients under a contract with an integrated care board (ICB).

The service was not yet providing endoscopy services at the time of our inspection.

The service was located in a newly refurbished premises in a shopping centre. The service was normally open 5 days a week, from Monday to Friday.

The centre is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Surgical procedures

• Treatment of disease, disorder or injury

The provider registered this location in April 2022, and we have not previously inspected it.

The service had a registered manager in post at the time of our inspection.

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

How we carried out this inspection

We carried out a comprehensive inspection of the service. The inspection team comprised of a lead CQC inspector and a specialist advisor with expertise in surgery. The inspection team was overseen by an operations manager and deputy director of operations. We carried out a short notice announced inspection on 3 July 2023. We returned on 7 July 2023 to complete follow-up observations.

Summary of this inspection

During our inspection we spoke with 9 members of staff. We observed 2 appointments and 4 operations. We observed the environment and spoke with 8 patients and relatives. We reviewed 9 patient records. We also looked at a range of policies, procedures and other documents relating to the running of the service.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

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:

- The service offered a free patient transport service to patients from their home to the hospital to receive treatment and returned them home.
- The provider had also developed a booking app that enabled patients to book or change appointments, 24/7, from their mobile device.
- The service worked with a dedicated eyecare liaison officer (ECLO) and the Royal National Institute of Blind People to assist people with practical issues such as welfare and benefits, to improve the quality of patients' life.

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 that risks are regularly reviewed and updated. (Regulation 17)
- The service should ensure that action plans are updated when actions have been implemented. (Regulation 17 (2))
- The service should continue to monitor the on-going risk of the clinical areas without hand wash basins and take steps to bring these areas into line with national guidelines. (Regulation 15)
- The service should continue the review of policies to ensure that they meet required standards. This includes ensuring that all policies have a review date and refer to national guidance. (Regulation 17(1)(2)(d))
- The service should ensure that they have a written explanation of any gaps in employment for all persons employed in the provision of services. (Regulation 19)

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding

Surgery

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

Is the service safe?

Good

This is the first time we have rated this service. We rated safe as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. At the time of our inspection, the overall mandatory training completion rate was 99.75%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff received training in an e-learning format. Training was tailored to the skill requirement of staff and was dependent on their role. Topics included, but were not limited to, infection prevention and control, moving and handling, conflict resolution, mental capacity, and resuscitation.

Clinical staff completed training on recognising and responding to patients with learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Members of staff and their managers were automatically sent a notification by the electronic training system when training was coming up for renewal.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff were required to complete safeguarding adults and children training at level 2, and managers were also required to complete safeguarding adults training at level 3. At the time of our inspection, safeguarding training compliance rates were 100%. There was a safeguarding lead at provider level, who had completed safeguarding adults and children training up to level 4. This reflected good practice in line with the Royal College of Nursing intercollegiate document on safeguarding.

The service did not treat children and young people. However, staff maintained children's safeguarding training in recognition that children may accompany patients to appointments.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and could describe how they would work with other agencies to protect them.

Staff had not made any safeguarding referrals since the service opened. However, staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the provider's safeguarding lead and knew how to contact them for advice.

Safeguarding information was displayed in clinical areas. This included a safeguarding flow chart with a step-by-step guide of the actions that staff should take when safeguarding concerns were identified. The flowchart also provided staff with access to up-to-date contact information for the local authority.

Safeguarding policies were accessible to all staff. The safeguarding adult's policy contained detailed guidance about different types of abuse, information to assist staff with recognising signs of abuse and the actions that should be taken in response. The safeguarding children's policy was less detailed and there was scope to provide more detailed guidance for staff in this policy. The provider stated that they were in the process of reviewing all policies to ensure that they met required standards.

The hospital had a chaperoning policy, which staff could access electronically. All patients were entitled to have a chaperone present for any consultation, examination or procedure. Signs were displayed in clinical areas to make patients aware that they could request a chaperone.

The provider mostly ensured safe recruitment practices. However, we did identify some gaps in the information held by the provider. We reviewed 5 personnel files during our inspection. All files had up-to-date DBS checks in place, copies of photographic ID, an employment history and evidence of professional registration or qualifications. However, we found that the files did not have a written explanation of any gaps in employment, as is required by in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified 1 personnel file which did not have any references. The provider stated that this member of staff was recruited using a HR system which was no longer in use and a more robust process was now in place.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff kept equipment and the premises visibly clean. However, staff did not always have access to appropriate hand washing facilities in all clinical areas.

All patient areas were clean and had suitable furnishings which were clean and well-maintained. This was confirmed through our observations on inspection.

The clinic was cleaned daily by an external company. Staff also carried out cleaning after each patient contact. Staff used daily cleaning checklists to document cleaning in line with the provider's policy. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

All reusable equipment was decontaminated off site. Clean and dirty equipment was managed well within the theatre and there was no cross contamination of equipment.

Outstanding ☆

Surgery

The service performed well for cleanliness. Managers carried out monthly audits of infection control and prevention standards, including hand hygiene and scrub procedures. Audits from April to June 2023 demonstrated 100% compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff adhered to 'bare below the elbows' principles. We observed consistently good hand hygiene by staff. Personal protective equipment was readily available for staff to use.

Staff did not always have access to appropriate hand washing facilities. There were 3 rooms which were designed for clinical use but did not have sinks; including the admissions room and the discharge room. The service had carried out a risk assessment and implemented actions to mitigate the risk. Staff used alternative rooms where possible. The activity levels at the Northampton clinic allowed rooms to be multi-functional. For example, the minor ops room had a sink and was used to admit patients instead of the admissions room. The discharge room was used to hold aftercare discussions with patients but this would not normally include any activity which would result in staff member's hands becoming visibly contaminated. Staff would move to a different room if they needed to provide any care or treatment for patients with an open wound, a known or suspected infection, or that would be likely to result in their hands becoming visibly contaminated. All rooms had hand gel to allow staff to sanitise their hands. The provider was putting a plan together to retro-fit hand wash basins into these rooms in all of their hospitals.

Staff did not label equipment to show when it was last cleaned. For example, through the use of 'I am clean' stickers. The registered manager said that they had already identified this concern through an audit and had placed an order for labels.

Staff worked effectively to prevent, identify and treat surgical site infections. There had been no incidents of healthcare acquired infection (endophthalmitis) in the 12 months prior to our inspection.

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 clinic was a stand-alone unit which was newly refurbished in 2022 to deliver surgical and outpatient eyecare services. The ground floor facility included 1 theatre, 2 consultation rooms, 2 diagnostic rooms, 1 treatment room and 1 laser room. Access to the clinic was via an intercom buzzer system.

The design of the environment mostly followed national guidance. For example, clinical areas had laminate flooring which ran up the walls a short distance to allow for easy cleaning. This was in line with the Department of Health's 'Health Building Note 00-09: Infection control in the built environment'. The theatre had laminar air flow ventilation systems, which was also in line with national guidance. However, there were 3 rooms designed for clinical use which did not have sinks. This was not in line with national guidance. The service had carried out a risk assessment and put actions in place to mitigate risk.

Staff carried out daily safety checks of specialist equipment. This was confirmed through a review of checklists during our inspection. For example, staff had carried out daily and monthly checks of the resuscitation trolley, in line with the provider's policy. The service carried out a monthly resuscitation trolley audit. We reviewed audit outcomes for the 3 months prior to our inspection and these showed 100% compliance.

The service had enough suitable equipment to help them to safely care for patients. There was a regular planned maintenance and equipment replacement programme. An external maintenance provider attended the clinic annually to service and safety test the electrical equipment. The equipment had been purchased new when the clinic opened. All equipment had been serviced and safety tested within the date indicated.

The YAG (yttrium aluminium garnet) laser was housed in an appropriate laser safe room. There was a warning sign on the door stating that the room was a laser-controlled area and not to enter when in use. Local rules were displayed in the room. A laser safety policy was also in place, which staff could access easily. An up-to-date list of authorised users was available and staff maintained a logbook to record each time the laser was operated. All staff who worked at the clinic had completed training to make them aware of laser safety. The service carried out a monthly laser room audit. Audit results showed high levels of compliance in the 3 months prior to our inspection. An action plan was completed in response to any concerns identified through audits.

Most consumables checked during our inspection were within their expiry date. However, we identified 2 consumable items in theatre that had expired in March 2023. This was escalated to the registered manager during our inspection, who removed them from the area. All storage areas were found to be clean, with consumables stored on metal shelves off the floor.

Surgeons used a combination of reusable equipment and single-use equipment. Staff maintained a log of serial numbers of each item in patient records. This was in line with national guidance and meant the service could trace equipment in the event of an infection or incident.

Staff disposed of clinical waste safely. Staff ensured that sharps bins were correctly assembled, labelled appropriately and below the fill line. Staff used the correct bins to dispose of clinical waste and domestic waste. Clinical waste was collected by an external contractor on a weekly basis. Clinical waste was stored in locked bins within a locked room whilst awaiting collection. The service carried out a monthly audit of clinical waste. We reviewed audit results for the 3 months prior to our inspection and these demonstrated high levels of compliance.

The service had appropriate arrangements in place for the storage and use of cleaning products which were subject to the Control of Substances Hazardous to Health (COSHH) regulations.

Staff had carried out specific risk assessments for fire, Legionella, and substances which met the COSHH regulations. Staff carried out weekly testing of the fire alarm system and for Legionella. Legionella is a type of bacteria commonly found in water that can cause Legionnaires' disease, which is a lung infection that can be severe and sometimes fatal.

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 and reviewed this regularly. Surgeons carried out a medical history and risk assessment of each patient before surgery or laser treatment. This ensured the treatment was appropriate and safe. The risk assessment was reviewed again on the day of treatment.

Staff knew about and dealt with any specific risk issues. Patient co-morbidities were highlighted on patient records and on theatre lists.

Surgery

The service had a medical emergencies and resuscitation policy should a patient deteriorate and require emergency medical attention. Staff we spoke with described the process they would follow if a patient was to deteriorate. There had been no unplanned transfer of patients to another healthcare provider in the previous 12 months.

There was appropriate resuscitation equipment available in case of an emergency. There was 1 resuscitation trolley, which was situated outside of theatre. The trolley was well organised and had tamper evident seals in place. An emergency endophthalmitis kit was present and easily identified in theatres. Endophthalmitis is an inflammation of the eye caused by infection. There is a risk of eyesight being reduced or lost if treatment is not started as early as possible.

All staff were trained in basic life support. Registered healthcare professionals were trained in immediate life support.

The service used an adapted 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist to ensure patients were treated in a safe manner and to reduce the rate of serious complications. Our observations and review of records on inspection confirmed that the WHO safety checklist was being completed. Theatre staff completed safety checks before, during and after surgery. The service audited WHO checklist compliance through a monthly audit. We reviewed audit outcomes for the 3 months prior to our inspection and these showed 100% compliance.

The service did not accept emergencies but did have an out of hours number for patients to ring should they require any advice or support after their surgery. This number was covered by doctors who were on-call 24 hours a day. The service also kept an emergency appointment slot available at the end of each day so that patients who raised concerns could be seen on the same day if necessary.

The service worked to ensure that patients could access emergency services at external healthcare providers in a timely manner when required. The service had a service level agreement (SLA) and emergency contact sheet for the local NHS hospital trust. This ensured that patients received treatments within agreed timeframes and national targets.

Staffing

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

The service had enough staff to keep patients safe. There were 10 substantive staff who delivered care in the clinic. The team included the hospital manager, 2 registered nurses, 4 optical assistants, 1 patient coordinator, and 1 doctor. The hospital also used sessional surgeons for theatre lists. The service had vacancies for 2 theatre practitioners at the time of our inspection.

The hospital manager calculated and reviewed the number and grade of staff required for specific consultation lists and clinics. They adjusted staffing levels according to the needs of patients and planned care.

There was a minimum number of staff scheduled on theatre days which included, an admissions nurse, the surgeon, 2 scrub nurses, a circulating nurse (runner), an escort nurse and a discharge nurse.

Where staff absences occurred, a suitably trained staff member from a nearby location could fill the gap. Staff with dual roles also flexed across different roles within the hospital to cover absences. This included the hospital manager. The service also had access to locum, bank and agency staff if required. The service had not had to cancel a theatre list due to staffing shortages since they had begun operating in 2022.

Outstanding ☆

Surgery

The number of staff matched the planned numbers. Data we reviewed, and observations made during our inspection, confirmed there were sufficient staff to provide the right care and treatment.

The service had low turnover and sickness rates. 1 member of staff had left the service since January 2023. The service was not able to provide sickness rates as a percentage but the data we reviewed demonstrated low sickness rates.

The service had not used any bank and agency nurses since they began operating. Managers could access locums when they needed additional medical staff.

Managers made sure locum staff had a full induction and understood the service.

Records

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

Patient notes were comprehensive. We reviewed 9 patient records during our inspection and found they were clear, up-to-date and all relevant information had been completed.

All staff could access patient notes easily. The service used a combination of electronic and paper records. Paper records were scanned onto the electronic record following treatment.

Records were stored securely. Electronic records were stored securely using passwords and access only given to authorised members of staff. Paper records were stored in a locked cabinet in the reception area.

Staff sent discharge outcome letters to each patient's GP through an electronic system.

The service carried out a monthly audit of patient record completion. We reviewed audit results for the 3 months prior to our inspection and these demonstrated high levels of compliance. An action plan had been completed in response to any concerns identified through audits.

Medicines

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

The provider had a contractual arrangement with a third-party pharmacy to manage medicine delivery and disposal.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were stored securely in all clinical areas we visited. Medicine storage areas were well organised and tidy. All medicines we checked were within their use-by date. Staff documented the temperature of storage areas daily to ensure medicines were stored within the safe limits established by manufacturers. The service carried out monthly audits to ensure that room and fridge temperature checks were being documented as required. The audits completed in the 3 months prior to our inspection showed 100% compliance.

Staff completed medicines records accurately and kept them up-to-date. This was confirmed through a review of medicine records for 9 patients during our inspection. All medicine doses and batch numbers were recorded in patient records. Details of post-operative medicine instructions given to patients were also recorded in patients records.

Staff stored and managed all medicines and prescribing documents safely. This was confirmed through our observations on inspection. The service carried out monthly prescription sheet audits. We reviewed audit results for the 3 months prior to our inspection and these showed that compliance rates were between 94 and 96 percent.

An annual medicines management audit was undertaken by an external provider to ensure compliance with the relevant standards. The most recent audit had been completed in May 2023. The audit had found that 'Medicine management standards were mostly compliant with regulatory and best practice requirements.' The audit had made some recommendations for improvement and the registered manager had completed an action plan in response.

Incidents

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

Staff knew what incidents to report and how to report them. Staff told us they were encouraged to report incidents and felt confident to do so.

The service used an electronic reporting system which all grades of staff had access to. The incident reporting system was linked with the electronic patient records system. This enabled incidents to be recorded specific to patients, appointments, and their care.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff had reported 30 incidents in the 12 months prior to our inspection. The service had identified 3 incident themes: surgical complications, facilities or premises issues, and clinical record keeping.

The service had reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff reported serious incidents clearly and in line with the provider's policy. Staff had reported 1 serious incident in the 12 months prior to our inspection. This related to a patient who had fractured their finger after it was trapped in a door in February 2023.

We reviewed the investigation report for the serious incident reported in February 2023 as part of our inspection. The investigation report provided during our inspection was not a full root cause analysis (RCA) investigation report. An RCA includes a documented analysis of how and why things have happened, to see if there are lessons to be learned. The provider's adverse incident reporting policy stated that "all serious patient safety incidents" should be "subject to a full root cause analysis". This therefore raised concerns that incidents were not always investigated in line with provider's policy. However, following our inspection, the provider was able to send us a draft RCA investigation report. The provider said that the investigation was still on-going as the patient had taken legal action. The provider had accepted liability and they were awaiting a formal outcome to conclude the RCA.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff had completed the duty of candour process for the serious incident reported in February 2023. Our review of documentation on inspection showed that staff had carried out duty of candour in line with regulations.

Outstanding ☆

Surgery

Staff received feedback from investigation of incidents. Staff met to discuss the feedback and look at improvements to patient care. This was confirmed through a review of meeting minutes during our inspection.

Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Good

This is the first time we have rated this service. We rated effective as good.

Evidence-based care and treatment

There was not always an effective system in place to ensure policies were up-to-date and reflected national guidance. Managers checked to make sure staff followed guidance.

There was not always an effective system in place to ensure policies, standard operating procedures and clinical pathways were up-to-date and reflected national guidance. We reviewed 21 policies during our inspection. We identified that 3 policies did not have review dates. This meant that these policies may not be regularly reviewed to ensure that they remained up-to-date and reflective of national guidance. We also identified 4 policies which did not contain any references to national guidance. This meant that it was not always clear what guidance had been referred to when writing the policy.

Leaders said that the process for the way that policies were written, ratified, stored and cascaded had been under review in the 6 to 12 months prior to our inspection. A policy sub-committee had been implemented at provider level to review and ratify policies before dissemination. At the time of our inspection, the provider was in the process of reviewing all policies, to ensure that they met the required standards.

Policies and standard operating procedures (SOPs) were stored electronically and staff had easy access to them. Once policies had been approved by the sub-policy committee, all employees received an update via email including what policies have been introduced and amended.

All new policies went through an equality impact assessment process before approval to ensure they met diverse needs.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Water dispensers were available in waiting areas for patients to use. Staff also offered patients drinks while they were in the waiting area and after surgery.

Most patients attended for a short period and therefore food was not routinely offered.

Staff had made arrangements with the hotel next door for patients diagnosed with diabetes, to ensure that these patients could be provided with food and drinks when required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Anaesthetic eye drops were used prior to treatment and this was documented within the patient's care record.

Staff assessed patients' pain using a recognised tool. Patients were asked to rate their pain on a scale of 1 to 10 after surgery. Pain scores were recorded in patient records.

The service did not routinely administer any pain relief. However, if patients reported severe pain, staff informed a doctor before the patient was discharged. Doctors could prescribe pain relief to be taken on discharge.

The patients we spoke with during our inspection said that they had experienced a pain free procedure.

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 participated in the National Ophthalmic Database on cataract surgery from the Royal College of Ophthalmologists.

Outcomes for patients were positive, consistent and regularly exceeded expectations, such as national standards. The service monitored post-operative vision outcomes. In the previous 12 months, 99% of cataract patients achieved their planned vision improvement after surgery. This was better than the national average of 98%. Data showed that cataract patients achieved an average vision improvement of around 3 LogMAR units after surgery. LogMAR scoring is a method of recording the smallest letters that can be read.

The service had a complication rate of 0.6% between April 2022 and June 2023, which was better than the national average of 1.1%.

Information showed that the service offered surgery to 94 % of patients that were referred. This was significantly higher than the national average which was 61 to 78%. Managers said this was due to the clinical assessments conducted prior to cataract consultation, ensuring that patients were thoroughly and effectively assessed prior to preparation for surgery.

Data relating to YAG (Yttrium Aluminum Garnett) laser treatment outcomes showed that the Northampton location used over 30% less energy than the provider national average.

Since April 2022 there had been no unplanned returns to theatre, and 1 planned return to theatre.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service's audit programme included audits on infection prevention and control, patient records, consent, and medicines management. These were completed monthly and fed back to staff at monthly staff meetings. Action plans were put in place in response to any concerns identified through audits. However, actions did not include a target date for completion. Action plans were not always updated to indicate when actions had been implemented.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. For example, the service had identified that they were an outlier for their YAG complication rate, which was 31.75% compared to the provider average of 9.69%. The registered manager had investigated and found that

staff were adding additional procedure comments into the complications box, which was driving up the complication rate. A further review of data showed that there had only been 1 complication for YAG laser, which amounted to a 1.6% complication rate. The registered manager had held discussions with staff to make them aware that additional procedure comments should not be added into the complications box.

Managers shared and made sure staff understood information from the audits. This was confirmed through a review of meeting minutes during our inspection.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Data showed 100% of eligible staff had completed revalidation with their professional body. Staff completed a set of competencies which were specific to their job role. Staff had to complete competencies to be able to work in each aspect of the surgical pathway. The provider's education team observed staff before signing off their competencies. Competencies were renewed on a regular basis.

Managers gave all new staff a full induction tailored to their role before they started work. New members of staff were paired up with a mentor, who was a more experienced member of staff working in the same job role. Staff initially worked alongside this member of staff and would continue to have regular check-ins on an ongoing basis.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal compliance was 100% at the time of our inspection. Staff also completed quarterly meetings with the registered manager to review their progress against objectives.

The clinical educators supported the learning and development needs of staff. A provider level education team supported staff at the Northampton location.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. This was confirmed through a review of meeting minutes from the 3 months prior to our inspection.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Development plans were completed as part of the appraisal process. This provided staff with an opportunity to identify internal and external training courses which they were interested in completing. For example, 2 members of staff had recently chosen to complete advanced dementia training with an external provider. This meant that staff were able to meet the needs of patients living with more complex cases of dementia.

Multidisciplinary working

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

We observed effective multidisciplinary working, and communication between staff in theatres and outpatient areas. All staff told us they had good working relationships with their colleagues. We saw good interactions between all members of the team.

Outstanding ☆

Surgery

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked with GPs and ophthalmology services in the area to provide care for NHS patients. Staff also worked closely with staff at the provider's other locations. Staff from the Northampton clinic would work at other locations when required.

Seven-day services

Key services were available to support timely patient care, but they were not available 7 days a week.

The service was open 5 days a week from Monday to Friday. The service occasionally provided additional appointments and treatment on a Saturday, if required.

Patients could call for support following surgery 24 hours a day, 7 days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. We noted there were various information leaflets and posters available to patients in the main waiting area. This included information on sight loss charities, diabetes, and smoking cessation. Staff regularly asked patients for feedback about the type of health promotion information that was available at the clinic and how this could be improved or expanded.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle. For example, the service had referred patients to the Northamptonshire Stop Smoking Service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff 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. There was an effective up-to-date consent policy for staff to follow.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed consent being obtained from patients prior to their procedure. The risks and benefits were explained in a clear and concise manner and patients were given the opportunity to ask questions.

Staff made sure patients consented to treatment based on all the information available. Patients were given information about their proposed treatment both verbally and in a written format. Patients said doctors fully explained their treatment and provided them with the opportunity to ask questions.

Staff clearly recorded consent in the patients' records. We confirmed this through a review of 9 patient records during our inspection.

Staff received and kept up to date with training in the Mental Capacity Act. Training compliance was 97% at the time of our inspection.

Outstanding ☆

Surgery

Managers monitored the consent process through monthly audits. We reviewed audit results for the 3 months prior to our inspection. The audits had demonstrated 100% compliance with the required standards.

Is the service caring?

Outstanding ☆

This is the first time we have rated this service. We rated caring as outstanding.

Compassionate care

There was a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Feedback from people who used the service and those close to them was continually positive about the way staff treated people. People thought that staff went the extra mile, and their care and support exceeded their expectations. For example, patients and relatives told us staff were "wonderful", "excellent", "really helpful", "friendly", "understanding" and "caring". One patient said "the whole thing has been really good" and another patient said "I can't fault them in any way". The patient feedback forms that we reviewed as part of our inspection were also consistently positive about the care provided by the service. For example, comments included "From start to finish everything has been excellent", "Everyone was absolutely brilliant and treated me wonderfully", and "Nothing was too much trouble".

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed all staff treating patients with kindness, compassion, courtesy and respect. We observed a friendly and welcoming environment.

Staff followed policy to keep patient care and treatment confidential. Consultations took place in private rooms with doors closed to maintain the dignity and privacy of all patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff were able to provide examples of going above and beyond to understand and respect the individual needs of each service user. For example, staff told us about a time that they had worked to remove barriers for a patient who found it difficult to access the service. The patient was a carer for their spouse, who was living with dementia. The patient's spouse could not be left unattended whilst the patient underwent surgery. Staff arranged for both the patient and their spouse to be transported to the service on the day of the patient's surgery. A member of staff supported the patient's spouse in the waiting area whilst the patient underwent surgery.

Another member of staff provided examples of having gone the extra mile to provide care for patients. This included supporting patients to fetch a newspaper or a prescription after their treatment.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, staff provided information and advice to Muslim patients taking part in Ramadan about how to continue using prescribed drops appropriately whilst maintaining fasting.

Outstanding ☆

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. Patients provided positive feedback about the support provided by staff and said that they felt able to discuss any concerns or worries with staff. Staff were described as "reassuring" and "supportive". The patient feedback forms that we reviewed as part of our inspection included comments such as "I was feeling very anxious. The staff had to keep me calm and held my hand throughout the procedure" and "I was made to feel at ease at all times".

We observed staff checking on patients' and relatives' wellbeing whilst they were in the waiting area. Staff provided reassurance and support for patients or relatives who were anxious or worried. Staff said that they tried to put patients at ease by talking them through the procedure and by making them aware of the support that was available to them. For example, staff would hold a patient's hand during the procedure for reassurance.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff had introduced a quiet zone seating area based on patient feedback. Staff could provide support to patients in this area.

Patients who were particularly anxious were offered a pre-visit to the clinic where staff showed them around and explained what would happen and how they would be supported. Staff said that they would also arrange off-peak appointments so that anxious patients could attend at a quieter time.

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. Patients and relatives felt they were fully involved in their care and had been given the opportunity to ask questions throughout their appointment.

Staff were able to provide examples of going the extra mile to ensure that service users understood their care. For example, staff had introduced wellness and check-in calls for patients with diabetes, dementia or Glaucoma during the 4 weeks post-surgery. Staff would answer any questions and ensure that patients were continuing to administer eye drops as required.

The service had also introduced a courtesy telephone call for all patients before they underwent surgery. The patient coordinator contacted patients 1 to 2 days before surgery to answer any questions and ensure that patients were prepared for surgery. For example, the patient coordinator would ensure that patients were aware that they should not wear make-up when they attended the service. The courtesy call had been introduced based on patient feedback.

Staff supported patients to make informed decisions about their care. Staff were observed providing clear explanations, giving advice, and answering questions.

Staff had access to an advocacy policy, which guided them on how and when to access independent advocacy support for patients. This ensured that patients without family or friends to accompany them or to help them understand care and treatment had access to advocates.

Outstanding ☆

Surgery

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service asked patients to provide feedback through an electronic tablet immediately after their appointment or surgery. Staff assisted patients to use the tablet if needed. The service also collected anonymous patient feedback after discharge through a text message service. Patients could also use the NHS Choices website to leave feedback.

The service had also completed the 15 steps challenge in March 2023. The 15 Steps Challenge focuses on seeing care through a patient's eyes and exploring their first impressions. The patient who completed the challenge provided positive feedback about their experience, alongside suggestions for potential improvements. The registered manager had identified a range of actions in response to the feedback provided.

Patients gave consistently positive feedback about the service. Patient feedback on the electronic tablet in the reception area had been 99.3% positive from May 2022 to May 2023. The feedback received through text message surveys had been 97.9% positive or neutral between May 2022 and May 2023. Reviews on NHS Choices were 4.9 out of 5 stars on average, based on 17 reviews. The service received numerous thank you cards, which were positive about the care they had received and the kindness shown to them.

Is the service responsive?

Outstanding ☆

This is the first time we have rated this service. We rated responsive as outstanding.

Service delivery to meet the needs of local people

People's individual needs and preferences were central to the delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care. The services were flexible and provided informed choice.

Managers planned and organised services so they met the needs of the local population. The service offered surgical eye services and outpatient appointments to NHS patients under local Integrated Care Board (ICB) contracts. Patients were referred by their GPs or optometrist. The service relieved pressure on local NHS services and this freed up time for local NHS hospitals to treat more complex ophthalmology cases.

There were examples of innovative service provision to ensure that the service met the needs of a range of people. For example, the service offered a 'home to hospital' transport service, which was free of charge for all patients. The service had their own minibus and a patient driver to deliver this service. The service also had a contract with a local taxi service, which meant that staff could book a taxi for patients if the transport service was not available when required. The provider had also developed a booking app that enabled patients to book or change appointments, 24/7, from their mobile device. Over 67% of patients self-booked appointments.

The service provided a range of examples of how they had adjusted service provision in response to patient feedback. For example, the service had introduced a quiet zone seating area for patients after cataract surgery, based on patient feedback. The service had also introduced an electronic tablet with large buttons in the reception area to assist patients with car parking payments. Staff had introduced a Bluetooth radio to escort patients after receiving feedback that music

or noise helped to distract and reduce stress levels. Staff had introduced eye drop bottles with dropper applicators, to assist patients with arthritis and mobility issues, after receiving feedback that some of these patients were struggling to apply eye drops. Staff said that the use of the dropper bottles could avoid the need for district nurses and additional care support.

The service offered some telephone appointments to minimise travel for patients.

The service worked closely with optometrists in the local area to gather feedback and service provision had been adjusted in response. For example, the electronic system used by optometrists had been adjusted to allow them to track patients after referral. Optometrists were also able to view waiting times for each clinic so that they could provide this information to patients before referral.

The service was a newly refurbished surgical centre with consulting rooms, treatment rooms and a theatre. The waiting area was pleasant with comfortable seating, TV and cold-water stations.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients with specific needs were identified at pre-assessment and flagged on the electronic patient record system. This meant appropriate arrangements could be made to meet individual needs prior to their visit.

The service worked with a dedicated eyecare liaison officer (ECHLO) and the Royal National Institute for Blind People to assist people with practical issues such as welfare and benefits to improve the quality of patients' lives. They also supported patients to complete the certification of visual impairment process.

Managers monitored and took action to minimise missed appointments. Staff contacted patients in advance of each appointment to ensure they planned to attend and this minimised the risk of a missed appointment. The service's did-not-attend (DNA) rate between January and June 2023 was 2.87%, which was better than the provider's national average of 4.25% and the national average for the NHS of 7.6%.

Meeting people's individual needs

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients who needed additional support were able to bring a carer or other person with them in the clinic. Patients were offered a pre-visit to the clinic where staff showed them around and explained what would happen and how they would be supported. Staff could also arrange off-peak appointments so that patients could attend at a quieter time. The service had introduced a quiet zone to provide a separate waiting area to support patients who experienced anxiety or sensory overload. The electronic patient records system included a section for special requirements where staff could highlight patients' individual needs. This helped staff to anticipate the needs of patients during their care and treatment. The service had introduced a dementia sensory box which included fidget toys and other activities to help keep patients focused and to remain calm whilst waiting to be seen.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff could use the patient record system to record any information and communication needs. Information and communication needs were also highlighted on theatre lists. A hearing loop was installed for hearing impaired patients and visitors.

The service ensured that patient information was available in languages other than English. The provider used an app to send patient information, including information leaflets. The app allowed patients to convert the text to their chosen language or to have the text read aloud in their chosen language.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to either in-person or remote interpretation and translation services, depending on the nature of care and the level of need. The service had also introduced a translator tablet for patients to help make their consultation easier. Staff gave examples of times where they had arranged translation services for patients even when the cost of the translation service outweighed the tariff that they would receive for the appointment. We were also provided with examples of multilingual staff having gone above and beyond to provide translation support for patients when this was required at short notice. This ensured that patients did not experience any delays and received appropriate support.

The provider had a range of measures in place to aid communication with patients. The service could print letters and other patient information onto coloured paper to assist patients with dyslexia or other visual impairments. Staff had access to animated videos which could be shown to patients to help them to visualise what would happen during a cataract consultation and operation. Staff said that the videos had been specifically designed to simply explain what would happen when patients came into the hospital and that the videos were appropriate for patients with learning disabilities. Staff also used images, such as a model of the eye, to help them explain and to help patients to visualise care and treatment. There was scope to further expand the communication aids available for staff to support patients who may have difficulty with their speech or understanding to become partners in their care and treatment. For example, through the use of a chart with pictures or symbols which patients could point to.

Patients with mobility difficulties could access the service easily as the main service was located on the ground floor. A wheelchair was available for patient use and staff would collect patients from the car park if necessary.

The service had a pro-active approach to understanding the needs of different groups of people and to deliver care in a way that met these needs to promote equality. The service was focused on improving access and services for patients with a learning disability. The provider had a designated lead for learning disabilities and autism. In 2022, the hospital manager had reviewed the service provided at the Northampton location against the criteria of the NHS Learning Disability Improvement Standards. The review had involved an assessment of which standards were already being fully met and to identify areas where further work was required. There was only 1 improvement measure where the service had RAG (red, amber, green) rated themselves as red, which related to their ability to show that services were codesigned with people with learning disabilities, autism or both and their families and carers. The provider planned to start work on this area in Autumn 2023.

All staff completed training on how to care for patients with dementia. In addition, 2 members of staff had recently chosen to complete advanced dementia training with an external provider. This meant that staff were able to meet the needs of patients living with more complex cases of dementia.

Staff were supported by a policy for supporting transgender patients. Staff demonstrated an awareness of this policy.

Access and flow

People could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure people had timely access to treatment, support and care.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. At the time of our inspection, the average waiting time for an outpatient appointment or cataract consultation was less than 1 week. The average waiting time for cataract surgery was less than 2 weeks.

The registered manager and the rota coordination team monitored referral numbers and capacity levels on a weekly basis. Between April 2022 and June 2023, the service had received an average of 156.4 referrals per month. The service accepted 94% of referrals. The 6% of patients who were not accepted were deemed to be more appropriate to be seen in a secondary care setting. The service had capacity to add additional outpatient clinics or operating lists if required, to meet demand.

All referrals from the local ophthalmology services went directly to a central booking team at head office, where a team of coordinators contacted patients with an appointment. Between March and May 2023, 100% of referrals were triaged within 2 days.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service monitored the time of patient arrival to discharge after surgery. On average, patients undergoing surgery were discharged within 90 minutes. No patients had been discharged after 5:30pm in the 12 months prior to our inspection. Patients were informed verbally if appointments were running behind.

Managers worked to keep the number of cancelled appointments, treatments and operations to a minimum. There had been no clinical cancellations in the 12 months prior to our inspection. The service closely monitored the numbers of patient-initiated cancellations, including the reasons for cancellation and the number of cancellations on the day of the appointment.

When patients cancelled their appointments, treatments or operations at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff followed up with patients who cancelled their appointment and offered additional dates. Data showed that 86% of patients were re-booked after cancellation. The service monitored the percentage of patients that were re-booked on the same day as the cancellation.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The integrated care pathway document for cataract surgery included a discharge checklist which ensured that patients were prepared for discharge and that all appropriate arrangements were in place.

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.

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas. The service had also implemented a patient query email inbox as an alternative means for patients to contact the service with any concerns or questions.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would attempt to resolve any complaints or concerns informally in the first instance. The service aimed to acknowledge a complaint within 48 hours of receiving it and to send a response within 20 working days.

Outstanding ☆

Surgery

Managers investigated complaints and identified themes. The service had only received 1 complaint in the 12 months prior to our inspection. The complaint related to concerns about the support that a patient had received from staff during a post-operative complication. We reviewed the documentation relating to this complaint as part of our inspection. Managers had not investigated the complaint in line with the timescales set out in the complaints policy. The registered manager stated that the investigation had been delayed when staff had been unable to contact the complainant. The complaint response included a full explanation of what had happened and the actions that had been taken in response to the complaint. The response was detailed, factual and sympathetic.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff were aware of complaints that had been received by the service and the action that had been taken in response.

Staff could give examples of how they used patient feedback to improve daily practice. For example, staff had received feedback from patients with visual impairment that they struggled to use the small buttons on the car parking payment machines. In response, staff had liaised with the car parking company to introduce an electronic tablet with large buttons in the reception area of the clinic to assist patients with car parking payments.

Is the service well-led?

Good

This is the first time we have rated this service. We rated well-led 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.

There was a clear management structure with defined lines of responsibility and accountability. The service had a registered manager who held overall responsibility for the leadership of the clinic, with support from a lead nurse.

Leaders had the experience that they needed. The registered manager had previous experience of managing surgical services in the independent sector. The registered manager did not have previous experience of managing ophthalmology services. The registered manager had therefore received support and training from another manager with an ophthalmology background when they first joined the service.

Leaders understood the challenges to quality and sustainability, and could identify the actions needed to address them. For example, the registered manager said that there was a challenge in ensuring that there was enough capacity to meet the continual increase in demand. The registered manager closely monitored data on the number of referrals, capacity levels, and waiting times. Additional lists were added when required.

The registered manager had also identified a challenge around ensuring that staff maintained their knowledge of the contents of the wide range of policies and procedures that were in place. The manager had introduced a game into team meetings where staff were asked to draw questions from a box which tested their knowledge about policies and procedures. The manager added incentive prizes, such as the first member of staff to get 5 questions right could go home 10 minutes early.

Outstanding ☆

Surgery

Leaders were well respected, visible, and approachable. Staff provided consistently positive feedback about their manager. Staff described the manager as "amazing", "professional", "accessible" and "always available to talk".

The registered manager provided positive feedback about the support that they received from their regional manager and leaders at provider level. Arrangements were in place with the manager from a nearby clinic to provide support in case of absence.

Vision and Strategy

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

The provider had developed a set of values which included 'caring', 'passionate', 'togetherness', 'listening' and 'focus'. During our inspection we saw that staff worked in line with the service's values. Staff we spoke to were committed to providing a high-quality service to all patients who used it.

The provider had developed a mission statement 'To provide and assist in the management of eyecare and endoscopy services by delivering high quality outstanding solutions in our purpose build centres.'

The vision and values were publicly displayed throughout the service.

The provider had developed a strategy which was focused on working with NHS commissioners to 'review pathways, increase the closer to home, out of hospital community offer, to enhance the current services provided by CHEC and support the NHS…' Progress against the strategy was monitored through an annual quality report.

Staff had a clear understanding of what the service wanted to achieve and there was a sense of motivation and enthusiasm amongst the team.

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 felt supported, respected and valued. Staff said that their manager went 'above and beyond' to provide them with support and they felt confident to discuss any concerns with them.

The culture was centred on the needs and experience of people who used services. Staff said that what they liked most about the provider was that "patients come first". Staff had put together a 'going the extra mile' notice board where they regularly added examples of staff that had gone above and beyond for patients.

There was a common focus on improving the quality of care. Staff contributions were recognised and celebrated. For example, one member of staff had been given responsibility for the patient information leaflets in the clinic and they spoke with enthusiasm about working to ensure that the patients who attended the clinic had access to information which was relevant to them and supported their needs.

Staff felt positive and proud to work in the organisation. All staff spoken with on inspection were proud of the organisation as a place to work and spoke highly of the culture. For example, one member of staff said "I love my job…I couldn't ask for a better place to work."

The culture encouraged openness and honesty at all levels within the organisation. Staff, patients and families were encouraged to provide feedback and raise concerns without fear of reprisal. Processes and procedures were in place to meet the duty of candour. A Freedom to Speak Up Guardian was in place at provider level and their contact details were displayed in the staff area.

There were mechanisms for providing staff at every level with the development they needed, including high-quality appraisal and career development conversations. Development plans were completed as part of the appraisal process.

There was a strong emphasis on the safety and well-being of staff. The service had a range of staff wellbeing measures in place. Staff were able to access up to 9 months of advice and guidance from a mental health professional through a mental health support service. An employee assist programme was also available to staff, 24-hours a day, seven days a week.

Equality and diversity were promoted within and beyond the organisation. All staff felt that they were treated equitably. The provider had sought feedback from staff about their experience of equality and diversity in the workplace, to identify any areas for improvement.

There were cooperative, supportive and appreciative relationships among staff. We observed positive and supportive relationships between staff at all levels and staff said that they regularly spent time together outside of work.

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 were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The registered manager attended a quarterly organisation-wide clinical governance meeting with senior leaders and other hospital managers. The meetings were attended by the provider's director of clinical services, the medical director, and the head of governance. The group reviewed known and emerging risks, audit outcomes, quality markers, and patient and staff feedback.

Governance structures and processes were regularly reviewed and improved. The provider had reviewed and improved their clinical governance processes and structures in 2022 and 2023. The provider had held staff engagement workshops to gather feedback about the approach to governance, to ensure that new processes would meet staff needs.

All levels of governance and management functioned effectively and interacted with each other appropriately. Managers held monthly team meetings for staff at a local level and this provided an opportunity for relevant information to be fed back down from governance meetings. This was confirmed through a review of the last 3 meeting minutes as part of our inspection. A quality bulletin was also sent to staff via email with information about incidents, risks, complaints, patient feedback, and patient outcome data.

Staff at all levels were clear about their roles and understood what they are accountable for, and to whom.

Outstanding ☆

Surgery

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.

There were processes to manage current and future performance. A quality and governance report was produced for governance meetings, which included data on patient outcomes, audit results, incidents, complaints and patient feedback, and staffing data. There was scope to add data to the report around capacity, demand and waiting times.

There was a systematic programme of clinical and internal audit. The service's audit programme included audits on infection prevention and control, patient records, consent, and medicines management. These were completed monthly and fed back to staff at monthly staff meetings. Action plans were put in place in response to any concerns identified through audits. However, there was scope for the service to improve their documentation to ensure that there was always a target date identified for the completion of actions and that it was always clearly documented when actions had been implemented.

There were some inconsistencies in the arrangements for identifying, recording and managing risks, issues and mitigating actions. The service had a local risk register, which included 11 risks. The local risk register sat alongside a provider-level corporate risk register. Risks on the local risk register were graded based on likelihood, consequence and impact. Each risk had a risk owner identified and details of controls in place. However, most risks did not include any updates or evidence of review since they had been identified. Risks did not include a date by which the risk should next be reviewed. We did not see evidence of the review of the risks on the local risk register in the meeting minutes that we reviewed during our inspection. Whilst documents such as the risk register and action plans were not consistently updated to reflect the actions that had been taken, there was evidence that the service had identified and acted on the key risks that we identified during the inspection.

Potential risks were taken into account when planning services. A detailed business continuity plan was in place.

Information Management

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

There was a holistic understanding of performance within the service. Leaders monitored a wide range of data relating to the service, including patient feedback, patient outcomes, operations, as well as a range of quality indicators. Information was used to measure for improvement, not just assurance.

Quality and sustainability both received sufficient coverage in relevant meetings at all levels. This was confirmed through a review of meeting minutes during our inspection.

There were clear and robust service performance measures, which were reported and monitored. Leaders completed a monthly key performance indicator (KPI) dashboard.

There were effective arrangements to ensure that data or notifications were submitted to external bodies as required. A notification had been submitted to the CQC as required when a patient sustained a serious injury in February 2023.

There were robust arrangements to ensure the integrity and confidentiality of identifiable data, records and data management systems. The service stored electronic records securely and these were password protected. Paper records were stored in a locked filing cabinet. All staff undertook training in information governance and application of the General Data Protection Regulations.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the services and culture. Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The hospital used the results of the surveys to improve the service. It was clear that they recognised the value of public engagement.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. Managers held monthly team meetings and daily team briefs, which provided an opportunity for staff engagement. The service had also completed a staff survey in 2022 to gather staff feedback. The survey results mostly showed high levels of staff satisfaction. Actions had been identified in response to any concerns raised through the survey. For example, the registered manager had introduced a staff suggestion box following the survey for any members of staff who did not feel comfortable sharing their suggestions verbally. The registered manager had introduced a ping pong table and a cookie jar into the staff room in response to staff feedback.

There were positive and collaborative relationships with external partners. A client relationship executive met with optometrists in the local area to provide support and get feedback.

There was transparency and openness with all stakeholders about performance. The service shared a monthly key performance indicator (KPI) dashboard with the Integrated Care Board (ICB). The dashboard included a range of data, including waiting times, outcomes data, as well as incidents and complaints.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Mangers were responsive to any concerns raised and sought to learn from them and improve services. Staff took time together in meetings to review the service's performance and objectives.

The service continuously sought feedback from patients to improve services. The service used patient feedback, complaints, and audit results to help identify any necessary improvements and ensure they provided an effective service.

The service had processes in place which meant that they had already identified the key areas of concern which were identified during our inspection. This included access to hand wash basins in clinical areas, policies which required review, and the labelling of equipment to show when it was last cleaned. Actions had been identified to address these concerns and these were in the process of being implemented at the time of our inspection. This demonstrated that the service did not rely on external parties to identify key risks before they started to be addressed.

Outstanding

Outpatients

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

Is the service safe?

Good

This is the first time we have rated this service. We rated it as good.

Safe systems to protect people from abuse and avoidable harm across the service were the same for both surgery and outpatients. The evidence detailed in the surgery section of this report is also relevant to the outpatient service and has been used to rate the outpatient service.

Is the service effective?

Inspected but not rated

We do not rate effective for outpatient services.

Processes to ensure an effective service that meant people's care, treatment and support achieved good outcomes were the same for both surgery and outpatients. The evidence detailed in the surgery section of this report is also relevant to the outpatient service.

Is the service caring?

Outstanding

This is the first time we have rated this service. We rated it as outstanding.

Processes to ensure a caring service was provided were the same for both surgery and outpatients. The evidence detailed in the surgery section of this report is also relevant to the outpatient service and has been used to rate the outpatient service.

Outstanding

Outpatients

Is the service responsive?

Outstanding

This is the first time we have rated this service. We rated it as outstanding.

Processes to ensure the service was responsive and met people's needs were the same for both surgery and outpatients. The evidence detailed in the surgery section of this report is also relevant to the outpatient service and has been used to rate the outpatient service.

Is the service well-led?

Good

This is the first time we have rated this service. We rated it as good.

Processes to ensure leadership, management and governance of the organisation assured the delivery of high-quality and person-centred care, supported learning and innovation, and promoted an open and fair culture were the same for both surgery and outpatients. The evidence detailed in the surgery section of this report is also relevant to the outpatient service and has been used to rate the outpatient service.