SpaMedica Ltd

# SpaMedica Norwich

**Inspection report**

West Suite Ground Floor Discovery House
4 Norwich Business Park, Whiting Road
Norwich
NR4 6EJ
Tel: 01618380870
www.spamedica.co.uk

Date of inspection visit: 27 September 2022
Date of publication: 25/11/2022

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

## Ratings

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

# Summary of findings

## Overall summary

This is the first time we inspected this service. 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. 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 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, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available when patients needed them.
- 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.
- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. It was 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 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:

- We found that some modules of the mandatory training programme for clinical staff had completion rates below the expected provider level target.
- We observed that during one procedure the World Health Organisation (WHO) check list had not been completed appropriately.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | Good  | We have not previously inspected the service. We rated it as Good. See the overall summary above for details. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to SpaMedica Norwich

SpaMedica Norwich is operated by SpaMedica Ltd and registered with the CQC in September 2021. The service is a private clinic that offers cataract surgery and yttrium aluminium garnet (YAG) laser capsulotomy services for NHS patients. YAG laser capsulotomy is a special laser treatment used to improve vision after cataract surgery. The service underwent 1612 surgical procedures between November 2021 and September 2022.

SpaMedica Norwich has a registered manager in post and is registered with the CQC to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Surgical procedures

The service does not treat children.

The main service we inspected was surgery, which incorporated diagnostic and screening checks of the eyes before and after treatment. We have not reported this aspect separately.

The service did not provide outpatient appointments at the time of our inspection therefore this was not included in our report.

## How we carried out this inspection

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

This was an unannounced inspection.

An inspector carried out the inspection on 27 September 2022 with off-site support from an inspection manager. During the inspection, we spoke with 6 members of staff, the hospital manager and the area manager for the organisation. We also spoke with 4 service users and their carers and were present during 3 surgical procedures, with the service user's consent. We reviewed five patient's notes, feedback forms and online reviews. We also reviewed a range of policies, procedures and other documents relating to the running of the service.

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 provided free transport to patients who lived within a set distance from the location.

# Summary of this inspection

- Patients stories were available as DVDs or on the website for patients to review prior to their procedure.
- The service ran accreditation evenings for local opticians to enable them to support patients post-operatively in the community.
- Staff ensured patients' needs were established at pre-assessment and appropriate support put in place to assist patients who had mental health needs and learning disabilities.

## Areas for improvement

Action the service 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 provider should ensure the World Health Organisation (WHO) check list is always completed appropriately (Regulation 12).
- The provider should ensure that all staff complete their mandatory training modules in line with the provider target completion rate within an appropriate timeframe (Regulation 12).

# Our findings

## Overview of ratings

Our ratings for this location are:

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

Good

# Surgery

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

## Are Surgery safe?

Good

We have not previously inspected the service. We rated it as good.

**Mandatory training**

**The service provided mandatory training in key skills to all staff and monitored compliance to make sure everyone completed it. However, some modules did not meet the provider target completion rate.**

Staff received and kept up-to-date with their mandatory training. The service provided statutory and mandatory training using a combination of 'face to face' training and e-learning. Compliance with mandatory training for all staff who had completed their 6-month probation period was 95%, against a target of 95%. Managers told us staff received protected time to complete mandatory training as a part of the induction programme.

We reviewed the mandatory training completion data for SpaMedica Norwich and found that some modules did not meet the provider target completion rate of 95%. As an example, basic life support training had a completion rate of 83%. However, we were provided with evidence that the remaining 17% of staff were booked for training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included courses covering basic and immediate life support, infection control, safeguarding children and adults, health, safety and welfare, fire safety, manual handling and equality and diversity. Staff also received mandatory training on complaints handling, conflict resolution and duty of candour.

Managers monitored mandatory training using a training matrix and alerted staff when they needed to update their training. Staff we spoke with told us they received reminders to complete mandatory training and were also reminded during staff meetings. Staff we spoke with told us they had enough time to complete their mandatory training.

Consultants completed mandatory training within their substantive NHS employer and provided annual confirmation of completion of this training to the service in line with the organisation's practising privileges policy.

**Safeguarding**

Good

# Surgery

**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. Safeguarding children and adults formed part of the mandatory training programme and staff received training which corresponded to their role.

Clinical staff received safeguarding adults and safeguarding children training to level 2. Completion rates for both sets of training was 100%. Non-clinical staff also received safeguarding adults and safeguarding children training level 1. They also achieved 100% completion rate for the training modules.

The service had a safeguard lead trained to level three who was able to support staff in escalating their concerns and supporting referral processes to the relevant local authorities. Staff also had access to safeguarding level four trained members of the corporate team.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of concerns they would report and knew how to access the contact details for the agencies they would need to report to. There were posters throughout the service informing staff on how to raise safeguarding concerns. The service also had an up-to-date safeguarding child and adults policy, with flow charts for the escalation of concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

The hospital had a recruitment pathway which helped ensure that relevant recruitment checks had been completed for all staff. This included a disclosure and barring service (DBS) check; occupational health clearance, references and qualification and professional registration checks.

The hospital had an up-to-date chaperone policy.

**Cleanliness, infection control and hygiene**

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

Clinical areas were clean and had suitable furnishings which were visibly clean and well-maintained. The reception, appointment offices, operating theatre, ward and recovery areas were visibly clean and had suitable furnishings which were clean and well-maintained. Seamless easyclean floor covering was used throughout all clinical areas, waiting rooms and toilets. Storage areas were tidy and free from clutter.

The service used records to identify how well and how often areas within the department were cleaned. Cleaning records were up-to-date and indicted that all areas were cleaned regularly. Cleaning staff were employed using a service level agreement and permanently allocated to the service. We also observed clinical staff cleaning equipment after each patient use. All other equipment was cleaned after patient contact. Records demonstrated 100% compliance with daily cleaning routines.

Good

# Surgery

We observed staff cleaning high touch surfaces and other areas such as dirty and utility rooms during the day. The registered managed stated that specialist contractors were available to perform regular deep cleansing actions including those such as 'high areas' and air conditioning filters. High areas were cleaned weekly. Air conditioning filters changed 6 monthly in accordance with manufacturer and servicing guidance. Should a deep disinfection clean be required the SLA with the cleaning company covered immediate action.

Staff used records to identify how well the service prevented infections. Staff followed infection control principles including the use of personal protective equipment (PPE). Hand-washing and sanitising facilities were available for staff and visitors. The service provided staff with sufficient PPE such as gloves and masks. We observed all staff members complying with the service policy for the use of PPE during our inspection.

In July 2022 the service achieved 78% compliance for infection prevention control measures. An action plan was put in place to address the concerns found and in the following audit in September 2022 the service achieved 100% compliance. The service achieved 100% compliance for hand hygiene audits in the same period.

Staff worked effectively to prevent, identify and treat post-surgery infections. Data showed that there was only one case of endophthalmitis (inflammation of the internal eye tissue) since the location started to operate in October 2021. We were told this low occurrence rate was because 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.

**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 building was modern, and the service was located on the ground floor. The reception, clinical assessment rooms, admission area/ ward, theatres and recovery area were designed to allow a smooth flow for the patients and staff.

Theatre suite lighting, ventilation, equipment and surgical consumables met national standards.

We also reviewed the consultation room in which the yttrium aluminium garnet (YAG) laser capsulotomy was undertaken and this met the national guidelines for use of laser surgery. The 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 a do not enter sign when in use. Local rules were displayed in the room. A laser safety policy was also in place which staff could access easily.

Non-public areas such as store cupboards, clinical waste room and clinical areas were secured by keypad locks to control access. Staff ensured doors were closed behind them when entering or leaving the rooms. Storage areas were visibly clean and well-organised.

Patients could reach call bells and staff responded quickly when called. Each bay within the ward area where patients were seated, had a call bell. The admissions nurse carried out regular comfort checks on patients waiting in the ward area prior to surgery.

Good

# Surgery

The service had undertaken Legionella, fire and health and safety risk assessment. Records showed that action plans had been put in place to mitigate the risks identified. Staff demonstrated how they had access to evacuation routes in the event of a fire. Water outlets and sinks were flushed to reduce the risk of Legionella build-up in line with Health and Safety Executive (HSE) guidance.

Staff carried out daily safety checks of specialist equipment. Staff carried out checks on equipment such as the resuscitation trolley. Resuscitation equipment was located on a purpose-built trolley and was visibly clean. Single-use items were sealed and in date. Resuscitation equipment had been checked daily and an up-to-date checklist confirmed all equipment was ready for use.

The ward and theatre areas were well equipped and faulty or damaged equipment was repaired or replaced quickly. An external provider attended the location to service and safety check all medical equipment. We reviewed equipment and maintenance logs and saw that the equipment used was serviced within appropriate time frames. Stock and equipment, including disposable instruments, were also well managed and recorded for restocking and traceability purposes.

Staff disposed of clinical waste safely. Clinical waste disposal was provided through a service level agreement. Clinical waste and non-clinical waste were correctly segregated and collected separately.

**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.**

The service provided ambulatory care where no general anaesthesia or sedation was used. All treatment was carried out as day surgery under local anaesthetic (eye drops).

The hospital had clear inclusion and exclusion criteria, which were reviewed regularly. Staff worked with local opticians and GPs to ensure they understood the criteria before referring a patient to the service. Patients identified as needing more complex surgery were referred to the local hospital or other locations with specialist surgeons.

Staff ensured they had adequate knowledge of the patient's health including any relevant test results and their medicines history. There was a comprehensive pre-operative assessment that was used for all patients. This was to ensure patients met the inclusion criteria for surgery and to allow any risks, that may lead to complications during the anaesthetic, surgery, or post-operative period, to be identified.

Staff completed risk assessments for each patient on arrival or admission, using a recognised tool, and reviewed this regularly. 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 followed an adapted World Health Organisation (WHO) five steps to safer surgery checklist, which we saw in use in theatre. Theatre staff completed safety checks before, during and after surgery. Audits reviewed from the service showed 99.6% compliance for clinical documentation.

We observed two surgeries and reviewed five patient notes, most had correctly completed checklists. However, we observed that during one procedure the WHO check list had not been completed appropriately. We discussed this with the managers during the inspection and it was immediately escalated to the clinical staff and completed correctly.

Good

# Surgery

Staff knew how to respond promptly to any sudden deterioration in a patient's health. The hospital had an escalation policy which was to call 999 and transfer the patient to an acute NHS hospital. Staff were trained in basic life support and clinical staff such as nurses were trained in immediate life support. At the time of inspection, staff who had not completed their basic life support training module were booked onto upcoming planned courses.

We observed nursing staff giving post-operative advice and medication instructions to patients. This was supported using patient advice leaflets. Patients were also observed for a short period following the operative procedure to ensure no immediate clinical complications occurred. Patients wore a protective eye shield post-surgery to reduce any injury to the eye.

Staff knew about and dealt with specific risk issues such as endophthalmitis. The hospital had an endophthalmitis box in case of an emergency. Endophthalmitis is an infection of the tissues or fluids inside the eyeball caused by infection. It is an urgent medical emergency and immediate treatment is vital.

Following surgery patients had access to a 24-hour helpline for any concerns and staff were available for emergency situations. Patients were provided with a discharge booklet that included information about how to access support.

The organisation had developed a post-operative review service with accredited community optometrists. Four weeks following surgery patients attended an appointment either in the community or at the services, premises to review the results of the treatment.

Staff shared key information to keep patients safe when handing over their care to others. Staff sent discharge letters to the patients' GPs and community optometrist.

We observed the morning safety huddle and saw all appropriate staff attended and relevant information was shared.

**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.**

The service had enough nursing and support staff to keep patients safe. The theatre team for the surgical list included a surgeon, two registered general nurses (RGN), two healthcare technicians (HCT) and two RGNs for admission and discharge. Staffing levels reflected demand on the service and known treatment support needs. The organisation had agreed minimum staffing for the hospital and surgery could only proceed when the standard of skill-mix was confirmed. This was in line with the Association for Perioperative Practice guidelines: Staffing for Patients in the Perioperative Setting, 2014.

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

The manager could adjust staffing levels daily according to the needs of patients. All theatre lists were pre-planned so the number of staff required for each shift could be pre-determined. Hospital managers liaised across the region to support and plan staffing. At the time of inspection, there were no vacancies for clinical staff.

Good

# Surgery

Managers limited their use of bank staff and requested staff familiar with the service. The service used bank and agency staff who were familiar with the service.

All staff had a period of induction, and supervision was required, on commencing work at the service. All bank and agency staff were required to undergo the same competency training as employed staff. Nursing staff had completed their Nursing and Midwifery Council re-validation checks and updates to develop their competencies.

The hospital regularly reviewed staff absence and recruitment and retention information.

**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. Managers regularly reviewed and adjusted staffing levels and skill mix.**

The service had enough medical staff to keep patients safe. The service had 3 surgeons assigned to the location working under practising privileges. The service was able to access more surgeons from a list of approved surgeons from a provider level list to support the services' needs if necessary.

Assessments of applications for practising privileges, from doctors and allied health professionals, were carried out 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.

The hospital monitored compliance with their practising privileges policy and no concerns had been raised in the Medical Advisory Committee meeting minutes we reviewed.

**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. Bank staff could access the records when required. The hospital used paper and electronic records, to document patient information securely.

Paper records were maintained for consent, demographics, copy of biometry, outcome forms and referrals. All scans could be viewed electronically. Biometry scans could also be viewed electronically as well as printing of hard copies if required at the service. Records could be accessed across all areas in the service, allowing for continuity of record keeping.

We viewed 5 patient care records, which contained the patient's consent form, pre-assessment, operative procedure and discharge information. Records we reviewed were completed appropriately.

Records were stored and archived securely using paper and electronic files. Paper records were stored securely in a locked cupboard and the electronic records were password protected. We observed staff maintaining the confidentiality of appointments and enquiry records. Computer screens were not kept 'unlocked' or left unattended.

Good

# Surgery

Staff had completed record keeping and information governance awareness as part of induction and mandatory training. We saw that completion rates for this training module were 100% among all staff groups.

The service audited their record keeping in line with their record keeping standards of practice and policy. The audit demonstrated 99.6% compliance within the established standards between October 2021 and September 2022.

**Medicines**

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

Staff followed systems and processes to prescribe and administer medicines safely. The hospital had a medicines management policy, which ensured staff practices were in line with national guidance.

The service used topical and local anaesthesia to the eye only. Eye drops were prescribed using patient specific directions (PSD). These were administered by health care technicians who recorded administration of the medication on the patient's record. The service also had PGDs in place. A patient group direction (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.

Staff completed medicines records and allergies were recorded and updated for in all patient records we reviewed.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked cupboards away from the patient areas. We saw that medicines were stored securely in temperature-controlled refrigerators that were monitored electronically. Designated staff had access to the locked medicine room and all stock including controlled drugs were logged, signed and dated when used.

Controlled drugs were checked daily, and the record log was completed accordingly. External arrangements were in place to remove expired stock and to destroy unused controlled drugs if required.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff said patients were given advice about medicines before surgery as well as post-surgery, patients we spoke with confirmed this. During discharge, patients were given clear verbal instructions on how to administer their eye drops. They were also provided with written instructions and a record hey could use to record when they had administered the drops to help them follow the correct post-operative regime.

The service circulated emails and used the staff safety huddle in the morning to highlight any safety alerts and incidents to improve practice.

**Incidents**

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**

Staff knew what incidents to report and how to report them. The hospital had an open incident reporting culture and staff were able to tell us what incidents they would report and how they would report them. They told us the hospital was very proactive in encouraging staff to record incidents on the incident reporting system. Staff said they were encouraged to report 'near miss' situations as well.

Good

# Surgery

Staff raised concerns and reported incidents and near misses in line with the hospital's policy. We reviewed the incidents reported in the previous 12 months and found they were reported and investigated in line with the service's procedure. Incidents were categorised into no harm or low, moderate or severe harm. For each incident the actions taken, and lessons learned were recorded where applicable. Staff discussed learning from incidents at the daily safety huddles.

The service had no never events. Records provided by the hospital showed there were no never events from October 2021 to September 2022.

The hospital reported 2 serious incidents between October 2021 and September 2022. Both were escalated to the board and a comprehensive root cause analysis was conducted. Incidents were reported accordingly to the correct regulatory bodies. The remaining reported incidents were of minimal harm or no harm.

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 gave an example of an incident where the duty of candour requirements applied.

There was evidence that changes had been made as a result of feedback and learning from incidents. For example, staff assessed and monitored patient's mobility needs throughout their pathway and implementing additional support, if required, to maintain safety.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The service used a root cause analysis approach to investigate incidents. Themes and trends were reviewed with any learning shared through clinical governance, medical advisory committee and health & safety committees.

## Are Surgery effective?

Good

We have not previously inspected the service. We rated it as good.

**Evidence-based care and treatment**

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The hospital policies we reviewed were up to date and had gone through the appropriate governance processes. The policies referenced, and were developed, in line with the Royal College of Ophthalmologists (RCOphth) standards. Other sources of guidance included the NHS and National Institute for Health and Care Excellence (NICE).

Compliance with relevant guidelines was managed through governance processes. There were systems to ensure policies, standard operating procedures (SOP) and clinical pathways were up to date and reflected national guidance. Any amendments to the patient pathway were reviewed at board level, through clinical effectiveness and operational meetings. When agreed they were then piloted and evaluated before cascading via area and service managers to all staff within relevant departments.

Good

# Surgery

The service monitored compliance with the relevant guidelines. As an example, audits reviewed from the service showed 99.6% compliance for standards of clinical documentation.

There were standard operating procedures and established pathways to support staff on the organisation's intranet and staff knew how to access the documents. We reviewed the SOP for cataract treatment pathway and protocols and found it to be easily legible, easily accessible and clear.

The service undertook regular audits to measure the outcomes of surgery and benchmarked the data with a national partner organisations to compare data and support best practice. Details of the outcomes can be found in the patient outcomes section.

**Nutrition and hydration**

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

The service provided treatment under localanaesthetic so there was no restriction on diet or fluids before surgery. This meant that patients were free to eat and drink as normal both pre- and post-surgery. The service provided snacks, water and hot drinks.

**Pain relief**

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

Staff prescribed, administered and recorded pain relief accurately. All patients received local anaesthetic in the form of eye drops before their procedure.

Staff assessed patients' pain during and after surgery and gave pain relief when required. We observed staff completing discharge consultations, asking patients if they had any pain and giving advice on managing any pain at home. Advice on pain relief was included in the discharge booklet given to all patients.

Patients were asked about pain following their surgery. From October 2021 to September 2022 most patients reported mild, no pain or a mild itching sensation.

**Patient outcomes**

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

All staff were actively engaged in activities to monitor and improve quality and outcomes. The service told us they participated in relevant national clinical audits. The service stated they were submitting data to the National Ophthalmology Database Audit (NODA) run by the Royal College of Ophthalmologists. NODA measures report the outcomes of cataract surgery.

Outcomes for patients were positive, consistent and met expectations, such as national standards for complications following eye surgery. As an example, between October 2021 and September 2022, the rate of posterior capsular rupture (PCR) following cataract surgery was 0.86%. This was against a performance of 0.5% for the provider nationally and a

national average of 1.10% across all cataract surgery. PCR is the most common potentially sight-threatening intraoperative complication during cataract surgery. Additionally the service collected other metrics related to post-surgery complications such as incorrect eye operated on, incorrect lens inserted, iris trauma and surgical error. As an example, the post-surgical complication rate for iris trauma was 4.9% in the previous 12 months to our inspection.

Data provided from October 2021 to September 2022 showed average outcomes for patient visual acuity following surgery for both eyes was 98.4% which was consistently better than the NODA average of 90% and above the provider benchmark of 95%

The hospital had a low risk of readmission, with no patients returning to theatre between October 2021 and September 2022.

Managers and staff used audit results to improve patients' outcomes. They carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment. A regular programme of internal audits was undertaken as part of the service's quality assurance strategy. The service performed consistently well over a 12-month period scoring on average over their target of 95%.

Patients reported on the outcomes of their surgery. Records showed that from October 2021 to September 2022, 99.95% of patients were happy with their treatment outcome.

**Competent staff**

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The hospital undertook regular reviews of staff competencies through a programme of self-assessment and appraisals including clinical skills. There was a comprehensive set of competencies which included pe-operative assessments, admitting patients for surgery, using the YAG laser and dispensing medication. The service maintained a skills matrix that showed staff who had been trained and deemed competent for certain roles and responsibilities.

Managers gave all new staff a full induction tailored to their role before they started work. Staff who completed the induction spoke positively about their experience and said managers and clinical leads were supportive.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal completion rates were 100% for staff eligible for this review. Remaining staff who had not yet completed a year of service had a 1 month, 3 month and 6-month review. We saw all reviews had been completed within these stipulated timeframes.

Consultants with practising privileges had arrangements for external appraisals within their NHS work. Assurances were provided through the governance process as well as the overview from the medical advisory committee (MAC). There was an effective process for validating and monitoring the credentials of any consultant or health professional with practising privileges working within the hospital.

Newly appointed surgeons had a period of supervised practice overseen by the medical director.

Good

# Surgery

The medical director oversaw training and supervision for the medical staff. The organisation assessed clinical performance as well as bedside manner. Each surgeon was given a rag rating (red, amber or green) which was reviewed through governance processes with actions taken to address any shortcomings.

Staff were proactively supported and encouraged to acquire new skills. Healthcare technicians (HCT) had the opportunity to train to undertake YAG admissions and instil eyedrops. They could also train to undertake post-operative cataract discharges where pre-ordered and labelled eye drops from pharmacy were provided to patients at discharge.

Managers encouraged staff to complete other learning modules above mandatory training as a part of self-directed learning. Records showed staff completed training on how to use lasers, dementia care, medicines management and supporting patients with learning disabilities.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

**Multidisciplinary working**

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

Staff worked across health care disciplines and with other agencies when required to care for patients. Multidisciplinary working was a fundamental aspect of the service and underpinned all elements of care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All staff worked as a team to plan and deliver treatment pathways. The service implemented a daily safety huddle which provided a forum for staff to communicate relevant issues and escalate any concerns for immediate action.

We observed an end of day huddle which helped to ensure the service had provided a safe environment. The manager monitored the effectiveness of the huddles through audits ensuring they were completed fully.

We heard positive feedback from staff of all grades about the excellent teamwork. We observed staff working effectively together.

Patients could be seen across other SpaMedica sites if this was their preference as they had a central recording system. Staff worked effectively with referring partners such as general practitioners (GP) and community opticians. Staff shared information with the patients' GP and referring optometrist to ensure continuity of care.

**Seven-day services**

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

The service was open Monday to Saturday from 8am to 6pm.

There was a national contact centre open from 8am to 6pm Monday to Saturday. Patients were informed of this on all discharge and information leaflets given and on the website.

Good

# Surgery

Patients were provided with a 24 hours a day, seven days a week contact number for any urgent concerns or queries. Staff triaged these calls and transferred any emergency call to the on-call optometrist if appropriate.

**Health promotion**

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

The hospital had relevant information promoting healthy lifestyles and support. The hospital had a dementia noticeboard which included information on how to access support groups.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle considering both physical and mental well-being.

The services' website included information from patients regarding eye health that included wearing sunglasses, medicines and driving advice.

**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.**

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff worked in line with the provider's consent policy. Staff used consent forms and records showed signed consent forms were documented in the patient's records.

Consent forms provided information on the potential risks, intended benefits and alternative options before each treatment. 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. Staff audited this process by reviewing documented evidence in care and treatment records. In September 2022 the audit reported a 99.3% compliance rate with the services standards. We reviewed five completed consent forms and found these were all completed fully and accurately at each stage of the surgical pathway.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff demonstrated that although this was a rare occurrence they understood how and when to assess whether a patient had the mental capacity to make decisions about their care and what steps they would take should a decision need to be made.

Staff received consent training as part of their induction and received mandatory training in the Mental Capacity Act. Compliance with the service's equality and diversity and human rights training module was 100% for all staff groups.

Good

# Surgery

## Are Surgery caring?

Good

We have not previously inspected the service. 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 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 spoke with four patients who provided positive feedback on the service. Patients said, “excellent service”, “staff were very attentive “, “first class attention” and “very prompt”. Patients told us staff were polite and considerate.

The results of the patient satisfaction survey completed from October 2021 to September 2022 showed patients highly rated their overall experience at the hospital with an average of 99.17% of patients saying they felt reassured by their surgical procedure.

Patients said staff treated them well, with kindness and were very helpful and reassuring. Staff answered patient enquiries and interacted with patients in a friendly and sensitive manner. We saw staff treating patients with respect and dignity. We witnessed staff knocking on doors before entering a room and staff introduced themselves.

Staff were able to give examples of how they had supported people who were experiencing high levels of anxiety. Staff had information and training to support people living with dementia.

**Emotional support**

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

Staff understood the impact that patients care, treatment and condition had on the patient’s wellbeing. There was a strong focus on ‘patient centred care’ with a holistic assessment of patient needs. Staff we spoke with stressed the importance of treating patients as individuals with different needs. They took time to reassure patients who were anxious about their procedure. Patients told us staff were always available to help and were understanding of their experience.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff gave examples of how they would reassure nervous patients and answer any questions. Patients said staff helped them to feel calm and relaxed. We spoke with one patent who had reported being very anxious about their procedure and they explained how staff had taken their time and discussed emotional needs to the point they felt reassured to undergo their procedure.

Good

# Surgery

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. 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. There was an option for staff to hold the patient's hand in theatre if a patient was particularly nervous or have a chaperone should this be required.

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 had access to information on dealing with patients with dementia and had completed dementia friends training.

**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. The service provided patients with information on their procedure. Staff asked patients about their procedure to ensure they understood.

We spoke with four patients and they told us they felt involved in their care and had received the information they needed to understand their treatment. The patient satisfaction survey showed patients understood what happened during the procedure.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed staff were proactive in engaging with patients about their experiences and frequently asked how they were doing. Staff encouraged each patient to complete a feedback form following their appointment.

The service collected feedback from patients using a patient satisfaction survey which looked at 10 aspects of the patients' care and experience. Some of the questions were if the patient was reassured and able to have all their questions answered and how satisfied they wer with the entire treatment process. We reviewed the results for SpaMedica Norwich and found that in 9 of the 10 questions patients answered with 99% satisfaction and above.

During care and treatment planning, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff worked with the patients' GP and district nurses for patients who needed additional support in the community.

## Are Surgery responsive?

Outstanding ☆

We have not previously inspected the service. We rated it 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. The service was flexible, provided informed choice and ensured continuity of care.**

Good

# Surgery

The location had streamlined its service to treat NHS patients through contracts with the local NHS integrated care board. Patients were referred by their GP or optometrist to the service to undergo cataract surgery and YAG capsulotomy.

Services were tailored to meet the needs of the local population. Managers planned and organised services, so they met the changing needs of the people who used the service. Managers were very knowledgeable about the characteristics of the local population and factored in elements of the local population such as age and comorbidities when setting up their service.

The service was flexible and provided choice to the people who needed eye surgery. Surgeries were performed six days a week and appointments were scheduled with the patients to a time to meet the needs of the patient group. Patients we spoke with confirmed being able to access the service in a timely manner and in a way that met their personal needs. Additionally, the organisation's centralised bookings teams managed patient referrals on an electronic patient administration system. Patients chose to attend the service, including which clinic location was preferable.

The service took into consideration the needs of the local population. Free patient transport was offered within a 10-mile range of the location. Patients' safety to travel was risk assessed individually. Drivers collected patients from their home with a reminder the day before of the expected time of arrival.

Facilities and premises were of a high standard and appropriate for the services being delivered.

There were photo boards of staff members in each department. This meant patients and visitors could easily identify staff and their roles within each area and promoted more familiarity between staff and patients.

The service ensured continuity of care for all patients. As an example, 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.

**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. This included people with protected characteristics under the Equality Act and people who were in vulnerable circumstances or had complex needs.**

The service was fully accessible to patients with limited mobility and wheelchair users and there were disabled parking bays.

Managers made sure staff, and patients, loved ones and carers could access interpreters or signers when needed. Information on interpreting services was readily available. Staff used the electronic pathway to document information that helped them deliver tailored, individualised care. For example, staff checked where patients had needs in relation to language, hearing, sight and mobility. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information in large print and a hearing loop was available to assist patients wearing a hearing aid. The service had dementia friendly décor.

Good

# Surgery

The hospital had clear inclusion and exclusion criteria and a comprehensive pre-operative assessment. The pre-operative assessment ensured patients were fit for surgery. Patients were offered an appointment within two weeks of the pre-operative assessment. However, if a patient needed to defer due to holidays, work commitments or religious festivals this was readily accommodated.

Staff worked tirelessly to make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were dementia champions available at the service who had undertaken additional training to promote the needs of people living with dementia. There was also a dementia folder which was a support pack to help staff support patients with dementia including hints and tips. The service also offered dementia friendly twiddlers for restless patients. For patients living with a learning disability or autistic spectrum disorder, they were offered additional visits, with those close to them, to help with preparations.

The service identified the need to support people individually whilst in their care. As an example, the service was training 2 mental health first aiders in their staff pool to support any patient who may have a mental health crisis whilst in the service.

The service facilitated and supported the use of chaperone services or made reasonable arrangements for carers and family to support patient needs during the surgical pathway.

The service had easy access and promoted the “This is me” patient passport to patients with protected characteristics or complex needs.

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

Following cataract surgery, all patients were given complimentary eye drops to use if their eyes became dry.

The service had developed several ways to effectively communicate the expectations of cataract surgery with all patients. The service had a patient journey map which was displayed in a clear and easy way, on a notice board for each type of condition and treatment which gave clear information on what to expect at each stage of treatment. This information was also available on SpaMedica’s website so patients could follow their treatment pathway as well as in the patient leaflets that were offered with the confirmation of the surgical date.

Patients were day cases who did not require overnight stays and they were provided with light refreshments such as biscuits, tea, coffee and water. The hospital introduced gluten free and vegan snacks to meet patient preferences.

**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.**

People could access services and appointments in a way and at a time that suited them. Staff worked together to facilitate access to the service. Patients were offered the first available appointment. From November 2021 to September 2022 the service completed 1612 procedures.

Good

# Surgery

Managers monitored waiting times and made sure patients could access services when needed and received treatment within the timeframes set by the NHS commissioner. The service tracked patient progress at key points of the surgical pathway and reported their data regularly to the senior management team and NHS commissioners.

There was a comprehensive pre-operative assessment to reduce risks and complications. This ensured the patients were fit for surgery and reduced delays to their treatment pathway.

Managers worked to keep the number of cancelled operations to a minimum. Patients were contacted prior to their appointment to minimise missed appointments. However, from October 2021 to September 2022 the service reported 21.6% of appointments were cancelled or had to be rebooked. Staff monitored the reasons for any cancelled appointments which was reported each month. We were told the high level of provider cancellations were mostly due to the fact that between opening in October 2021 and February 2022 lists were being scheduled before a surgeon was booked and lists having to be cancelled when no surgical lead secured. New surgeons were employed during this period and cancellations have since the reduced significantly due to this. Additionally, as part of safety measures when humidity in the operating theatres was too high appointments had to be cancelled. Due to the heatwave in July and August 2022, the service had to cancel surgical lists as humidity within the theatre suite was over the threshold limit.

When patients had their admissions cancelled, staff ensured they were rearranged as soon as possible. Staff contacted patients who had their appointment cancelled to re-book their appointment. The patient's GP was also informed of any changes. We were advised that where procedures had been cancelled patients would be placed on the next scheduled surgical list where possible. The average time between cancellation and surgery was 9 days for SpaMedica Norwich.

The service reported a did not attend rate of 0.67%.

There was an 18-week referral to treatment (RTT) pathway. The service proactively collaborated with the trust and clinical commissioning groups (CCG) on waiting times. The service reported the average RTT from October 2021 to September 2022 was 5 weeks. Patients underwent the whole surgery pathway on average within 8 to 9 weeks.

Staff planned patients' discharge individually. This included those who were in vulnerable circumstances or who had complex needs. All patients had a discharge consultation with a registered nurse after their procedure. We observed a discharge consultation and saw patients were given appropriate guidance and information both verbally and in writing. Staff made sure patients were safe to leave and travel home.

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.

The service had a contact centre. Patients could access emergency support by calling the contact centre or the direct contact provided on their discharge booklet.

Staff supported patients when they were referred or transferred between services. If patients were referred to other clinics, then staff would assist with this process. Additionally, discharge letters were sent to referrers soon after the close of theatre to ensure follow up was arranged immediately.

**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.**

Good

# Surgery

Patients, relatives and carers knew how to complain or raise concerns. Information on how to make a complaint was available at the service. The complaint procedure explained the stages of the complaint process including investigation resolution and independent external adjudication.

Patients treatment was funded by the NHS, so the hospital provided information on how to contact the Parliamentary and Health Service Ombudsman (PHSO), if patients were not happy with the outcome of a complaint. This information was available on the website and in patient information leaflets.

Staff knew how to acknowledge complaints. Staff understood the complaints policy. Staff were trained to resolve minor concerns as part of an approach to meeting individual expectations and avoid minor issues escalating into a formal complaint. We spoke with staff who were able to identify how to support a complaint, be it informal or formal, how it was escalated and managed by senior managers.

Managers shared feedback from the service's complaints by emails, meetings and learning was used to improve the patient's experience. From October 2021 to September 2022 the service received 15 complaints of which only one was escalated to senior level. Records showed the complaints were reported and investigated in line with the service's complaints procedure.

Staff could give examples of how they used patient feedback to improve the service. For example, ensuring patients whose surgery had been cancelled to have clear communication and set a quick follow up.

The service promoted learning from concerns. As an example, the service had a scheme called the SpaMedica Stars which promoted individuals, be it staff or patients, who had made a significant contribution to the service in addressing a concern. We heard how one staff member was nominated as an office hero when due to humidity patients' surgeries were cancelled. This staff member developed a standard statement and supported other staff in explaining in a clear and effective wat to patients why their surgery had been cancelled, the risks associated with operating in such conditions and facilitating the rebooking process, so it had the least impact possible on people's lives. Another example of this scheme was a patient with a health and safety background who highlighted a trip hazard in the service and offered a solution to this leading to a corporate change in how the hazard was addressed.

Managers also shared feedback from complaints from other SpaMedica locations with staff and learning was used to improve the services offered.

## Are Surgery well-led?

Good

We have not previously inspected the service. 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.**

Good

# Surgery

Leaders at all levels demonstrated the capacity and capability needed to deliver sustainable care. There was an organisational structure with a chief executive, chief operating officer, medical director and head of clinical services. These were supported by other senior managers that included infection, prevention and control leads, regional directors and an advanced nurse practitioner.

The hospital's manager had recently been promoted and was supported by the area manager and hospital director. Each manager had clearly defined roles and responsibilities. This was supported by an effective recruitment program ensuring that the skills and abilities of leaders matched the job profiles required within the service.

We found all managers had the skills, knowledge and experience to run the service. Leaders demonstrated an understanding of the challenges to quality and sustainability for the service. For example, the recruitment and retention of staff and adequate staffing levels to match the increase in activity, as well as the challenge in managing a service that is looking to expand.

There was a system of leadership development and succession planning. The organisation supported managers in their roles. Managers new to their roles had mentorship from an operational development manager at provider level. There was a hospital manager training plan to support managers in developing key skills. The hospital manager completed a peer review exercise which involved visiting other locations to observe practice and share learning.

Managers demonstrated leadership and professionalism. Staff we spoke with said managers were accessible, visible and approachable.

**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. Leaders and staff understood and knew how to apply them and monitor progress.**

The service had a clear vision and strategy. The hospital followed the SpaMedica vision of 'every patient, every time: no exception, no excuses. Staff were guided by the values of safety, integrity, kindness and transparency and patients were put at the centre of delivery of care and treatment.

Plans were consistently implemented and had a positive impact on quality and sustainability of services. The strategic objectives were regularly reviewed to ensure the sustainability of the service and to measure its success. The hospital would achieve its objectives by working as a team, with patients and stakeholders such as GP and optometrists. Quality measures included patient experience, clinical outcomes, staff engagement, recruitment, retention and development.

Staff we spoke with understood the vision and quality measures of the service and how it had set out to achieve them. The staff worked in a way that demonstrated their commitment to providing high-quality care in line with this vision.

The service had a statement of purpose which outlined to patients the standards of care and support the service would provide.

**Culture**

Good

# Surgery

**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 we met with, were welcoming, friendly and passionate. It was evident that staff cared about the services they provided and told us they were proud to work at SpaMedica Norwich. Staff were committed to providing the best possible care to their patients.

Managers supported an open and honest culture by leading by example and promoting the service's values. We heard this was promoted by having an open-door policy, interacting with staff daily and doing a walk around the service every day.

Staff said they enjoyed working at the service; they were enthusiastic about the care and service they provided for patients. They described the service as a good place to work. The organisation had an incentive reward scheme and a staff recognition scheme.

All staff we spoke with said they felt their concerns were addressed, and they could easily talk with their managers. Staff reported that there was a no blame culture when things went wrong. The service created a learning environment so staff could learn from feedback, incidents and complaints. Conflict resolution was a part of mandatory training programme.

All managers and staff worked collaboratively to improve care, treatment outcomes, quality and patients experience throughout the entire service.

**Governance**

**Leaders operated effective governance processes throughout the service. 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**.

Staff at all levels were clear about their roles and understood what they were accountable for and to whom. There were effective governance structures, processes and systems of accountability to support the delivery of ophthalmology services and safeguard high standards of care.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, consent, and health records. Audits were completed monthly, quarterly or annually depending on the audit schedule. Results were shared at relevant meetings, such as governance and team meetings. The service participated in national audits including the National Ophthalmology Database.

Leaders operated effective governance processes that evidenced the quality of care. There was a clear structure for governance and sharing of information across all leadership levels, staff working at the service and for staff working across the organisation. Daily safety huddles and end of day briefing meetings attended by all staff working at the clinic that day allowed sharing of essential safety, performance and activity information.

Quality governance was incorporated into every level of the organisation through a variety of processes. We saw through meeting minutes that Information was filtered up from and down to staff. This was done by the area managers who had weekly meetings with the organisations' senior team.

Good

# Surgery

There was an effective clinical governance structure which included a range of meetings that were held regularly. There were also various committees with a lead responsible for the meetings and escalating issues. Governance structures included the Clinical Governance Committee, Clinical Effectiveness Group, the Operational Managers Meeting and the Risk, Health and Safety Committee.

Clinical governance meetings were held bimonthly. We reviewed 3 sets of meeting minutes and observed they were well attended by the representatives from the senior leadership team, hospital managers and clinical leads. Agenda items included clinical governance, quality, risk, compliance and audit.

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.

The Medical Advisory Committee (MAC) represented the professional needs and views of medical practitioners and advised the senior leaders on medical policy and standards. The MAC reviewed the clinical performance of staff who had been granted practising privileges. They provided a quarterly forum for consultation and communication between medical practitioners and the hospital's senior management team.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

The service operated a formal risk management process to ensure risks were identified and mitigation measures put in place. Staff and managers could easily identify the three top local risks at the service and had strategies in place to mitigate them. Examples of risks included slips, trips and falls and safe management of equipment. Staff discussed the risks to the service at various meetings and documented the progress of any outstanding actions. Progress on each action was reviewed at subsequent team meetings. Staff understood the risk management strategy and actively contributed to it.

There was a systematic programme of clinical and internal auditing to monitor quality and operational processes. The service had a comprehensive list of audits, safety checks and risk assessments that were completed on a regular basis. These were completed on a daily, weekly or monthly basis and were guided by provider level directives. Safety checks included those such as ensuring cleaning, safety checks to equipment and completion of safety briefs were done effectively. The service also regularly reviewed stock and equipment availability. Monthly checks included completion of mandatory training and cyclical audits such as hand hygiene, surgical outcomes and reviewing patient satisfaction and responses to the care they received.

The service collated patient outcomes and benchmarked their performance against other service providers. Data provided showed they met performance targets for all indicators.

The service reviewed how it functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. The service had key performance indicators (KPI's) which were regularly reviewed. For example, managers planned services and used resources effectively to ensure they met referral to treatment times. The service continuously monitored safety performance and these outcomes were discussed at regular management, governance and staff meetings.

Good

# Surgery

The service had a business continuity plan that could operate in the event of an unexpected disruption to the service, such as power failure, staffing loss or information services disruption.

**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. Information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The information used in reporting, performance management and delivering quality care was consistently accurate, valid, reliable, timely and relevant. The service had an electronic quality management system, which monitored the performance of the service through data collection on all aspects of the service including incidents, complaints, mandatory training and audits.

Integrated reporting supported effective decision making. All staff had access, by secure logins, to the organisation's intranet to gain information relating to policies, procedures, national guidance and e-learning. All staff were able to demonstrate the use of the system and retrieve information.

There were systems in place to ensure data and statutory notifications were submitted to external bodies. The registered manager, who was the hospital manager, was responsible for submitting notifications to the Care Quality Commission and had done so in the case of a serious incident.

The service had arrangements and policies to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards. The service provided data security protection and awareness training and all staff had completed it.

The service had a robust website, which assisted patients and visitors to familiarise themselves with the services offered at SpaMedica Norwich and what to expect during their appointment or procedure.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services.**

Managers and staff understood the value of engagement in supporting safety and quality improvements.

Staff actively sought patient feedback and patients provided this through surveys, online feedback and emails. The service engaged with patients to ensure they had a high response to the patient survey. The service performed highly and consistently in all the questions on the survey. Staff acted on patient feedback and there was a “you said, we did” poster displayed which informed patients about the changes that were made.

The service also engaged with special interest groups such as the national institute for the blind and the Alzheimer’s society. This had led to improvements in the provision of services and identifying key areas for the development of tailored services for NHS patients.

The hospital had a staff forum and regular meetings where staff could discuss their concerns.

Good

# Surgery

The website had a section specifically for health professional referrals and information.

There was a weekly bulletin so staff could share news and achievements.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services.**

Improvement was seen as a way to manage performance and used to promote learning within the organisation. The senior leadership team and staff shared a wide range of innovation and research within the organisation that were improving outcomes for the organisation and patients.

The provider had wet and dry labs throughout England and pop-up dry labs that enabled ophthalmology trainees to learn and practice cataract surgery. These training tools for surgeons, allowed them to practice cataract surgery using artificial, yet realistic nuclei and lenses. The labs allowed for repetitive practice of both manual instrumentation (dry lab setting) and machine operation (wet lab setting). The dry labs were also used by surgeons to perfect techniques and practice using the providers standard instruments.

The service provided ophthalmological and accreditation evenings. These were used to show clinical staff including doctors the facilities at the location including the theatre and relevant equipment. These evenings also supported referrers to understand the referral criteria and the importance of the post operation 4 week follow up intervention.

Staff carried out a risk stratification assessment at pre- assessment clinic for cataract surgery and patients' post-operative medicine regime was then tailored accordingly. The stratification took account of a range of factors including ethnicity and social factors. The risk stratification had been designed and validated by the medical director following a clinical study.

We heard examples within the team of staff members who had gained further qualifications within the service to develop and progress their careers. This was the case at different clinical and managerial levels and the service supported the development of their staff.