Hereford Vision Surgical Group Limited

The Wye Clinic

Inspection report

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Date of inspection visit: 26 July 2023
Date of publication: 01/09/2023

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

Ratings

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

Summary of findings

Overall summary

- 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, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good	

Summary of findings

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Summary of this inspection

Background to The Wye Clinic

The Wye Clinic is a small private medical clinic in the heart of Hereford. They provide an outpatient space for consultant led consultations, an ophthalmic investigation suite with laser facilities and a clean room suitable for minor local anaesthetic surgical procedures.

The service is open on Monday to Friday from 08:30am until 5pm.

The service registered with the CQC in November 2021. The service has had the same registered manager in post since registration.

The service provided the following regulated activities:

- Surgical procedures
- Diagnostic and Screening Procedures
- Treatment of disease, disorder or injury.

How we carried out this inspection

We carried out this unannounced inspection of the outpatient core service using our comprehensive inspection methodology on 26 July 2023. Whilst this service does surgery, this was a small part of the service and therefore this is all reported within this outpatient report. The inspection team consisted of an inspector and a specialist advisor with expertise in outpatient and surgical care. An operations manager provided off site support. During the visit, the team:

- spoke with 5 patients,
- spoke with 9 members of staff,
- looked at 7 sets of notes,
- looked at a range of policies, procedures, audit reports and other documents relating to the running of this 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.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that all staff have level 1 safeguarding children's training. (Regulation 13: Safeguarding).
- The service should ensure that all action plans from audits are completed (Regulation 17: Good Governance).
- The service should ensure that data is submitted to the Private Healthcare Information Network (Regulation 17: Good Governance).
- The service should consider creating a business plan.
- The service should ensure that the laser lighting is visible enough to stop people entering the room when it is in use (Regulation 12: Safe care and Treatment).

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Outpatients

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

Is the service safe?

Good

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. Managers monitored mandatory training and alerted staff when they needed to complete any updates. Training was completed electronically. When staff were due to renew their training, they received emails reminding them weekly and once it was expired, they received daily emails. At the time of our inspection there was an overall compliance of 96%; the target was 90%. Staff had supervision meetings with their managers monthly and discussed training needs and booked onto courses when needed.

Consultants and bank staff received and kept up-to-date with their mandatory training. All consultants and bank staff were employed substantively at a local NHS trust or private provider. They provided confirmation to the registered manager of their completed training. The registered manager also had access to the trust's training system and checked this monthly. We saw they emailed staff when their training was about to expire and asked for confirmation of completion.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included fire safety, moving and handling, infection control, and health and safety.

The manager acted on feedback from the staff around the training sessions. For example, some staff had said they did not feel confident to initiate basic life support after just the online learning, so the manager arranged a face-to-face training session for all staff to increase their confidence. We saw this had been put the risk register until the training had been completed. All ophthalmology consultants had been trained in advanced life support by their substantive trusts and 2 substantive nurses had completed immediate life support training.

We saw 96% of staff had completed level 1 training in recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Managers had added a risk register entry to reflect staff had not received level 2 training. They had plans to audit their patient demographics in 6 months' time to assess if staff needed to complete level 2.

The manager completed a 'safety culture' review monthly where they looked at how much time had been logged by staff completing training, how many users were active, what training had not been completed, and put together an action plan for improvements needed.

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. The service had safeguarding processes and procedures in place. All staff were trained to level 2 safeguarding. At the time of our inspection 100% of staff were trained to level 2 safeguarding vulnerable adults. The safeguarding lead for the service was the registered manager; they were trained to level 3.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Children under the age of 18 did not undergo consultations or procedures at this clinic and were not insured to be on site. Staff were not trained in safeguarding children. However, the intercollegiate document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) states that all staff who work within a healthcare setting but do not treat children, should have training to safeguarding children level 1.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were told about a referral they had made following a patient disclosing potential abuse. They had also followed this patient up in clinic and put them on their safeguarding register. Staff told us signs of different types of abuse, and the types of concerns they would report or escalate to the safeguarding lead. There was an up-to-date safeguarding policy and chaperone policy. All staff had completed chaperone training, we saw their completed competencies for this.

Cleanliness, infection control and hygiene

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

All areas of the clinic were clean, well-organised and had suitable furnishings which were well-maintained. Guidance was available for staff in the form of an infection prevention and control (IPC) policy. The policy detailed all protocols required to maintain a good level of cleanliness, infection control and hygiene. At the time of the inspection, 100% of eligible staff had completed IPC training. Cleaning records were up-to-date and completed daily. The service had a cleaner who cleaned the clinic daily provided by an external company; they had recently changed cleaners as their previous cleaner did not clean to a high enough standard.

The lead nurse for the clean room was the IPC lead; they had been trained at the local NHS trust where they also worked as a theatre manager. The service performed well for cleanliness. The service completed monthly IPC audits which included checking the environment, waste disposal and general cleanliness; compliance was above 95% for the 3 months before we inspected. We were told the IPC lead had increased the frequency of audits from monthly to weekly during a period when compliance was low. Due to improved compliance, they had recently changed the frequency back to monthly. They completed an annual IPC audit which looked at all aspects of IPC across the whole building. We saw actions were put into place to make improvements. For example, the storeroom was deemed to be not up to standard, so this was scheduled to be replastered in September 2023. They completed an annual hand hygiene audit; it was 100%

for June 2023. Audit results were discussed in senior management meetings and clinical governance meetings. In July 2023, the lead nurse discussed that since the hand hygiene audit, they felt the standard had slipped, and hands were not always being gelled or washed at the right moments. Therefore, they decided to move to monthly audits for a period of 3 months, and to add it to the team brief to remind everyone of the handwashing protocol.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand sanitiser was available in every room. Staff cleaned equipment after patient contact. They mostly used single use consumables, but some items were sent to the local trust sterile services to be cleaned. The service used a bike courier to reduce the impact on the environment.

The procedure room had an airflow system which gave the same surgical field as laminar flow within a theatre. A laminar flow airflow system provides clean air to the theatre room to minimise the risk of surgical site infection. This meant they could use the room for cataract surgery.

Staff worked effectively to prevent, identify, and treat surgical site infections. Staff looked at infection data. For example, in June 2023 at the clinical governance meeting they discussed 2 wound infections that occurred within a month following surgery by the same consultant and looked into whether there was a link between them; they found there was no relatable link. Data showed there were 2 suspected infections in 2023; this was a surgical site infection rate of 3.7%. The rate of infection for cataracts, (over 1000 cases) was 0%.

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 service had suitable facilities to meet the needs of the patients and their families. The ground floor comprised of a reception with a small waiting area, large waiting area, 5 consultation rooms (including an ophthalmology diagnostics suite), a peri-operative clinical space with a changing room, clean room, clean store, dirty utility and the administration offices. The larger waiting room was accessible via 3 steps. There was a mobile ramp available to those patients who required it, and the service due to have a bespoke wheelchair lift, which folded away against the wall, installed in September 2023. There was 1 consultant room which was accessible without the need for a ramp which included basic ophthalmology diagnostic equipment.

The design of the environment followed national guidance. Clinic spaces were compliant with Health Building Note 00-10 Part A Flooring. All flooring was laminated and included coving to ensure effective cleaning. There were hand washing basins in each clinical area and foot pedal operated clinical waste and domestic waste bins.

The clinic was in a large grade 2 listed building, and it did not have a straightforward layout. There were lots of corridors and stairs over 3 levels. Whilst there were fire risk assessment and equipment in place, staff had told managers they were not confident in the fire evacuation pathway out of the building. Managers had therefore arranged for an onsite fire training session to ensure the evacuation routes were appropriate and to increase the staff's confidence. They also did a practice fire evacuation bi-annually. We saw this had been completed in May 2023, at that time it showed staff had not been signing in and out. Therefore, it was difficult to ascertain if all staff members had left the building safely in the fire drill. To mitigate this risk the sign in and out sheet was redesigned to make it more user friendly and reminded staff of the importance of signing in and out. We found the managers had made reasonable adjustments to the building to their

best ability which we were told was a challenge due the buildings listed status. The administration office was on the third floor, a hatch with a ladder had been installed as a second means of escape from a fire. All staff had to do a practice evacuation from the hatch annually and sign a declaration to say if they were happy to evacuate via the hatch if required. If they were unable to do this, they were moved to work in a different area of the building.

There was a large open changing room for staff which the service had plans to refurbish in September 2023 to create male and female cubicles.

There was a peri-operative room which had 3 pods. Each pod had a recliner chair for patients to wait in ahead of their procedure. The room had lighting which could be dimmed to ensure the patients were comfortable after their eyes had been dilated; this is when drops were put into a patient's eye to allow for the iris to enlarge to let more light into the eye for examination.

The service had enough suitable equipment to help them to safely care for patients. All single use equipment we checked was in date. All equipment was within service date and there was a maintenance programme in place, which included service agreements with the manufacturers of specialist equipment, such as the ophthalmic diagnostic equipment. The service agreement included emergency cover; this meant broken equipment could be fixed within 24 hours. Some equipment had regular software updates; these were all done remotely and managed by the manufacturer. All electrical equipment had been tested within the last 12 months; they tested all equipment annually in November.

The service had a YAG (Yttrium Aluminum Garnet) laser on site; this was used to treat patients with cataracts. They had a laser safety officer, who had received the appropriate training, including passing an examination, who ensured the safety of the laser. They had risk assessments in place for the risks associated with the laser and most risks were mitigated where possible. The room had anti-glare surfaces to protect staff and patients from harm. When lasers in use, there should be a visible illuminated sign outside the room to ensure that no one enters the room. The service had a small light however that staff did not feel was obvious enough to stop people from entering the room. To reduce this risk, staff put a laminated piece of paper on the door to highlight that the laser was in use as well as using the illuminated sign.

Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation equipment daily when the clinic was open. We saw staff recorded when these checks had been carried out and all checks had been done in line with policy. They also completed daily checks within the procedure room; we saw these were completed daily when a list was being completed.

The service undertook a medical devices audit in March 2023 which was 69% compliant. They looked at 12 medical devices and spoke to 6 members of staff. They found the results were low because although staff had been trained to use the equipment there were not specific competencies for some of the equipment. These had subsequently been created and staff had been signed off as competent.

The service had a fire risk assessment which was reviewed regularly. We saw it had been updated in both May and June 2023 to contain changes to the escape routes from the second floor.

Staff completed an office housekeeping audit of 3rd floor within the clinic. This looked at the health and safety of the office, including the condition of the floor, clear fire exits, and trailing computer wires; the service was 100% compliant with this audit for the 5 months before our inspection.

Staff disposed of clinical waste safely. The service had an external contract for the management of clinical waste. They had completed a clinical waste disposal audit in August 2022 which was 85% compliant; it showed staff were not assembling sharps bins correctly. They had also completed a sharps bin audit in May 2023 which showed sharps bins were correctly assembled in all rooms apart from 1. They had since created a new standard operating procedure to show how to assemble the sharps bins correctly and staff had completed training in this. They had a plan to re-audit compliance in November 2023. We saw this was also discussed in the clinical team meeting in May 2023.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff were able to identify and quickly act upon patients at risk of deterioration.

The service saw private patients only, there were no NHS referrals. The service only considered patients for procedures on site if they were assessed as low-risk by the consultants. If a patient was higher risk, the consultant would operate on them at the local private hospital or NHS trust. Eighty % of the patients seen by the service were from the ophthalmology specialty. They were mostly referred by optometrists; the referral letters contained significant medical history. Other treatments provided included a specialist menopause clinic, cosmetic and plastic surgery, varicose vein treatments, hand surgery and dermatology, which were accessed through a self-referral. A detailed medical history for each patient was taken at their first consultation and if additional medical history was required staff contact patients' GPs. All procedures were performed under local anaesthetic with light oral sedation if required.

The service had a clear process if a patient became unwell or deteriorated during a procedure. There was a policy in place for the transfer of people using the services to the local NHS hospital where they had an agreement with the local emergency department. This agreement was put into practice when a staff member became unwell and had to be evacuated from the top floor and was transferred via ambulance to the local NHS hospital; staff reported this transfer went well. Patients had their blood pressure and pulse taken before and after their procedure. Staff told us if the patient's blood pressure was not stable prior to the treatment, they would not go ahead. They told us about a patient who had very high blood pressure on admission, they phoned their GP, and arranged for a taxi to take the patient there. The patient subsequently received treatment with the service as their blood pressure had improved following GP input.

The service completed practice scenarios monthly; this was to ensure staff felt confident in different situations. We saw a range of different training scenarios had been carried out, they included dealing with a patient with a low blood sugar level, poor staff communication, and a leaking ceiling during a medical procedure. All of these were documented and discussed as a team to share learning. For example, the scenario when a patient had a low blood sugar had been recognised and dealt with, the bank staff nurse was not aware of the location of the blood glucose monitor or medication to treat the low blood sugar. Following this, the managers ensured all staff, including bank staff, knew where the emergency medications and equipment were stored.

Patients were given advice about the potential side effects of surgery in writing and verbally. They were told who to contact if they became unwell or had any concerns. Patients could ring the clinic between 9am and 5:30pm from Monday to Friday. All Ophthalmic patients were given the number of the consultant to speak to directly out of hours. They were phoned the day after their procedure by the consultant to check on their wellbeing. Other specialities were given information leaflets which gave them instructions on what to do if they needed advice out of hours.

The service used a modified version of the World Health Organization (WHO) surgical safety checklist. The WHO surgical safety checklist is a tool used to improve the safety of surgical procedures by ensuring all the theatre operating team conduct a series of safety checks. We looked at 7 sets of records and found they all contained completed WHO

checklists. The service completed an annual WHO audit in February 2023, they looked at 5 sets of notes and found them to be 90.5% compliant. Although the WHO checklist information in all 5 files had been completed, 1 nurse had not attended the brief and debrief, and 1 set of notes did not have the nurses name printed on the form after the signature. An action plan had been created to improve compliance, but this had not been completed.

A recent practice scenario had been carried out to assess if staff were following the WHO checklist procedure correctly. During the scenario, the consultant (purposefully) did not engage with the WHO checklist and the scrub nurse refused to go ahead with the procedure until they did. This demonstrated a high level of compliance with this safety tool.

The service completed a brief and de-brief before and after each procedure in theatre. Staff told us they found this meaningful especially when learning could be shared.

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 service employed 6 clinical members of staff, 3 full time and 3 part time. The service had a registered manager, 3 directors and a team of administrators and reception staff.

Managers accurately calculated and reviewed the number of nurses needed for each shift. The manager could adjust staffing levels daily according to the needs of patients. They had a utilisation meeting weekly with managers, the clinical lead and the lead administrator to discuss the following week clinics and procedures and ensured they were staffed correctly.

All staff received an induction to the service including a supernumerary period. All staff files we checked had completed checklists for this.

The service had no vacancies, low sickness, and low turnover rates and staff described the team as consistent and stable. They used bank staff when needed but they mostly were not required. All bank staff worked at the local trust alongside the consultants in their NHS practice. They were familiar with the consultants as well as with the service.

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

The service employed 11 consultants and 3 general practitioners who had a specialist interest in menopause. They were employed under practising privileges. The service had a policy in place and collected pertinent information about medical staff such as references and appraisals for the consultants prior to them working at the clinic. They were required to complete a practicing privileges declaration annually. The registered manager monitored their practice through outcomes, feedback and appraisal documentation.

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.

Good

Outpatients

Patient notes were paper-based and scanned onto the system following appointments. All staff could access them easily. All records were kept safe and secure within a locked filing cabinet. We reviewed 7 sets of patient records. We found they were all complete. They included initial consultation, consent forms which stated risks, complications, and procedure documentation. The electronic scanned notes could be access by the consultants when working at the local private hospital if required; this was useful as at times, they operated on the patients there if they were higher risk.

The service completed audits of their records annually, this was last completed in January 2023. The audits were mostly 100% compliant, the exception to this was the post operative vital sign audit which was only 60% compliant. We saw the action plan to improve compliance with this audit, and the post operative vital signs were completed in all the notes that we checked.

We saw that staff reported General Data Protection Regulations (GDPR) incidents. An incident was raised in May 2023 where notes were left unsecure. The manager undertook a debrief with the staff member to ensure their understanding of GDPR and patient privacy. They also checked their training was in date. Following this the manager was satisfied that the staff had the required learning and had learned from the incident.

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. Medicines prescribed during the procedure such as local anaesthetic were given by the consultants. All medicines were stored appropriately in a locked cabinet; the key was held by the lead nurse and signed in and out at the beginning and end of each shift. All medicines we checked were in date. The ambient temperature of the medicine's cabinet was checked daily to ensure they were stored in line with manufacturers recommendation.

The service stored light sedation medication within a sealed bag. This was sealed and the serial number was checked daily and resealed monthly by 2 members of staff.

Staff were aware of how to destroy out of date medication; we saw a completed destruction form and that out-of-date medication had been returned to the local pharmacy.

Staff stored and managed prescribing documents safely. Each consulting room had their own private prescription pad which was locked away; the key was signed in and out by the consultant when entering and leaving the room. The registered manager kept a log of the prescription documents and completed an audit of these; this had last been completed in July 2023 and was 95% compliant.

Staff learned from safety alerts and incidents to improve practice. For example, patients had given feedback that the post operative eye drop schedule was difficult to follow so they created a chart to make it easier for patients to follow.

Incidents

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

Good

Outpatients

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. Incident forms were paper-based. There was a very good incident reporting culture. There were 64 incidents reported in the last 18 months since the clinic had opened. The most recent theme with their incidents was breaching patient confidentiality; they had had an incident where a letter had been sent out to a patient containing another patients information and another letter sent to an optician which had 3 patients' information and the envelope was open when it arrived at the opticians. These had been discussed in the clinical governance meetings and within the staff meetings and learning had been identified and actions put into place including putting fewer letters in 1 envelope.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The staff could explain the process they would undertake if they needed to implement the duty of candour because of an incident, which was in line with the requirements. We were told about a patient safety incident where they had used the duty of candour in June 2023 and saw the letter sent to the patient in line with policy.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were discussed monthly at clinical governance meetings and the senior management team meetings. Staff met regularly to discuss feedback from incidents and there was evidence that changes had been made because of feedback. For example, the consultant ordered the wrong lens for the patient, this mistake was realised after it had been put into the patient's eye. The patient was informed, staff completed the duty of candour and the correct lens was implanted the following day. The consultant did a reflective piece, and it was discussed at the debrief following the procedure. Following learning from the incident the service implemented a system for consultants to double check the prescription for the lens prior to surgery.

We saw evidence that all staff do reflective work following incidents to show how they learn from them. This was also discussed within supervision meetings to ensure staff felt supported following the incident.

Managers received patient safety alerts and acted upon them when required. The registered manager completed a monthly Medicines and Healthcare products Regulatory Agency (MHRA) report. We looked at the May 2023 report and saw they looked at MHRA notices, medical device alerts and national patient safety alerts; no action was required for any of the alerts that month.

The registered manager had just initiated an incident forum for both clinical and non-clinical staff to appraise how incidents were investigated. The first meeting using this multidisciplinary approach took place in July 2023. We saw they did a deep dive into 7 incidents and developed actions to improve patient safety.

Is the service effective?

Good

We rated effective as good.

Good

Outpatients

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. Staff knew how to access policies and where to find them. They were accessed online and managers could see how long staff had read a policy for and could highlight specific policies for staff to read. The manager highlighted a policy of the month in the newsletter. The service used an organisation to write their policies for them and managers adapted them where necessary to fit the service. They also had several standard operating procedures where they felt that policies did not contain the level of detail required.

The service provided care to patients in line with National Institute for health and Care Excellence (NICE) guidance. The clinical governance lead reviewed new NICE guidance monthly and brought forward anything that needed to be added to policies to the following clinical governance meeting; we saw this was a standing agenda item. For example, the manager had highlighted in July 2023 NICE update that there was an ophthalmology cataract audit; they had added it to the agenda to discuss at the next clinical governance meeting to assess if they were compliant with the guidance and if they needed to implement the audit tool.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. They used a pain tool which scored from 0 to 10. Patients undergoing ophthalmic surgery were given a local anaesthesia via eye drops to stop the nerves in the eye sending pain signals to the brain during the operation and reduce discomfort. This meant patients were fully conscious and responsive before, during and after the procedure. This allowed patients and staff the ability to communicate with each other about pain at all points of the procedure. Patients were provided with a leaflet which gave advice on expected symptoms post-surgery and how to treat any pain they might have.

Patient outcomes

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

The service participated in some national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. They completed patient reported outcome measures (PROMS) for carpel tunnel procedures. However, only 6 patients had agreed to complete the PROMS survey and of these, only 2 had progressed to a procedure. Both patients reported a positive outcome.

Staff completed an audit on excisions in 2023. They looked at 50 patients who had a skin biopsy and found that 95% of patients who were found to have a skin cancer had excisional biopsies done at the first biopsy with 100% clearance of the cancer. This meant that only 5% of patients needed further treatment following their first biopsy for cancer.

The service collected patient feedback and used this to monitor patient outcomes. For example, ophthalmology patients went to their community optometrist post operatively and they submitted data back to the service through a portal which included feedback from the patient. Consultants were able to review their own outcomes. There was a monthly report which was reviewed by the directors. They had also commissioned 3 quarterly reports to assess their cataract outcomes within the first year of opening. Outcomes for patients were positive, consistent and met

expectations, such as national standards. The service had no re-admission within 28 days following surgery and had 1 unplanned return to theatre in the 12 months prior to inspection. These reports were comprehensive, contained actions and recommendations where required to improve patient outcomes. The most recent report from May to July 2022 showed that 54.5% of patients had a community optometry review. This met the guidelines from the Royal College of Ophthalmologists standard for having a postoperative review as 100% of their patients had a review by the consultant within the clinic within 1 week of surgery; this was something that the service was proud of.

An audit had recently been conducted looking at the last 12 months of data into the refractive outcomes for patients who attended the clinic. We were told that these results were good, and their current biometric machinery was functioning well.

The service did not comply with the Competition and Markets Authority legal requirements to submit private patient episode data to the Private Healthcare Information Network (PHIN). They had only had 6 patients who were happy for their information to be used and they had not yet inputted this data onto the system. They told us that as they only did minor outpatient procedures and the patients were not admitted into a theatre, it was not necessary to report to PHIN. This was discussed within their monthly senior management team meetings and clinical governance meetings, and they had decided they did not meet the criteria to submit data to PHIN. However, they were seeking further guidance on this.

Staff carried out a programme of repeated audits to check improvements over time. Managers used information from the audits to improve care and treatment. They shared and made sure staff understood information from the audits. We saw when audits demonstrated noncompliance action plans were devised to improve compliance. Whilst most action plans we saw had been completed, we found a few audits where actions had not been acted upon.

The service did not benchmark against other services. All cataract patients were seen by the consultant both pre-operatively and for a follow-up appointment within the clinic. This included patient subjective outcome review and recorded their visual acuity, refractions, and a full clinical examination.

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. We looked at 6 staff files and saw that employment checks, references, Disclosure and Barring System checks and professional body checks had been completed. Managers gave all staff a full induction and competency booklet to complete before they started work. Clinical staff had a supernumerary period until they felt competent in their role. We saw induction checklists and competency booklets were completed in all the staff files that we looked at.

Managers supported staff to develop through yearly, constructive appraisals of their work; 100% of staff had received an appraisal in the last 12-months. We saw completed appraisals where staff had asked for development opportunities which had subsequently been arranged. Managers also held regular supervision meetings with their staff to ensure they felt supported throughout the year. We read some supervision records and saw evidence managers supported staff to develop, learn and progress within their roles. All staff we spoke with said their appraisals were meaningful, and the managers focussed on their development.

Managers made sure staff received specialist training for their role. For example, the clinical support worker had completed laser safety training and a biometry course which was pertinent to their role within the ophthalmology service, and 2 nurses were sent on an enhanced vitrectomy course. Vitrectomy is a type of surgery to treat problems with the retina and vitreous within the eye.

Staff training needs were discussed at the monthly senior managers meetings. As well as identifying training needs managers ensured staff had the time and opportunity to develop their skills and knowledge. For example, the service occasionally closed so they could hold training events for staff. The consultant who worked at a local trust had invited all staff to attend their ophthalmology audit day in July 2023.

Managers knew how to identify poor staff performance and support them to improve. However, they had not had to implement performance management in the 18 months since the service opened.

Staff working under practising privileges had checks completed by the registered manager to ensure they were fit to work at the service. We looked at 4 consultants files, we found they had up to date appraisals, references, indemnity insurance, and a signed practising privileges contract. We were told they had revoked a consultant's practising privileges as they were not happy with how they were performing within the clinic or their attitude towards the patients. We were told that 1 of the directors was the clinical lead for ophthalmology at the local trust and was line manager for the other ophthalmologists who worked under practising privileges at the clinic. This meant they were aware of their practice elsewhere as well as within the clinic.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service ensured that regular staff meetings for administration and clinical teams took place every 4 weeks. Minutes from these meetings were sent to staff to read to ensure consistency with communication.

Multidisciplinary working

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

The team worked well together and communicated effectively for the benefit of the patients and their families. This included the registered manager, nurses, bank staff, administrators, consultants and directors.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw evidence of changes staff had made following team meetings when patient feedback had been discussed.

We observed positive staff working relationships which prompted a relaxed environment and helped put the patients at ease. Directors and staff at all levels felt they all worked well as a team.

The consultants worked closely with the NHS to get the best outcomes for the patients. For example, if a patient was found to have a squamous cell carcinoma (SCC), they would be discussed at the NHS multidisciplinary team meeting to get input when required from more healthcare professionals. A SCC is a type of skin cancer.

Seven-day services

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

Good

Outpatients

The service was open Monday to Friday 8:30am to 5pm. They also opened some evenings if there was patient demand. For example, 1 dermatologist had left the service and this created a high demand for the appointments, so they added some evening clinics to accommodate this. The service provided out of hours consultant support over the weekends if patients had had a procedure on a Friday. Patients were also able to contact their consultant in the evenings following their procedure if required.

The service had policies in place for the management of a deteriorating patient which included contacting emergency medical services. The service also had established links with their local NHS trust.

Health promotion

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

The service gave relevant information promoting healthy lifestyles and support. They had recently started up a menopause service and this involved advice regarding weight loss, diet and stress management.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There was a consent policy. Staff made sure patients consented to treatment based on all the information available. Each patient file contained a form which showed that staff had discussed the risks and benefits of treatment with patients prior to any procedures being undertaken. This was done as a 2-stage process. Firstly, they gave all the patient the information at their initial appointment and asked them to sign the information leaflet to say they had received it and would read the information before consenting to treatment. There was an example of a consent form within the information leaflet so that patients were aware of the forms they needed to sign on the day. Secondly, patients were required to give their consent on the day of the procedure. Staff made sure patients consented to treatment based on all the information available. We looked at 7 sets of patient notes and saw consent was recorded in all these records. The clinic only completed procedures on patients who could give consent. If they lacked the ability to consent to treatment they did not meet the clinics eligibility criteria and were referred to NHS services or private hospital. People who required sedation to remain still for treatment were referred to services who were set up to offer this.

Is the service caring?

Good

We rated caring as good.

Compassionate care

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

Good

Outpatients

Staff and leaders promoted strong, caring, respectful and supporting relationships with their patients. Staff were passionate about ensuring there was a strong and positive patient-centred culture at the clinic. They focussed on patients feeling valued, important, and cared for every time they entered the clinic.

Patients said staff treated them well and with kindness. Feedback from patients was continually positive. We read comments such as “welcoming, warm, lovely team”, “fabulous crew at Wye Clinic” and “friendly and reassuring staff”. We saw staff interact with patients on arrival and throughout their time at the clinic with compassion and kindness. They took time to interact with patients and those close to them in a respectful and considerate way. We observed 3 consultations where the consultant treated the patients with compassion and respect throughout.

Staff understood and respected the needs of the individual patients. For example, 1 of the nurses noted that a patient had a Zimmer frame which was too small for them; they organised for the patient to have physiotherapy support as they recognised that the patient was struggling.

Patients were able to have a chaperone for support if required and all staff had received chaperone training.

Staff followed policies and kept patient care and treatment confidential.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment, and tried to reduce their anxiety by providing patient-centred care. For example, staff were told in advance if a patient was anxious so they could arrange for them to have the small waiting room within the reception area to themselves. One of the receptionists was a mental health champion, when they recognised anxious patients, they would offer to sit with them.

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 could have their relative or carer stay with them whilst their eyes were dilated until they went into the treatment room and as soon as the procedure was finished.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff ensured that patients had the information they needed to make decisions relating to their care and treatment, including surgery. This was evidenced from the start of the process at the initial consultation where information was gathered, and patients were given time to make decisions about their care and ask questions.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw that staff listened to the needs of the patients. For example, they had received feedback that some patients had cold hands during procedures so the service had bought hand warmers. They also played music during the procedure and patients were asked what they would like to listen to.

Good

Outpatients

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were sent feedback forms to complete after their appointments and these were overwhelmingly positive. There were also cards available within the waiting area to provide feedback. We saw in June 2023 the service had received positive feedback from 54 patients. We saw comments within the waiting room on the board which included "excellent service, brilliant welcome", "All staff extremely friendly, put you at ease. All very well qualified and experienced which is reassuring. Couldn't fault experience" and "From my first contact with the receptionists and through various stages of pre-operative process, I was made to feel comfortable and relaxed. Total confidence in the clinic and consultant. Heartfelt thanks to everyone involved. Everyone is excellent in their own field of expertise".

Is the service responsive?

Good

We rated responsive as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The service was open 08.30am until 5pm Monday to Friday but was flexible and would offer a range of evening appointments when required. The service saw private patients only. However, if they saw someone who needed treatment that the service could not provide, they would arrange to treat the patient at the local private hospital or local NHS hospital. The service could mostly offer an appointment within 1 to 2 weeks and surgery within 2 to 3 weeks following the initial consultation. We saw that waiting times were discussed in monthly senior management team meetings to ensure the service was responsive to the needs of patients.

Managers monitored and took action to minimise missed appointments. All patients were contacted the day prior to their appointment to confirm the date and time and attendance. Managers ensured that patients who did not attend appointments were contacted, however, the service reported very few missed appointments.

Meeting people's individual needs

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

The service provided private care and did not undertake any surgery on behalf of the NHS or other private providers.

Facilities and premises were appropriate for the services being delivered. The clinic had a car park with ample parking and designated disabled parking spaces available. The clinic was easily accessible for patients with mobility issues including wheelchair users. There was enough seating in the waiting area. There were 3 steps into the waiting room and they had a portable ramp that patients could use if required. They also had a consultation room which could be accessed via the ground floor for patients who had mobility problems or used a wheelchair. There was a plan to install a bespoke stair lift to ensure that patients could access the range of diagnostic services offered.

Good

Outpatients

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was a hearing loop in the reception area which staff knew how to use. They had larger print information leaflets for patients who needed them. All patients were asked to bring someone with them as a lot of patients needed someone to drive them home after their appointment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service did not have a translation service. However, they said that if a patient required a translator, they would be able to arrange this for them.

The service did not see many patients who were living with autism or learning difficulties. If they were able to tolerate the procedure without sedation they would be seen at the clinic. If not, the service, alongside the patient, would make the decision for the patients to be seen at the local trust where they could have involvement from the specialist nurses. They also had a link with an anaesthetist who specialised in learning difficulties and autism and asked them to advise where needed. Whilst the service did not regularly see patients who were living with dementia, the manager wanted to invite the dementia nurse from the local NHS trust to speak to the staff as they see a lot of elderly patients. The manager had recently ordered a 'This is me' document to see how it could be adapted to the service.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed. Patients were given the first available appointment; this was mostly within 1 to 2 weeks of the request and tests were mostly performed at the time of the appointment. For example, we observed a consultation where a patient was seeing the consultant for a follow up due to irritation in their eye; they were able to scan them and have the results immediately for the consultant.

Managers worked to keep the number of cancelled appointments to a minimum. Patients mostly did not cancel their appointments but if they did, they were rescheduled for the next available appointment. Administrators contacted the patients if they did not attend to rebook their appointment.

Admission times for patients who were having procedures were staggered which meant there were minimal delays. Patients were discharged promptly after their procedures when they were deemed fit. Patients were given the consultants number to call if they had problems post-operatively. They were given a discharge letter which contained information about any aftercare and medication required.

The manager ran a weekly utilisation meeting which looked at the clinics that due to run the following week/fortnight, the number of people due to be seen, to ensure they had the right staff and right equipment for the clinics to run smoothly.

The managers were proactive at ensuring that clinics ran on time. We saw that 1 consultant had consistently ran late, this was monitored, and their practising privileges were revoked as the managers felt that this, alongside other issues, was impacting on patients' experience. At a senior management meeting in July 2023, they discussed adjusting a consultants clinic timing to reduce their tardiness; they created an action to monitor the clinic timings and planned to feedback at the next meeting.

Good

Outpatients

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The manager had a complaint tracker to look for themes in the complaints received; they had 1 formal and 1 informal complaint in 2023. We saw that complaints had been investigated and responded to. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, a patient had a complication with their surgery and the nurse told the patients relative that the procedure did not go to plan and no further information was given. The relative was unhappy with how this was communicated. The service discussed this, and they were planning on doing a practice scenario based around communication to ensure there was learning from this incident and practice was improved.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. The manager phoned all complainants to discuss their concerns and completed an investigation into the complaint. All learning was shared with the staff at team meetings and clinical governance meetings and learning was used to improve the service.

Is the service well-led?

Good

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.

The Wye Clinic is a small service run by 3 directors and the registered manager. It had a clear leadership structure in place. They had recently implemented a memorandum of understanding between the directors to ensure they were all aware of their roles and the expectations of their relationships. The managers were aware of the service's performance, limitations, and the challenges it faced. We were told that 1 of the main challenges was the service was not recognised by some of the insurance companies which meant that this reduced the number of patients they were able to see.

Staff told us the managers were friendly and approachable. Staff felt confident to discuss any concerns they had with them and were able to approach the managers directly, should the need arise.

The managers encouraged staff to develop and had examples of where they had supported staff to build on their own confidence and to progress in their roles.

Regular communication took place between the registered manager and staff. There was a daily huddle which had recently been introduced following an incident where communication between the administration team and clinical team was poor and this was highlighted as needing to improve.

Staff attended a monthly clinical or administration team meeting where they were kept informed about the clinic. They discussed incidents, complaints, training, and feedback. Managers made sure staff attended team meetings or had access to notes when they could not attend.

Vision and Strategy

The service had a vision for what it wanted to achieve. Leaders and staff understood and knew how to apply it and monitor progress. However, there was no clear strategy for the service.

There was a clear vision and values for the service. They were focused on the needs of the patients, and this was evident with the care that the patients received.

The service vision was to work in partnership with staff and to be able to provide the best healthcare service possible. Staff were aware of the vision of the service, and this was discussed within their meetings. The service's values were clearly embedded in the way the staff worked. Staff we spoke to referred to the values and managers told us they recruited staff who they thought would work in line with their values. Most of the staff that worked in the service had worked with the managers or directors for a long time and had good relationships with them. All staff when they started were given a values document which set out what was expected of them.

The values were:

- Put patients first,
- Act with integrity,
- Respect others,
- Take pride in what they do,
- Strive to be the best.

There was no documented strategy for the service and how it planned to develop over the next few years. However, the managers said they wanted to utilise the space within the clinic, as they often have consultation rooms empty, but they want to hand pick the services they deliver and ensure they were high quality. They were very clear they did not want to compromise the care and high-quality service they were giving patients. Managers told us they wanted to develop their core service, which was ophthalmology, over the next 12 months but there was no clear business focus for the service and its priorities.

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 worked together as a team to identify and address concerns to continually improve.

Staff felt positive and proud to work at the organisation. The culture was centred on the needs and experience of patients and staff consistently demonstrated passion towards putting patients first. Staff described the culture as "refreshing" and "bliss" and we were told the leaders thought as much about the staff as they did the patients. We asked staff what they would improve and most said nothing. We were told "this is how working life should be". We were told they were able to go the extra mile for their patients as the managers were so flexible.

The culture encouraged openness and honesty. Leaders and staff understood the importance of staff being able to raise concerns without fear. Staff told us that there was no "hierarchy", and the managers were incredibly supportive and approachable with a real focus on learning and a no blame culture. Staff felt listened to. We were told that all improvement ideas were taken seriously and implemented following discussions. For example, the nursing team asked for call bells for patients, and these were installed.

We looked at the senior management team meeting minutes for July 2023 and they discussed that staff wanted more annual leave and had been struggling with their allocation. The managers had agreed to increase the staff leave entitlement to give them additional days.

There were mechanisms for providing all staff with the development they needed, such as high-quality appraisals and career development conversations; staff told us they felt supported to develop.

The organisation was committed to the wellbeing of the staff and staff felt managers were supportive to their needs. We were told of situations where the managers had been supportive when staff had difficult home life experiences and adapted their work to suit their needs. A member of staff completed mental health training and was the champion for the service.

We saw cooperative, supportive, and appreciative relationships amongst staff. Staff told us they worked collaboratively as a team and resolved conflict quickly and constructively. Staff regularly connected outside of the work environment and took part in team bonding outings. For example, they had recently closed the clinic for the day all attended a 'bake off' day as a team. They did an away day once a year, these were mostly fun rather than educational.

Governance

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

The service had service level agreements; these were well managed and reviewed on an annual basis.

The service had an agreement with a company who managed all their policies and procedures. These were also looked at annually by the registered manager and standard operating procedures were put into place where the policy needed further clarification.

The service had an annual audit scheduled; we saw these audits were regularly completed and feedback was given in meetings. All the audits we reviewed had action plans, but we saw the action had not always been completed.

There were effective structures, processes, and systems of accountability to support a good quality sustainable service. Senior staff regularly met to review these and made improvements when needed. The team was very small, and the leaders worked closely with the staff on the ground. This enabled effective two-way communication channels for raising concerns and providing feedback.

The service had a good governance structure. They had a monthly clinical governance (CG) meeting and a CG lead which attended by the CG lead, the infection prevention and control lead, lead nurse and registered manager. They also

had a monthly senior managers meeting with the registered manager and the directors. Both meetings had a set agenda which identified what was to be discussed and included actions taken from the previous meeting. We looked at minutes from May to July 2023 and found that actions were reviewed and acted upon. They discussed health and safety concerns, risks, complaints and incidents and were proactive in making improvements within the clinic where needed.

They ran a quality improvement month annually in November. Staff put what they wanted to improve on a poster, and this was actioned or addressed by the managers. For example, staff said they wanted a bench outside in the garden to eat their lunch on and this had been provided. The registered manager did observations of staff in the quality improvement month to ensure that the standard the staff were providing was in line with the service's values.

The consultants held a monthly morbidity and mortality meeting at the trust when they also discussed patients from this service if required to ensure a multidisciplinary approach was taken to patient care and treatment. We were told other members of staff from the clinic also attended the meeting to promote their learning and development.

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 assurance systems that allowed performance issues to be escalated appropriately through clear structures and processes. These systems were reviewed and improved as needed.

Senior staff monitored staff performance through annual appraisals. These focussed on staff development and learning.

Staff working under a regulatory body were required to demonstrate an up-to-date knowledge of their clinical practice.

There were arrangements for identifying, recording, and managing risks, issues, and mitigating actions. The service had risk assessments which were associated with the laser service and reviewed these regularly to ensure the risks were mitigated.

We found that managers were proactive in reducing the risks where possible. For example, the building was grade 2 listed and had 3 floors and a few different sets of stairs which meant that the layout was challenging. The managers had an onsite fire risk assessment to ensure that all escape routes were highlighted, and risks mitigated where possible. They completed practice fire evacuations from the building bi-annually and we saw evidence that there was learning from these practice scenarios and changes had been made because of this.

The service had started to collect information for Patient Reported Outcome Measures for certain procedures. Patients were required to complete a questionnaire prior to and after their procedure; only 6 patients had consent for their data to be submitted. The managers submitted monthly adverse events data to PHIN and were planning on submitting the data for the 6 patients who had consented within the submission time frame.

There was a risk management policy which was in date. There was a risk register which contained 8 active risks and 17 archived risks. Staff were aware of the risks that were on the register. Managers reviewed the risk register at the senior management meetings and clinical governance meetings. We looked at minutes from July 2023 and saw that each risk and mitigating actions was discussed in detail. Managers told us their top risks were the access to the building as there were 3 steps from the entrance to the waiting area and consultation rooms and the drainage of the site; whilst this had been partially resolved, the next stage of the work was not due until September 2023.

There was a business continuity plan which the managers reviewed annually and employer liability insurance.

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.

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.

Records were paper-based and then scanned onto an electronic system which was password protected; paper records were stored securely.

The service had a data protection policy and all staff completed training in information governance.

Staff knew what data and notifications required submission to external bodies. Staff were aware of the need to report to the Information Commissioner's Office for data breaches, CQC in relation to incidents in line with Care Quality Commission Registration Regulations 2009, and UK Health Security Agency.

Engagement

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

The service gathered and acted on people's views and experiences to shape and improve the services. Staff routinely monitored feedback to analyse trends and themes in both positive and negative feedback. We saw staff had implemented changes when areas of improvement were highlighted.

Managers created a monthly newsletter to engage with their staff to ensure they were well informed about the clinic. They also had an employee of the month which staff voted for themselves; staff were rewarded with vouchers or outings for winning this.

The service had created a patient participation group to hear the patient voice and make improvements within the clinic where needed. The manager had a plan to write to 10 patients inviting them to a meeting in September 2023. Attendance to a previous meeting had been poor, however many of those invited had written in to say they did think there was anything to improve on.

The staff were passionate about ensuring the culture was open and inclusive, to enable a positive patient experience. They actively engaged in meetings so that their views were reflected in the planning and delivery of services.

The service had positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population.

Learning, continuous improvement and innovation

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

Good

Outpatients

The clinic used an airflow machine to enable them to complete cataract procedures in an outpatient environment; this had won an award for innovation. They were the first outpatient facility in the country to use this specific airflow machine and operate on cataracts within an outpatient setting. We saw they had published a paper in 2022 on its use and the patient outcomes pioneering the use of the machine for the Royal College of Ophthalmologists.

Following nomination by the staff team the registered manager had won the award for private healthcare staff member of the year within the Hereford area in October 2022