Leicestershire Consultant Eye Surgeons LLP

Leicestershire Consultant Eye Surgeons LLP @ The Stoneygate Eye Hospital

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
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

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well, although we saw gaps in safeguarding training for 5 staff who's training had expired. Staff were aware of how to report safeguarding concerns and the provider was arranging training. The service generally controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- We found medicines in open cupboards in the laser room. Although the laser room had a keypad lock on the door, all staff had access to this room, therefore medicines were not stored securely and safely. There were medicines in plastic boxes for consultant clinics left on a worktop in the laser room, these were also not stored safely. Medicines were stored in the main storeroom in a locked cupboard, we found boxes of medicines on top of the locked cupboard as there was no room to store them, they were not stored safely, and all staff had access.
- The store person was responsible for ordering and receiving drug deliveries and storage. The provider was not able to demonstrate the member of staff had been given appropriate training for this role.
- Although the private prescription pads were stored in a locked cupboard and audits carried out on usage they were accessible for all staff and therefore not as secure as required.
- There was carpet in the room that was used as a waiting area, recovery area and, discharge area for patients. This prevents effective cleaning and infection prevention and control and does not meet buildings guidance.
- Policies were updated by individuals, but it was unclear if these were reviewed and approved by managers or at a governance meeting.
- Some staff training was out of date and did not meet the providers target of 95% for safeguarding adults level 3.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated it as good see the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Leicestershire Consultant Eye Surgeons LLP @ The Stoneygate Eye Hospital

Stoneygate Eye Hospital is operated by Leicestershire Consultant Eye Surgeons LLP. The hospital opened in 2013. It is a privately-run eye hospital in Leicester. The hospital primarily serves the communities of the Leicester, Leicestershire and Rutland areas. It also accepts patient referrals from outside this area.

The service offers NHS and private patients access to services. The service is registered to provide the following regulated activities:

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

All surgery undertaken by the service is for adults aged 18 years and over, providing day case, ophthalmology surgery under local anaesthesia and light sedation. There are no overnight patient stays. The ophthalmic team consists of:

- Ophthalmology and Anaesthetist consultants
- Optometrists
- Registered nurses
- Ophthalmic technicians
- Administration staff

Support services provided includes contract management, finance support, human resources and marketing.

The location had a registered manager who had been in post and registered with CQC in December 2022.

From January 2023 to December 2023, the service undertook 5,204 surgical procedures. The majority of these patients were seen as part of the cataract surgery pathway.

The main service provided at this location was surgery, with the majority of outpatient appointments being provided as part of the surgical pathway. We did not inspect the outpatient services separately as part of this inspection as the main service was surgery.

The service was previously inspected in September 2017 and rated as requires improvement overall, with safe, responsive and well led rated as requires improvement and effective and caring rated as good. The service had 3 requirement notices relating to regulation 13, safeguarding service users from abuse and improper treatment, regulation 5, fit and proper persons and regulation 17, good governance.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 9 January 2024. The team that inspected the service comprised of 1 CQC inspector and a specialist advisor with surgical and ophthalmology experience. During the inspection visit, the inspection team:

Summary of this inspection

- Spoke with the registered manager and 14 members of staff, including registered nurses, consultants, clinical support staff, administration and human resources staff.
- Spoke with 2 patients and 1 relative.
- Looked at 6 patient medical records.
- Observed care and treatment provided in the centre.
- Looked at a range of policies, procedures, audit reports, notes 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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a 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 MUST take to improve:

- The service must ensure that all medicines are stored safely and securely. (Regulation 12 (2) (g) Safe Care and Treatment).

Action the service SHOULD take to improve:

- The service should ensure staff training for safeguarding is up to date and meets their own target of 95%. (Regulation 18. Staffing (1)).
- The service should ensure that private prescription pads are stored safely and securely and staff have limited access. (Regulation 12. Safe Care and Treatment (1)).
- The service should ensure that all flooring in patient areas comply with Infection Control in the Built Environment guidance HBN 00-09. (Regulation 15. Premises and equipment (1)).
- The service should ensure that all equipment in the storeroom is stored off the floor. (Regulation 15. Premises and equipment (1)).
- The service should consider the process to review and approve policies. (Regulation 17. Good governance (1)).

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

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. The service provided mandatory training for staff and monitored completion rates. Staff told us they received reminders to complete mandatory training.

The service provided statutory and mandatory training using a combination of 'face to face' training and e-learning. The mandatory training was comprehensive and met the needs of patients and staff. The human resources staff maintained a spreadsheet with detail of individual staff training requirements and dates for when these were due. They would prompt staff to attend training. The service held an annual training day to support training and development.

Training included modules in fire safety, equality, diversity and human rights, mental health training which included autism and learning disability awareness, dementia awareness, infection prevention and control, basic life support and manual handling. Staff had a list of training they would need to complete dependent on their job role. Compliance with mandatory training was 94%, this was in line with the providers target of 95%.

All staff had received training on duty of candour and female genital mutilation which was an improvement from the last inspection.

Most consultants would complete training in their substantive NHS role, and provided evidence, but also had access to the training provided by the service.

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.

Safeguarding training was provided to level 3 in safeguarding adults and children for all clinical staff. Administrative and support staff received level 1 training in safeguarding adults and children. This was in line with national guidance.

Staff knew how to identify adults and children at risk of, or suffering significant harm and, if needed, would work with other agencies to protect them. At the time of the inspection 93% of staff had received relevant safeguarding training for level 1 adults and children and 89% for level 3 safeguarding adults and children training. This did not meet the providers target of 95%. Training was being arranged for 5 staff whose training had expired.

The service had an appropriate safeguarding policy and procedure in place.

The service had a vulnerable adult policy and child protection policy which included contact details for local safeguarding teams, support groups and referenced relevant legislation and guidance. This contained information for staff on how to identify adults and children at risk. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There were no safeguarding incidents reported in the 12 months prior to our inspection.

Posters were displayed in the clinic reminding patients of the chaperone service.

Recruitment pathways and procedures were in place to ensure relevant recruitment checks had been completed for all staff. These included a Disclosure and Barring Service (DBS) check, occupational health clearance, references and qualification and professional registration checks.

Cleanliness, infection control and hygiene

The service generally 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. However, there was carpeting in some clinical areas which prevented effective cleaning and did not meet building safety guidance.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Handwashing facilities were in line with good practice recommendations and available in all clinical areas.

The service had an up-to-date infection prevention and control policy which included information on hand hygiene, use of personal protective equipment (PPE), Covid 19 and decontamination.

All areas, including clinic and theatre areas were visibly clean, tidy and had suitable furnishings which were clean and well-maintained. Seamless easy-clean floor coverings were used in most clinical areas, this made cleaning easier and more effective. However, we saw carpet in the room that was used as a waiting area, recovery area and, discharge area for patients. This was not in line with Infection Control in the Built Environment guidance HBN 00-09. Following our inspection, the provider had plans to change the floor covering to meet the required standards.

Cleaning staff had a daily cleaning schedule, and these were signed to indicate when they were completed. An external company was used to clean theatres in the early morning so they were clean and ready at the start of the day. Cleaning staff would clean the environment and equipment. Staff would clean equipment after each use, surface wipes were available in each room.

Good

Surgery

Staff followed infection control principles including the use of PPE. We saw staff wash their hands regularly and wear correct PPE for the tasks being performed. We saw supplies of PPE items, such as disposable aprons and gloves in dispensers on walls and we saw these items being used. Antimicrobial hand-rub dispensers were mounted on the walls or on surfaces at strategic points in each room as well as at the reception desk. Infection control audits were carried out monthly, although audits were not rated the narrative results showed good compliance between September to December 2023 for hand hygiene, use of PPE and environmental cleaning.

Spill kits were available to enable staff to safely clean fluids from floors and worktops.

Most equipment was single use, and the service used an external company for decontamination and sterilisation of reusable equipment. The service had a small autoclave and washer to clean some equipment, and all equipment was logged and decontaminated in line with guidance. Clean and sterile equipment was stored in the storage area.

Theatre staff wore scrubs that were laundered by an external company; we saw adequate supply of scrubs. Some staff wore a uniform that they laundered themselves. Staff would change on arrival to work and before they left work.

Staff worked effectively to prevent, identify, and treat surgical site infections. In the last 12 months 1 surgical site infection had been recorded.

The provider completed regular water testing for legionella and other organisms. Water outlets and sinks were flushed daily to reduce the risk of legionella build-up and temperature checks were carried out in line with Health and Safety Executive guidance.

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 patients. The building had been adapted to suit the needs of patients. There was adequate car parking directly outside.

The service operated across 3 building that were joined on the ground floor. Not all of the first floor was linked and staff and patients would use the stairs or lifts to access other parts of the building. Reception, 4 outpatients rooms, diagnostics and 2 theatres were on the ground floor. Admission, recovery, discharge and administration offices were on the first floor. There were 2 accessible lifts, disabled toilets and a wheelchair available if required.

There were call bells in patient areas that alerted staff and reception.

The hospital maintained equipment under contracts with the companies supplying the equipment and was up to date with portable appliance testing.

There were storage facilities, however we found boxes were stored on the floor and on top of cupboards, the storage area was cluttered. Following our inspection, the provider installed additional storage racks.

There was appropriate ventilation in the operating theatre in line with national guidance Health Technical Memorandum 03.01 on specialist ventilation. We saw staff monitor the air flow daily and recorded temperature and humidity. There was a contract for maintenance of equipment and ventilation and deep cleaning was carried out annually.

Good

Surgery

The service had suitable facilities to meet the needs of patients' families. There was enough seating in waiting areas for a family member or carer to accompany patients to their appointments. Relatives and carers could help themselves to complimentary drinks and biscuits, and there was a television in the waiting area and the discharge areas.

The service had enough suitable equipment to help them to safely care for patients. The contents of the resuscitation trolley were in-date and the trolley was visibly clean. We saw the trolley was checked daily and a full check completed weekly. This was an improvement from the last inspection where we found drugs stored on top of the resuscitation trolley.

The laser room was keypad locked and temperature checks completed daily. There was a laser warning sign outside the door to alert staff when the laser room was in use.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. There was a locked storage area outside the main building to store clinical waste and sharps bins. These were collected 3 times a week.

The sharps bins were stored safely and labelled correctly; bins we saw were not over filled. Sharps bins were collected quarterly and store in a locked garage outside the main building.

Hazardous cleaning products were stored in line with the Control of Substances Hazardous to Health (COSHH) Regulations 2002.They were stored in a locked room.

There was clear signage about what to do in the event of fire, fire extinguishers were available and maintained. Fire extinguishers had in date service checks and there were signs pointing out fire exits throughout the service. Staff were required to complete fire training as part of mandatory training requirements, we saw 94% compliance. An external company checked fire risk assessments 6 monthly and staff carried out fire drills every 6 months.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service provided ambulatory care, meaning that all treatment was carried out as a day surgery admission under local anaesthetic or light sedation. The service had clear guidelines for assessment of patients for surgery. Checks were made to ensure the patient was suitable to undergo surgery. The service had guidance on exclusion criteria, and patients who did not meet the criteria were referred back to the referrer or local NHS hospital for onward treatment. All patients received a telephone pre-operative assessment call with the nurse and consultant prior to surgery to ensure they were fit enough for surgery.

Staff could identify deteriorating patients and escalated them appropriately. Patients had to be medically fit for surgery before the service could deliver treatment and so deterioration was rare. However, appropriate equipment, training, and protocols were in place.

All staff were trained in basic life support (BLS). Registered healthcare professionals were trained in immediate life support (ILS). Surgeons were trained in advanced life support (ALS). If a patient deteriorated the service would commence emergency treatment and dial 999 for assistance. The service had a policy on management of the deteriorating patient, which included information on monitoring, escalation and transfer of patients.

Good

Surgery

We saw the compliance for BLS was 99% with and ILS training was 98%. The staff training that had recently expired was being planned.

There was a new policy on sepsis recognition and response, which included diagnosis, treatment and roles and responsibilities. Staff had specific training on sepsis and there was toolkit. This was an improvement from the last inspection.

World Health Organisation (WHO) checklists were completed in line with the National Patient Safety Agency and surgical safety including the completion of safety checklists. We reviewed patient records and saw WHO checklists were completed correctly. We observed the WHO checklist being completed correctly on 1 patient during surgery. The WHO checklists were audited monthly, we saw compliance for September to November 2023 was 100%.

Staff carried out a daily huddle to discuss patients on the list for that day, processes and share information.

Patients allergies were recorded and written on the white boards in theatre for all staff to see.

Patients could access a 24-hour emergency telephone line. A consultant and manager were on call who would verbally assess the patients' needs and provide advice if needed. Consultants would review patients as required.

Administrative staff carried out post operative calls to patients the day after the procedure, and any concerns or clinical queries would be passed onto the clinical staff to deal with.

Staff shared key information to keep patients safe when handing over their care to others. Information relating to individuals who had received treatment at the service was passed on to their GP and optician to ensure information was shared. Post operative and follow up appointments were generally carried out by local opticians, but the service also offered appointments to patients and would follow up care if required.

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 staff a full induction.

The service had enough nursing and support staff to keep patients safe. Staffing levels reflected demand on the service and known treatment support needs. The organisation had agreed minimum staffing for the service and surgery would only proceed when the standard staffing levels and skill mix was confirmed. 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. Surgery was always consultant led; an anaesthetist was sometimes present if patient were having light sedation.

Two optometrists were employed who mainly managed pre-operative and post operative assessments, and Yttrium Aluminium Garnet (YAG) laser pre-assessment and procedures. YAG procedures treated cloudiness after cataract treatment.

Managers limited their use of bank staff and used regular staff familiar with the service. All staff, including bank staff had a period of induction, and supervision where required, on commencing work at the service. All staff completed the mandatory training during induction.

Nursing staff had completed their Nursing and Midwifery Council re-validation checks and updates to develop their competencies.

The service regularly reviewed staff absence and recruitment and retention information. At the time of our inspection there were vacancies for a compliance manager, ophthalmic technician and theatre runner.

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, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. There were 14 consultants working at this site:

- 3 consultant ophthalmologist partners of the business
- 3 consultant anaesthetists
- 7 consultant ophthalmologists who all have practising privileges
- 1 consultant ophthalmologist who is involved in NHS pre-assessments only

We reviewed consultant records and found they were registered with the General Medical Council and had up to date DBS and indemnity insurance.

Three of the consultants were directors for the service. Other consultants and anaesthetists worked for the service under practising privileges. 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. Practising privileges was discussed with the directors and members of the medical advisory committee.

The service had a consultant on call during evenings and weekends, 365 days a year.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed 6 patient records. They contained patient's consent forms, pre-operative assessment, procedure records and discharge information. We found consent was completed, notes were legible, signed and dated by staff, this was an improvement from the last inspection. All labels for lenses and equipment sets were attached and traceable.

Records were stored securely in lockable cabinets in the admissions area, recovery and reception, this was an improvement since the last inspection. Records were stored in the administrative office, across 3 different offices and some were in cabinets, some archived records were stored off site. Staff told us the storage of records wasn't ideal and they would run out of storage space. Patients' records were passed between staff and departments safely and not left unattended. However, we found a folder with patient information regarding cancellation of procedure in the admission room not stored securely when we raised this the folder was locked away.

Clinical documentation audits were carried out quarterly. Although audits were not rated the narrative results showed good compliance between September to December 2023.

Good

Surgery

Medicines

The service used systems and processes to safely prescribe, administer, record medicines. However, some medicines were not stored safely and securely.

We found medicines, mainly eye drops, in open drug cupboards in the laser room. Although the laser room had a keypad lock on the door, all staff had access to this room, therefore medicines were not stored securely safely. There were medicines in plastic boxes for consultant clinics left on a worktop in the laser room, these were also not stored safely. This did not comply with the providers policy which stated that all medications are then put away in the locked drug cupboards and fridges for storage. We raised this at the time of our inspection. Following our inspection the service installed locked drug cupboards in consultation rooms, provided additional locked storage for medicines and restricted access to medicines.

Medicines were stored in the main storeroom in a locked cupboard, we found boxes of medicines on top of the locked cupboard as there was no room to stored them, they were not stored safely and all staff had access. We raised this at the time of our inspection. Following our inspection, the service installed locked cupboards in the laser room to provide additional storage.

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

Checks were made to ensure any out-of-date medicines were disposed of. No controlled drugs were used within the service. Fridge temperatures were monitored daily, and staff ensured these were within the required range, there was a process to escalate any concerns.

Staff completed medicines records accurately and kept them up to date. We viewed 4 patient records where medicines had been prescribed and saw that all medicines prescribed were signed for by a consultant. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients were given verbal and written advice when discharged on how and when to dispense eye drops and post operative care about their particular condition and procedure.

Optical technicians were trained to dispense eye drops to patients and completed specific competencies for this role. These were given under a patient specific directive and consultants reviewed and signed these for the daily theatre list.

The store person was responsible for ordering and receiving drug deliveries and storage, we were not assured of their training and competency to carry out this role. Following our inspection training was provided for staff who were responsible for ordering and storing drugs.

The private prescription pads were stored in a locked cupboard and audits carried out on usage. We were not assured they were stored safely as all staff could access them. We raised this at the time of the inspection. Following our inspection, the service installed a new locked cupboard and reduced access to the prescription pads.

Incidents

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

Good

Surgery

Staff knew what incidents to report and how to report them. The service used paper records to report and record all incidents. All staff we spoke with were familiar with the process to report incidents. The service had a policy for incident reporting which outlined the expectations for staff in the event of an incident.

From January to December 2023, the service had reported 57 incidents. No serious incidents or never events had occurred during this time. Leaders described a good reporting culture amongst staff and staff felt happy to raise concerns. Learning included improve communication and documentation and staff to have dedicated time to complete tasks. Incidents and learning were discussed at the medical advisory committee and team meetings.

Patient safety alerts were shared with staff, they were reviewed by the registered manager and shared with department managers to act upon and disseminate to staff.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. All staff we spoke with were clear in their understanding of the duty of candour and felt the service was open and honest. This was an improvement from the last inspection.

Is the service effective?

Good

Our rating of effective stayed the same. 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 service followed National Institute for Health and Care Excellence (NICE) guidelines. The policies referenced and were developed in line with the Royal College of Ophthalmologists standards. There were standard operating procedures and established pathways to support staff available as hard copies in the reception area, staff kitchen and on the organisation's intranet. Staff knew how to access the documents.

Policies were monitored and the owners reminded when they needed updated or updated in line with new guidance, although it was unclear if these were reviewed and approved at a meeting or by a manager.

The service complied with the Competition and Markets Authority legal requirement to submit private patient episode data to the Private Healthcare Information Network (PHIN). This information was discussed at the medical advisory committee.

Nutrition and hydration

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

The service provided treatment under local anaesthetic so there was no restriction on diet or fluids before surgery. Staff made sure patients had access to food and drink if required. Patients attending for day surgery were offered tea and biscuits following operations. Hot and cold drinks were available in the reception area.

Good

Surgery

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 and managed the pain of patients well. Surgery was undertaken using local anaesthetic. Staff monitored for signs of pain or discomfort throughout the patients care and treatments using a pain scoring chart.

Monthly pain audits were carried out, although audits were not rated the narrative results showed good compliance between September to December 2023. Action plans included reminding staff to complete documentation in full.

Staff gave patients verbal and written advice should they feel any discomfort or pain on discharge.

Patient outcomes

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

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. All staff were actively engaged in activities to monitor and improve quality and outcomes.

The service participated in relevant national clinical audits. They submitted data to the National Ophthalmology Database Audit (NODA) run by the Royal College of Ophthalmologists. NODA measures the outcomes of cataract surgery. At the time of our inspection the service had not received a full report of outcomes as they had not been submitting data long enough to have a full report. However, they reviewed the data which showed the results were within expected tolerances.

The service carried out an audit on 39 patients with one of the providers who refer patients to determine that they meet the referral criteria and post-operative complications. The outcomes showed that 95% of patient met the referral criteria, 100% were provided with postoperative information and 3 patients reported post operative complication, of which 2 were resolved quickly and 1 case was referred to the local NHS for further treatment.

The revision and readmission rate for the last 12 months was 0.35%, with no clear trends identified. All cases were discussed at the medical advisory committee and relevant referral partners.

Managers used information from the audits to improve care and treatment. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. We saw evidence of monthly and quarterly audits, information was shared with staff and action taken if required, such as reminding staff about documentation.

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. A number of checks were carried out by the organisation before staff commenced employment. We saw a database which demonstrated when each individual employee had completed a clear Disclosure and Barring Service (DBS) check,

references had been taken and checks on qualifications and identity had been made. For consultants this also included General Medical Council membership, indemnity insurance and revalidation and appraisal dates. For nursing staff information collected included DBS issue number, references and Nursing and Midwifery Council PINs. We reviewed 5 staff files and found all the information available and up to date.

The service had a process in place to ensure directors completed a declaration to conform to the fit and proper persons regulation. We reviewed directors' files and found the information was available and up to date. This was an improvement from the last inspection.

Managers provided a full induction to all new staff tailored to their role. All staff underwent a 6-month probationary period when they started working within the service.

Staff had to pass competency assessments in their own area of work before the end of the probationary period. This was an improvement from the last inspection. They had a regular one to one meeting with a manager during their probation period and regularly thereafter. Annual appraisals took place where staff could discuss training and development needs. At the time of our inspection 93% of staff had completed an annual appraisal, those outstanding were being planned.

Staff who undertook YAG laser procedures were trained to use this equipment. The service had dedicated laser supervisors to ensure safety of the equipment and the environment.

Managers made sure staff attended online team meetings or had access to minutes when they could not attend. Some meetings were held for specific roles, such as scrub nurses.

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. Staff worked effectively with referring partners such as community opticians and shared information to ensure continuity of care. GPs and opticians were contacted to share information about patients and their treatment with the provider to ensure all agencies could care for patients safely and effectively.

We observed positive communication taking place amongst staff and staff told us they worked well together and felt part of a team.

Seven-day services

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

The service was open Monday to Saturday for outpatient and surgical treatment.

Following their surgery patients had access to an emergency contact number which was accessible 24 hours a day, 7 days a week. A manager and a consultant were always on call to provide advice and guidance should a patient have concerns following surgery.

Health promotion

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

Good

Surgery

The service supported that national priorities to improve the populations health. We saw poster for helplines available in the discharge rooms and waiting area.

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 understood how and when to assess whether a patient had the capacity to make decisions about their care. The service had an up-to-date consent and mental capacity policy which included information on general consent and the Mental Capacity Act 2005 (MCA). Compliance with MCA training was 93%, training included dementia awareness, autism and learning disability awareness.

Consultants assessed patients for their suitability for surgery. Consultants provided patients with information on their treatment. Leaflets were provided to patients relating to specific eye conditions that would be treated by the service. The providers website also provided patients with information about eye conditions and treatment.

We saw staff clearly recorded consent in patient records. They provided information on the potential risks, intended benefits and alternative options before each treatment. We reviewed the records of 2 patients who had been for surgery, and found consent had been recorded appropriately. We observed a consultant explaining the procedure to a patient, a good explanation was given including the risks and benefits and the patient had an opportunity to ask questions.

Consent audits were carried out monthly. The service would select 5 sets of notes from a different consultant to review the consent forms. Although audits were not rated the narrative results showed good compliance between September to December 2023. Action plans included reminding staff to sign and print names on consent forms.

Is the service caring?

Good

Our rating of caring stayed the same. 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.

Patients said staff treated them well and with kindness. One patient said they were "happy with the treatment so far and pleased with it all". A relative and patient told us that the hospital had been recommended to them and they had an appointment within 1 week as they were visiting from abroad.

Staff followed policy to keep patient care and treatment confidential. Discussions with patients took place in consulting rooms to ensure privacy and confidentiality. We saw doors were closed when treatment and conversations occurred.

Good

Surgery

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff explaining clearly what to expect during and after treatment.

Nursing staff were kind, caring and compassionate towards patients. We saw staff offering a patient additional time to prepare for the surgery and supported them with their anxiety. Staff explained the procedure and answered all their questions.

We saw staff allowing a relative to stay with a patient throughout the pathway apart from when they entered theatre, and supporting the concerns.

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff had access to interpreting services when needed and information was available in different languages.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback leaflets were available in reception and waiting areas for patients, their relatives, and carers. Every patient was given a feedback leaflet at the end of their treatment pathway asking them to rate their satisfaction with the service, their treatment, the staff and with the level of pre-operative information they were given about cataract surgery.

Patients gave positive feedback about the service those who responded stated they had a positive experience. Between October and December 2023, 95% of patients were happy with the outcome of their treatment and would recommend the hospital. Feedback from patients included 'everyone was very kind and supportive' and 'very satisfied with the treatment received'.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good.

Good

Surgery

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The service had contracts in place with another healthcare provider and a local GP consortium to carry out treatment for NHS patients. Some referrals were made direct from the GP or opticians.

The organisation managed patient referrals on an electronic patient administration system. Patients' information was reviewed to ensure the referral was appropriate for this service. Inappropriate referrals were sent back to the referrer and referred onto an NHS provider.

Managers monitored and took action to minimise missed appointments. From January to December 2023, 1% of patient cancelled or did not attend appointments. The service monitored the cancelled appointment and procedures for trends.

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 was fully accessible to patients with limited mobility and wheelchair users. There were disabled parking bays and accessible toilets. Lifts were available to access the first floor and a wheelchair if required. A hearing loop was in the reception area.

Managers made sure staff, patients, loved ones and carers could access interpreters or signers when needed. Information on interpreting services was readily accessible. Staff had access to a telephone interpreting service, we saw posters informing patients this was available. This was an improvement since the last inspection.

We saw that 1 consultant had learnt some significant words in another language to use during a conversation with a patient whose first language was not English.

Information booklets on a variety of eye conditions and procedures were available, such as how to care for cataracts before and post-surgery. Information leaflets were available in different languages on request. This was an improvement since the last inspection.

Discharge areas had televisions; one area had a television which showed educational videos to provide information for patients.

Private patients were given a box of items following their surgery including, eye mask, roll of micropore, fridge magnet with the hospital's direct number and emergency number and a small note book and pen.

Patients could request a chaperone to accompany them to their appointments. Information on chaperones was displayed in the waiting areas.

Good

Surgery

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.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The waiting times for NHS patients were within the required 18-week referral to treatment time (RTT) target. From January to December 2023 the service completed 5204 surgical procedures; the majority were cataracts. The average RTT for the last 12 months was 6 -8 weeks.

The service monitored waiting times and ensured no one waited too long for treatment. Referral could be made directly from a GP or an optician. Some referrals were made from another healthcare provider and a local GP consortium.

Appointment times were flexible, patients would be offered an appointment for the procedure following the telephone preoperative assessment call with both the nurse and the consultant. Staff would assess the patient's suitability for surgery at this service to reduce risks and complications. This ensured the patients were fit for surgery and reduced delays to their treatment pathway. Some preoperative assessments would be face to face if there were any concerns raised about the patient's condition.

Staff made sure patients and carers understood the importance of caring for the operated eye after treatment and were careful to ensure patients or carers would be able to administer prescribed eye drops.

Surgery times were staggered so patients did not have to wait too long before they were seen, and the waiting area did not become crowded. On the day of our inspection appointments were running on time. This was an improvement since the last inspection.

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. Information on how to make a complaint was available at the service. We saw posters and leaflets in the main reception area and discharge areas clearly advertising how a patient could raise concerns or make a formal complaint.

Any concerns or complaints raised informally were monitored for themes and trends. Staff understood the policy on complaints and knew how to handle them. All staff we spoke with were comfortable in handling complaints and were able to advise what action they would take. All staff were familiar with the duty of candour and stated they were honest and open with patients. This was an improvement since the last inspection.

Managers investigated complaints and identified themes. They would offer the complainant a meeting to discuss the concerns. The service had received 4 formal complaints from January to December 2023.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning included listening to patients and communication.

Complaints were discussed at both the governance and medical advisory committee meetings.

Good

Surgery

Is the service well-led?

Good

Our rating of well-led improved. 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.

There was generally effective leadership at all levels. Leaders demonstrated the required levels of experience, integrity, capacity, and capability needed to manage and lead the service. Leaders understood the challenges to quality and sustainability and took proactive action to address them. Managers demonstrated leadership and professionalism.

The service was led on a day-to-day basis by the hospital manager, who was also the registered manager. They were based full-time within the service. There was a deputy manager, matron and office manager who were responsible for their own departments. Managers attended weekly departmental meetings and monthly management meetings.

There were 3 consultants who were the directors for the service, they all attended medical advisory committee (MAC) or had access to the minutes. The directors had completed a declaration to conform to the fit and proper persons regulation. This was an improvement from the last inspection.

Staff spoke positively of the management team, they told us the manager 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 service.

The service had a clear vision and strategy. The business development plan objectives included:

- Continue to provide a high quality, comprehensive service to all patients, both NHS and private.
- Support the NHS in tackling ophthalmology waiting lists, for example cataract surgery.
- Continue to invest in our staff and services whilst improving operational resilience.
- Explore opportunities to extend our service.
- Continue to deliver positive financial returns to the LLP partners.

There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. This was an improvement since the last inspection.

Staff understood the strategy and quality measures of the service and how it had set out to achieve them.

Staff we spoke with were committed to providing safe care and improving patient experience.

Good

Surgery

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.

Managers supported an open and honest culture by leading by example and promoting the service's values. All staff we spoke with felt supported, respected, and valued. The culture was centred on safety and the needs and experience of patients.

The culture encouraged openness and honesty at all levels within the organisation. Staff told us they felt able to raise concerns and they were listened to by the leaders of the service and that the culture in the organisation had improved since the last inspection. There was a suggestions box where staff could leave comments and suggestions anonymously.

The service encouraged feedback from patients and their carers and reviewed and shared any comments and learning with staff.

The service recognised staff achievements including employee of the month, life events and birthdays. A staff member who had been with the company since it first opened received flowers and a thank you card from the management team. A life coaching session was arranged for staff.

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 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 governance framework was based on a provider-level accountability structure that included the medical advisory committee (MAC), a governance meeting, compliance meeting and management and team meetings. There was a written governance and accountability framework that included guidance on leadership accountability, decision making process and roles and responsibilities. Quarterly meetings were held with external companies who referred patients for treatment to review patient pathways, compliance, audits and outcomes.

The MAC met bi-monthly and provided clinical and professional oversight and a review of all medical practitioners, incidents, complaints, audits and staffing data. We saw minutes of meeting which discussed patient incidents, patients feedback, risks and patient outcomes.

Monthly compliance meetings reviewed audits, complaints, incidents and patient feedback.

Daily safety huddles, weekly departmental meetings and monthly management meetings were held to share information with staff. This was an improvement since the last inspection.

Although policies were monitored by the owner, it was unclear if these were reviewed and approved at a meeting or by a manager.

Good

Surgery

The provider had several service level agreements in place to provide advice, monitoring and audits for example for health and safety, fire, water management and infection prevention and control.

Staff were clear about their roles and accountabilities and timely information was provided and shared.

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.

Systems were used well to monitor and manage performance. The service had effective systems, such as audits and risk assessments, to monitor the quality and safety of the service.

Performance and risks were discussed at all levels within the governance system. A programme of clinical and internal audit was undertaken to monitor quality, operational processes, and systems to identify where action should be taken. Records showed audits were discussed at various management and staff meetings.

There were arrangements for identifying, recording and managing risks and monitoring mitigating actions. The service had a risk register which used a tool to identify the impact of the risk on the service and assigned a level of risk. Examples of risks included the use of bank staff, use of prescription pads and COVID-19. The risk register included mitigations and was regularly reviewed by hospital managers as part of the governance structure. This was an improvement since the last inspection.

The service had a business continuity plan that could operate in the event of an unexpected disruption to the service.

Information Management

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

There were arrangements to ensure data or notifications were submitted to external bodies as required. The information used in reporting, performance management and delivering quality care was consistently accurate, valid, reliable, timely and relevant. The service held information electronically on all aspects of the service including incidents, complaints, mandatory training, and audits. All staff had access, with secure logins, to the organisation's intranet to gain information relating to policies, procedures, national guidance and e-learning. Staff knew to log out of computers when they were left unattended.

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 information governance training for staff.

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 engaged with patients and staff to ensure people's views and experiences were gathered and acted upon to improve services. Complaints had been reviewed by managers and responses given to patients.

Good

Surgery

Patient feedback was encouraged and patients were given a feedback leaflet at the end of their treatment with a stamped envelope to return the forms. Most feedback was positive, and results and comments were shared with staff.

For example, patients said they would like lockers to store belongings when they attended for a procedure. Lockers were now available near theatre for patients to store their belongings.

Staff feedback was sought via an annual staff survey, staff said they were proud to work for the organisation and felt they made a positive impact on patients. We saw an action plan which included implementing a suggestion box for staff, introduction weekly team meetings and quarterly management meetings and recognition for good work. The service acknowledged and celebrated staff life events such as birthdays and long service awards.

The provider held team building events, away days and social events. Staff carry out charity events such as marathons and donations of hampers for the local community.

Learning, continuous improvement and innovation

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

Staff throughout the organisation told us they were committed to learning and improving. There was a focus on growth, patient care and improving service.

Since the last inspection we found the following areas had improved;

- **Patient medical records were generally secure at all times in locked cabinets and locked rooms.**
- **Patient records were in line with General Medical Council standards they were legible, signed, dated and complete.**
- **The provider had a risk register in place to record, manage and mitigate ongoing risk.**
- **The provider had a sepsis policy in place with sepsis toolkit and provided training for staff.**
- **The provider had documented evidence that directors conform to the fit and proper persons regulation.**
- The provider held regular staff team meetings to ensure staff were engaged and informed with regards to strategic direction, incidents, complaints, performance and risk.
- The provider had specific staff competency ensure staff know their roles, responsibilities and identify areas for development.
- The provider had written information and materials (including signage) for people with visual impairments.
- The provider had access to a professional translation service for all non-English speaking patients.
- All staff had training on the duty of candour regulation and female genital mutilation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not stored safely and securley. We found medicines in unlocked cupboards, on top of cupboards in the stores room and in storage boxes. Although the rooms were locked, all staff had access.