Leeds Newmedica Limited

Newmedica Community Ophthalmology Service

Inspection report

St Martin's House Medical Centre
210-212 Chapeltown Road
Leeds
LS7 3JT
Tel:

Date of inspection visit: 12 July 2022
Date of publication: 09/09/2022

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

Ratings

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

Summary of findings

Overall summary

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in most key skills, understood how to protect patients from abuse, and managed safety well. The service had agreed systems and processes in place to safely prescribe, administer, record and store medicines and infection risk. The service had a robust process for safety incidents and lessons learned.
- Staff provided safe care and treatment and made patients comfortable when needed. 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 useful 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 and carers.
- The service planned care to meet patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Governance processes were in place, however, we found that the audit processes for some areas needed further development. 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 to plan and manage services and all staff were committed to improving services continually.

However:

Surgery:

- Performance meetings were not documented and shared with the respective NHS Trust.
- Two medical staff had not had regular appraisals and the staff competency documentation seen did not contain ticks against each competency completed by staff.
- Not all patients received postoperative follow-up calls and where a patient did not respond another attempt was not made to contact the patient.
- We did not see evidence that a set number of patient records had been audited to confirm whether the records were fully completed, signed, dated and contained all the relevant information pertinent to that patient.
- Shortfalls identified either as a result of audit processes or patient experience exercises were not identified against an action plan.
- Some action plans were not implemented, for example, Legionella risk assessments, and if present, for example, medicines management audits did not confirm all recommendations were completed.
- The business continuity policy was past its review date.

Outpatients:

- Within the storage area we observed some items stored on the floor, which would have made cleaning less effective.
- In the minor operations room, we found some items of equipment were out of date.
- The service did not undertake audits for the completion of consent information.
- Some staff were unfamiliar with the local (Leeds) vision involving the role of 'patients, people and partners.
- The service had not completed a risk assessment for the use of latex gloves to reflect HSE guidance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	See the summary above for details. We rated this service as good overall and good for being safe, caring, effective, responsive and well-led.
Outpatients	Good 	See the summary above for details. We rated this service as good overall and good for being safe, caring, responsive and well-led. Effective is not rated in outpatients.

Summary of findings

Contents

Summary of this inspection

Background to Newmedica Community Ophthalmology Service

Newmedica Community Ophthalmology Service in Leeds is an independent provider registered with CQC since 2019 and this is the first inspection since registration. The registered manager is registered across two locations in Leeds and Wakefield.

The inspection was announced on the Thursday before the inspection on the following Tuesday. The inspection was announced to ensure that we could inspect both the surgical and outpatients' services as we were aware that surgical sessions took place on specific days. The surgical sessions took place every weekend, Tuesdays and alternate Wednesdays. Outpatient activity took place throughout the week.

The service provides a range of ophthalmic treatments for NHS and other funded (insured and self-pay) adults. The services provided include:

- General ophthalmology and cataract surgery including pre- and post-operative assessment.
- Yttrium aluminium garnet (YAG) laser treatment. YAG laser capsulotomy is a type of laser treatment that is used to make a hole in the capsule to allow light to pass through to the back of the eye to improve vision. The YAG laser is used as the final part of the cataract surgery.
- Ocular hypertension and glaucoma treatment and monitoring
- Eyelid and tear duct surgery
- Medical retina services – for conditions that affect the back of the eye
- Oculoplastic, (which is a broad term for several surgical procedures on the eye and the surrounding structures, including the eye socket, eyelids, tear ducts, and parts of the face) and medical retina.

The hospital is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

• Surgical procedures

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited one location, looked at the quality of the overall environment and observed how staff were caring for patients.
- Spoke with the Registered Manager, Nominated Individual and members of the senior management team.
- Spoke with 18 staff members.
- Reviewed 13 patient care records and treatment records.
- Observed part of five patient surgical pathway sessions
- Attended one theatre briefing
- Observed one surgical procedure.
- Spoke with five patients.
- Looked at a range of policies, procedures and other documents which related to the running of the service.

Summary of this inspection

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

Areas for improvement

Action the service SHOULD take to improve:

Surgery:

- The provider should ensure that all Legionella risk assessments recommendations are actioned so that full compliance is achieved.
- The provider should ensure that all meetings with the local Trusts are documented, agreed and shared with the respective NHS Trust.
- The provider should ensure that the competency documentation contains ticks against each competency completed by staff so it is clear that all competencies have been achieved.
- The provider should ensure that all patients receive postoperative follow-up calls and where a patient does not respond another attempt made to contact the patient.
- The provider should ensure that patients records are accurate, complete and contemporaneous, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- The provider should ensure that action plans including updated action plans are available following medicines management audits so they can be assured that all the recommendations have been completed.
- The provider should ensure that all staff including medical staff have regular appraisals.
- The provider should ensure that the business continuity policy is reviewed in line with business policy.
- The provider should ensure that were shortfalls are identified either as a result of audit processes or the patient experience exercises action plans are identified, managed and monitored.

Outpatients:

- The provider should ensure that within the storage area items are not stored on the floor.
- The provider should ensure that in the minor operations room, out of date items of equipment are removed.
- The provider should ensure that the storage area for clinical waste outside the building is kept tidy.
- The provider should ensure that the risk assessment for the laser room includes the risk presented by reflective taps.

Summary of this inspection

- The provider should consider liaising with each of the NHS trusts in its area to track the completion of patients' treatment.
- The provider should ensure that audits are undertaken for the completion of consent information.
- The provider should ensure that it develops staff understanding of the local (Leeds) vision involving the role of 'patients, people and partners'.
- The provider should consider resuming cultural events following the pandemic.
- The provider should ensure risk assessments are completed for the use of latex gloves to reflect HSE guidance.
- The provider should explore further ways of increasing the proportion of patient survey forms returned.
- The provider should explore opportunities of developing further engagement with external stakeholders.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

Mandatory training

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

Managers monitored mandatory training and alerted staff when they needed to update their training. The mandatory training target was 95% for Newmedica staff and 80% for bank nurses. Training records were kept on the company's human resources system. Individual staff members mandatory training years commenced the month they commenced employment and thereafter. Staff and human resources were informed by email when the mandatory training subject was due to be completed.

Staff received and kept up to date with their mandatory training and training statistics for 2021/22 confirmed 98.52% of employed staff had completed their mandatory training for this year. Bank staff compliance was at 80.11%.

Managers said consultants with substantive NHS roles attended mandatory training at their NHS trust, which was monitored corporately through the appraisal process and consultants provided evidence of this training to Newmedica.

Mandatory training was comprehensive and met the needs of patients and staff. However, staff told us that they did not complete stand-alone sepsis training. The staff training which related to level 2 infection control training confirmed sepsis, antimicrobial resistance, healthcare associated infections and personal protective equipment were all subjects included within this training subject. Sepsis posters were displayed throughout the service. The level 2 infection control training was completed by 89% of staff. (monthly mandatory training report, June 2022).

The provider confirmed all staff would be completing sepsis training planned for the next all-stop day on the 22 July 2022 where face to face sepsis training would be delivered by a qualified healthcare professional. The infection control policy also contained a section detailing how to spot the signs of sepsis.

The staff training needs analysis identified staff groups and the required training subjects.

Mandatory training matrix updates had taken place. The June 2022 mandatory training matrix report identified the changes to the current matrix. These changes were communicated clearly and recognised new statutory training requirements such as the introduction of learning disability and autism awareness training sessions from the 1 July 2022.

Staff said, although, not currently included as a mandatory training subject online autism awareness training from e-learning for Health was being rolled out for staff from the 11 July 2022. Clinical staff had completed training on recognising and responding to patients with dementia. The report recognised that there was no equivalent module for learning disabilities, however, content aligned to the framework was covered in the human rights section of 'Equality, Diversity and Human Rights level 1' training which had been completed by 96% of staff. (Monthly mandatory training report, June 2022)

The training matrix for bank staff was colour coded. The colour coding confirmed whether the training was due or whether the bank staff member had not completed the training subject. We saw evidence of the mandatory training subjects bank staff had completed.

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.

The National Safeguarding Lead was trained to level 4 and supported local teams with advice and facilitated the sharing of any learning across the teams. All reports of safeguarding concerns are reported to the Quality Management Committee for discussion. (Quality Report 2021/22)

Staff received training specific for their role on how to recognise and report abuse. Training statistics confirmed that staff including bank staff had completed training in adults and children's safeguarding training at either level 1, level 2 or level 3 dependent on their role. All patient facing staff completed level 2 adults and children's safeguarding training. The administration staff had completed level 1 adults and children's safeguarding training. Two staff had completed level three adults and children's safeguarding training. The module compliance identified in the June 2022 monthly mandatory training report confirmed all staff had completed the adults and children's safeguarding modules relevant to their role.

Local and national safeguarding leads were identified and could be accessed by staff.

Staff were informed by appropriate guidance which included local adult and children's safeguarding guidance and female genital mutilation (FGM) guidance. Local safeguarding teams contact information was stored in the managers room. In addition, all staff had completed the preventing radicalisation level 3 – adults training and conflict resolution training. (June 2022 – Monthly mandatory training report)

Staff said there had been no safeguarding events over the last 12-months, however, should concerns be raised staff said they would talk with the local authority safeguarding team and submit a safeguarding referral to this team. Following a safeguarding event staff said the learning from this event was shared across both the Wakefield and Leeds sites of Newmedica.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff said patients with specific needs or characteristics were identified through the referral process. These characteristics and / or needs were identified on their patient record and referral forms.

Documentation confirmed all staff and consultants had disclosure and barring checks completed and updated as required.

Good

Surgery

Cleanliness, infection control and hygiene

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

The clinic was visibly clean and had suitable furnishings which were clean and well-maintained.

There were no reported cases of MRSA, MSSA or Clostridium difficile within the Leeds Newmedica Community Ophthalmology Service during 2021/22.

The monthly mandatory training report confirmed all staff had completed level 1 infection prevention and control (IPC) training and all except one staff member had completed level 2 IPC training by June 2022.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore PPE, which included gloves, masks and apron's when treating a patient. We observed -one patient's surgical pathway experience from arrival to discharge and noted that clinical staff wore masks and gloves throughout this process. Staff cleaned the local environment and equipment, after patient contact.

Hand gel was located throughout the practice for the use of staff and patients. We observed different staff members frequently gel their hands. Clinical staff's arms were also bare beneath the elbows. Handwash guidance was displayed above sinks.

Cleaning services were provided through property management company and agreed through a service level agreement with the GP service. Cleaning schedules identified cleaning regimes, for example, a monthly theatre cleaning schedule was in place with records which confirmed this cleaning had taken place.

Cleaning audits for demonstrated good standards of hygiene were being maintained with compliance identified as between 99% to 100% compliance from April to June 2022.

Compliance levels of 99% and 100% respectively were awarded following the health and safety and waste and sharp management audits which took place in March and May 2022 respectively.

Infection control during the Pandemic audits were carried out From October 2021 to May 2022; compliance ranged from 93% to 100%.

Health and Safety Executive Legionella risk assessments had taken place on the 4 July 2019. The Legionella risk assessment review date was the 3 July 2020. Actions were identified following this inspection; however, we saw no evidence these actions were actioned to achieve full compliance. Since the inspection the manager arranged for the Leeds Newmedica location to have another Legionella risk assessment and this is planned for the 8 August 2022.

Staff confirmed that weekly checks included flushing taps and the shower which were documented.

Hand hygiene audits compliance over the last 12 months was between 97% to 100%.

Reusable instruments were sent to an external Independent Health provider for decontamination. Despatch issues reports for decontamination, wash area return's reports confirmed reusable instruments were being managed effectively. Decontamination policy guidance was also available to advise staff.

Good

Surgery

In response to Covid, the service had followed NHS guidance. Staff completed twice weekly lateral flow tests and continued to wear personal protective equipment. We observed patients and visitors prior to entry to the clinic were given a choice around mask wearing and all were temperature checked.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance, Health Building Notes 10-02-day surgery facilities. Clinical and consultation rooms allowed for patient privacy. The outpatient's consultation rooms were located on one side of the clinic, whilst the theatre and minor surgery areas were located on the other side. A large waiting area which had seating well-spaced was located between both operational areas.

We observed close circuit television on the premises and saw entry to clinical rooms was via an electronic key fob to ensure the premises was secure. Patients and visitors were greeted by a staff member and the necessary checks made prior to being allowed entry into the clinic waiting area.

The building was compliant against the Equality Act 2010, for example, toilet areas had call bells in place should the patient require assistance and these facilities could accommodate patients with disabilities.

A daily checklist was in place for clinical assistants which involved testing of the nurse call bell system and room cleaning. We saw that these checks were completed.

Portable appliance testing records confirmed checks took place on the 17 June 2022. The lift's last service was on the 22April 2022.

Equipment service schedules confirmed the service for the Infiniti Repro was 14 October 2021 and for the microscope the 19 November 2020. The provider said the 2020/21 service on the microscope was due.

A positive pressure ventilation system was present in the theatre and dirty utility areas. This system was serviced on the 8 March 2022 and found to be in working order.

Audit data confirmed checks by the provider and an external company took place against the resuscitation drugs and trolley. Actions were identified from both audits which included the removal of expired items. During the visit we saw the resuscitation trolley was secured by a plastic tie which was replaced after each use or when the resuscitation trolley was checked. Resuscitation equipment records check lists confirmed daily checks had taken place. We also undertook random checks of the resuscitation equipment and found all the equipment and medicines to be in date.

Business continuity plans were in place.

Clinical waste was tagged and disposed of safely through an external provider.

Controlled substances hazardous to health (COSHH) were locked in a separate cleaning cupboard which could only be accessed by designated people at the clinic. A COSHH file was available which informed staff about the COSHH substances in use.

Good

Surgery

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 confirmed that protocols were in place for emergency, sepsis and cancer patients. The 'situation, background, assessment, recommendation '(SBAR) tool was used for the escalation of care and treatment amongst all healthcare professionals in Newmedica.

Staff confirmed and we saw a call bell system and panic buttons to alert staff should a patient deteriorate. A staff member dialled 999 for an ambulance and the patient transferred to the local NHS Trust. Staff said there was always an immediate life support trained staff member on duty.

Clear guidance advised on 'How to run a cataract service'. Patients preoperative risk assessments identified potential risks and whether the patient met the referral criteria. Cataract categorisation (categories 1-4) was part of the local safety standards applied preoperatively and identified levels of complexity, for example, category 1 was any straightforward cases.

Staff said and we saw through observation of the patient journey health problems were identified at the patient's preoperative review. If the patient exhibited health issues, they were referred to their GP and investigation results awaited before they could attend for surgery at the clinic. Through our observation of the patients journey we observed that several checks took place prior to the patient's treatment taking place. Some checks included rechecking the patient's consent, confirmation of which eye was being treated, allergies, a temperature check on arrival and a check of the patients' blood sugar.

An onward referral clinical support (April 2019) service level agreement was in place with a local Trust which was approved by the Trust in December 2020. Staff said this agreement was reviewed with the local NHS Trust verbally, however, no written minutes existed of these conversations.

An agreement was in place with a local NHS eye casualty to see patients overnight should concerns be raised. Patients were also given an emergency number to call out of hours.

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared key information to keep patients safe when handing over their care to others through safety huddles which took place twice daily. Surgical team brief's took place in the theatre prior to surgery commencing.

Evidence seen confirmed compliance with the 5 steps to safer surgery. The tools used included the surgical safety checklist; checks preoperatively as to which eye was to be treated and the eye was marked by the consultant. The service had audited the use of the surgical safety checklist from January 2021 until December 2021. The outcomes were:

- Cataract WHO Checklist, the service (St. Martin's and Wakefield) had an average performance of 100%.
- Minor Ops Consent and WHO Checklist, the service (St. Martin's and Wakefield) had an average performance of 87%.
- Oculoplastics Consent and WHO Checklist, the service (St. Martin's and Wakefield) had an average performance of 86%.

Confirmation of capacity to consent was the reason why the service performance remained under 100%. The service had discussed the gap with consultants who were completing minor operations activities

Cataract audit checklists from March to May 2022 compliance levels were identified as 94% (May) to 100%.

Training statistics confirmed staff had completed training to enable them to respond to the deteriorating patient. Two consultants were advanced life support trained, two permanent staff and six bank staff were immediate life support trained, whilst, all staff had completed adult basic life support training.

Staffing

The service had enough nursing, allied health professional 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.

Staff confirmed the service had enough nursing, allied health professional, administration including support staff to keep patients safe. The lead theatre practitioner provided line management, support and mentorship of the clinical team. Guidance in the 'Pathway delivery book (v1) identified proposed staffing for each scenario, for example, theatre, clinic, follow-up sessions. This staffing model was adopted by the service.

The manager could adjust staffing levels daily according to the needs of patients. We asked to see the actual verses planned levels of staff information, however, the information provided in the Leeds People's Report – May 2022 only provided the actual staff employed. The report confirmed the number of employees as 28 supported by a team of four managers.

The Newmedica people flow chart clearly identified the people structures within the service. The service was led by two clinical directors and one operational director who was also the registered manager. Three additional managers included a patient's services manager, clinic services manager and lead theatre practitioner. A human resources lead was also based on site.

Additional staff included two senior ophthalmic assistants, six ophthalmic assistants, one senior clinic assistant and two clinic assistants. The administration team comprised of six administrators, a patient services co-ordinator and two reception staff.

On the day of inspection theatre staffing included two registered nurses and one runner which staff confirmed this was normal practice. One registered nurse saw the patient preoperatively; whilst the operating department practitioner was available for post-operative patient support.

The service had appointed 12 people since January 2021; Three staff had left the service in the same time period. We reviewed the personnel file and the recruitment checks undertaken for one new staff member and noted that all the necessary checks were completed prior to them starting in post. However, we observed that some of the ticks were missing to confirm that this person had achieved competency on the competency documents, although the documents were signed and dated by the employee and doctor undertaking the assessment.

Monthly sickness levels from January 2021 to May 2022 were mainly low and ranged from 0 to 1.4% (0 to 7 days sickness). The highest sickness levels took place between December 2021 to March 2022 when 13 – 16 days per month.

Bank staff were employed to provide additional support where needed. Managers limited their use of bank staff and requested staff familiar with the service. Staff said that all bank staff completed local inductions where they worked through the assigned competencies specific to their role. Bank staff also completed a shadow shift on their first shift.

Good

Surgery

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 was led by a lead clinical director and a clinical director. In addition, two consultant staff were employed to work within the service.

Recruitment and approval processes of medical practitioners included a policy for the engagement of doctors (v01). We observed that employment checks took place and reference to the Medical Advisory Committee for approval of each medical practitioner was identified within this guidance. We reviewed two medical practitioners' personnel files and noted that all the necessary pre-employment checks were made for both consultants.

The service had enough medical staff to keep patients safe. The service was supported by locum consultants and one associate specialist. These medical staff were bought into the service to undertake clinics for the service and on occasion operate. Information provided in the Leeds People's Report – May 2022 confirmed that in May 2022 there were 12 locum consultants including one associate specialist who worked within the service.

Locum consultants provided additional support where needed. Staff said that new locum consultants completed local inductions. New consultants were supervised at their first theatre list and the second theatre list was reduced.

The service had a consultant on call during evenings and weekends. The May 2022 clinicians' rota confirmed how many and which consultants and associate specialists covered outpatients and theatre days. The service triaged patient calls to ensure that the patient was directed to the right person. An agreement was in place with a local NHS eye casualty to see patients overnight should concerns be raised.

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.

Records were stored securely and could be accessed by staff easily. A mixture of paper and electronic patient records was in use at the clinic. Staff confirmed that any paper records such as the 'cataract pathway' were kept and archived.

We reviewed five patient records and saw confirmation that consent, pain management, patient involvement and multi-disciplinary team input was documented in the records. Two patient records showed some shortfalls in information which related to the postoperative follow-up call. One patients' notes did not identify whether a postoperative follow-up call had taken place; the second patients records identified 'no answer' to the follow up call made.

The Leeds service dashboard, governance and quality report 2021/22 confirmed 100% of discharge and update letters were generated and sent within 48 hours of the patients discharge or outcome of their consultation.

Documentation audits around patient consent and the World Health Organisation surgical safety checklists were completed. The 8 July 2021 and 11 March 2022 audits identified some recommendations for these audits. The 11 March 2022 audit did not identify any specific progress made since the 8 July 2021 audits recommendations. Action plans were not identified for each audit.

Good

Surgery

We did not see evidence that a set number of patient records had been audited to confirm whether the records were fully completed, signed, dated and contained all the relevant information pertinent to that patient.

Medicines

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

Newmedica had a chief pharmacist contracted through a registered pharmaceutical advisory service. This service included annual medicines management audits, observational audits of medicines management, procurement support, patient group directions/prescriptions, policy development and technical advice.

The service could access on on-site pharmacy as this service was located on the first floor of the building which also accommodated a GP surgery. Staff said this meant patients if they required prescriptions could access them from the onsite pharmacy.

Medicines management policies and procedures were in place. Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up to date. Patients allergy status was checked preoperatively and documented in their notes and on the front sheet sticker.

The day surgery prescription charts identified the patient's details, including allergies and patient weight. When medicines were prescribed to take home, the prescriber identified the medicine, frequency, batch number and expiry date of the medicine, signed and dated each prescription.

Staff stored and managed all medicines and prescribing documents safely.

FP10 prescriptions were locked away when not in use. The FP10 prescription and outpatient's prescription pads were held at the main reception during the day. When used the patient details were documented in a book. This information was then transcribed onto a spreadsheet daily.

The medicines cupboard and the medicines in the resuscitation trolley were secured. The pharmacy cupboards contents were in date and a system of rotation in place. We were told that all staff were responsible for ensuring that stock was rotated; a designated staff member monitored this at the weekly Monday check.

Fridge temperatures were recorded daily, and room temperature checks took place, were recorded and satisfactory.

The service did not use controlled drugs.

Staff learned from safety alerts and incidents to improve practice.

The last internal medicines management audit on the 6 June 2022 confirmed 100% compliance. Medicines management was also audited by an external pharmacy provider. This last took place on the 4 March 2022 and resulted in some recommendations. The provider did not provide an updated action plan to confirm that all the recommendations were actioned.

Monitoring of formulary compliance and critical medicines were completed quarterly.

Good

Surgery

Incidents

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

A corporate incident policy was in place. The central governance team informed services across the UK on incidents so that sharing could be shared, and learning identified. Incidents were discussed monthly at both the corporate quality management committee and medical advisory committee. Incidents were also discussed at staff meetings and managers said staff would be debriefed and supported after a serious incident. To-date, the service had no serious incidents.

An incidents register was in place. We tracked one incident with staff and saw follow-up was identified as part of the incident review process.

Incidents learning was captured and displayed in the clinic. Leeds recorded 43 incidents from the 1 April 2021 to 30 June 2022 which related to a mixture of events, for example, patient accidents, administration, behaviour, clinical practice and procedure.

Staff said should an incident occur the incident would also be documented in the patients notes, in the patient's electronic record and the incident reporting system.

We asked staff about their knowledge of the 'Duty of Candour' and staff were aware of what it meant and how to implement this. Staff knew this meant they were open and transparent and gave patients and families a full explanation when things went wrong.

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

Are Surgery effective?

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. National Institute of Clinical Excellence and the Royal College of Ophthalmologists guidance was in use. We selected random policies, protocols and procedures and we found they were in date and had been reviewed three-yearly.

The patient access policy identified the management of referrals and admissions to the service and the responsibilities of Newmedica staff. The policies aim was to ensure fair and equal access to services for all patients and ensure it met its obligations towards people who had had or have disabilities under the Equality Act (2010). We asked staff how they ensured patients could access the service and reasonable adjustments made and were told patients with specific needs or characteristics were identified at the initial referral screening process so that decisions could be made around the required support and access needs.

Good

Surgery

The service participated in national audits; the national ophthalmology audit for 2020-2. Please see the audit outcome in patients' outcomes section.

Patients were given guidance sheets specific to their treatment and advice as to what they should do in an emergency.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Day case patients used this service. Due to the patients limited stay they were not offered meals. Water and hot drinks were available should the patient require them. Staff said post-surgery patients would be offered a drink and biscuits.

The day following surgery patients were contacted by the clinic staff by phone to ask about their recovery and whether they had any concerns or experienced post-operative nausea and vomiting. If nausea and vomiting was experienced the clinic would follow the emergency referral protocol so that the patient was seen.

Pain relief

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

During our observations of patient consultations, we observed that staff asked if the patient was in pain and made sure they were comfortable before proceeding.

The day following surgery patients were contacted by the clinic staff by phone to ask about their recovery and whether they had any concerns or experienced post-operative pain. If they had the patient would be asked to reattend the clinic within 24 hours to be seen by a consultant.

Pain management audits were not completed by the service.

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 had been accredited under relevant clinical accreditation schemes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. A regular programme of internal audits was undertaken to monitor quality assurance. The findings were used to benchmark against standards and guidelines set by relevant national bodies such as the Royal College of Ophthalmologists (RCOphth) and National Institute for Health and Care Excellence (NICE). Audits were presented and discussed at the Medical Advisory Committee. Clinical monthly audits included cataract pre-assessment and consent, cataract World Health Organisation check list and the Consent Audit for Oculoplasty.

In 2021, for the first time, the service participated in the National Ophthalmology Database (NOD) Audit. The data collected was for surgeries completed during the period 1 September 2019 to 31 March 2021.The audit reported on posterior capsular rupture (PCR) rates. PCR is a break in the posterior capsule of the lens, which can occur as a

complication of cataract surgery. This benchmarked and assured the service, commissioners and patients, of outcomes and complication rates following cataract surgery by individual surgeons and drive continual improvement. The national ophthalmology audit confirmed that Newmedica scored 0.32% against the NHS average of 0.67% for adjusted posterior capsular rupture (PCR).

Patient outcomes were monitored using the NOD audit which the service said they benchmarked these outcomes against other services.

Patient experience was monitored through patient feedback (29% of patients responded, 100% recommended the service to friends and family).

In 2021/22 three additional monthly clinical audits were undertaken all of which confirmed good levels of compliance. (Quality Report 2021/22)

The Quality Report (2021/22) confirmed additional audits which had taken place and compliance. These included: quarterly consent (100%), monthly hand hygiene (100%), monthly theatre scrub (100%) and annual infection control audits (95%). Managers shared and made sure staff understood information from the audits. The service participated in relevant national clinical audits.

Newmedica reported data to the Private Healthcare Information Network (PHIN) on a voluntary basis, in the interests of transparency. (Quality Report 2020/21)

We found no evidence which confirmed that complication rates were higher than expected. The Leeds dashboard (June 2021 to June 2022) recorded complications; over the 12-month period 23 complications were recorded.

Feedback from the integrated care system ensured key performance indicators were being met against the service provided.

Audit and other types of feedback was given to staff through local clinical governance committee meeting minutes, for example World Health Organisation surgical safety audits, consent and hand hygiene audits, patient and incident feedback.

Newmedica undertook a mock CQC inspection in February 2020 which resulted in some recommendations to further develop the service.

The service collected and submitted discharge data to the Private Healthcare Information Network.

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.

The service policy for training, experience and qualification of staff provided clear guidance to ensure all staff both permanent and locum could access the necessary training and support for their respective roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Good

Surgery

The service supported four medical trainees onsite which included pre-registration optometrists and surgical trainees. The surgical trainees attended the clinic on Tuesdays.

Newmedica is a designated body for the revalidation of doctors. A responsible officer (RO) and appraisal leads had been appointed. The RO, appraisal lead and appraisers were supported by the human resources team. Revalidation dates were confirmed for nine of the 11 bank consultants.

Registration status for qualified healthcare professionals including consultant staff was checked which confirmed all registrations were active and within their expiry date. We reviewed three personal files which confirmed the necessary checks were completed and registration status was active.

The provider confirmed that each surgeon's performance was monitored through submission of cataract performance to the National Ophthalmology Database on an annual basis, which allowed open comparison of the surgeon's performance by the Royal College of Ophthalmologists, referrers, patients and any potential future employer of a surgeon. In addition, since 2018 the service had submitted private patient outcome and performance data to PHIN.

Staff confirmed that locum consultant staff provided a copy of their latest annual appraisal. Both clinical directors' appraisals were completed through the NHS Trust they were contracted to and remained to be completed. We saw that two doctors were overdue a clinician appraisal which had been due in 2021.

Managers gave all new staff a full induction tailored to their role before they started work. We saw examples of the induction and competency documents tailored to each staff member's needs.

Managers supported staff to develop through yearly, constructive appraisals of their work. We received confirmation that 100% of staff had received an appraisal in 2021. The appraisal process for 2022 had commenced and we saw most staff had their appraisal. The remaining staff were either scheduled for their appraisal or on probation. The appraisal information provided also confirmed three staff members appraisals were still required to be scheduled.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Discussions with staff confirmed they felt supported and had been able to develop their skills throughout their time in the service. Training certificates confirmed that individual staff had completed training in areas such as fire marshal, immediate life support and level 3 vulnerable adults safeguarding training.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held multidisciplinary meetings with the local integrated care system commissioners and two NHS Trusts to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, the service had links with local sight loss charities and had a good relationship with the eye clinic liaison officers who provided emotional support for patients diagnosed with sight loss.

Good

Surgery

The service worked closely with and supported pre-registration optometrists and medical trainees attended the clinic every Tuesday from the NHS Trust.

The service also worked closely with the pharmacy which was based on the ground floor of the building in which the clinic was based.

Seven-day services

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

The service operated seven days a week. The clinical directors operated alternate weekends and every Tuesday surgery took place from 8am until 8pm.

Patients were reviewed by consultants prior to surgery and postoperatively.

Staff could call for support from doctors and other disciplines seven days a week.

The pharmacy located on the ground floor of the building operated five days per week.

Health promotion

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

Staff said they did not provide information directly to assist patients lead healthier lives, however, there had been a healthy eating initiative prior to the pandemic.

Staff assessed each patient's health prior to and at every appointment confirming their previous medical history and asking whether they had any health concerns they needed to raise.

Information was shared with other healthcare professionals prior to their surgery to ensure the patient was as fit as possible for surgery.

The service ensured that national priorities to improve the populations health were supported. This support included dementia champions, the creation of a dementia charter and patient information on falls, weight watching and smoking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Discussions with staff and the June 2022 monthly mandatory training report confirmed to-date 77% of staff had completed training in the Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and ensured that patients consented to treatment based on all the information available. We observed preoperatively that staff checked with patients they were informed about the procedure and understood the risks.

Good

Surgery

Staff clearly recorded consent in the patients' records and this was confirmed by the presence of signed consent forms in the five patient records we reviewed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff told us that a person's mental capacity was identified initially at the pre-operative assessment process. If there were concerns about a patient's mental capacity two consultants would review and take part in the consent process with the patient.

Policy guidance on consent and mental capacity was available for staff to refer to.

We also saw that consent form 4 identified exclusion criteria which was clarified at the patient's initial referral. Should the patient have mental capacity shortfalls the patient would be referred to more appropriate services such as the NHS.

Patient consent audits which took place in 2022. Two of the consent audits scored 75% (April 2022) and 87% (November 2021) because the consent form for oculoplastics had changed and the audits findings confirmed that the forms were not fully completed.

The April and May 2022 Cataract pre-assessment and consent audit's compliance was 97% and 96% respectively. Five patients' forms were reviewed, and shortfalls found in some patients' documentation as patients had not printed their names on the consent form.

Are Surgery caring?

Good

Compassionate care

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

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

In June 2022, 100% of patients confirmed they were treated with dignity and respect by staff.

Chaperones were also available for patients if they felt they needed additional support.

We spoke with five patients who all said they had been treated with respect and felt fully informed. Patients said they understood the procedure and what to expect following their procedure.

We observed parts of the patient's surgical journey for five patients and observed the clinician was respectful and respected the patient's dignity.

Staff checked the patient's comfort and condition throughout their surgery.

Good

Surgery

Training records confirmed that 96% of staff had completed level 1 equality, diversity and human rights training to enable them to support the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

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

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

We observed five patients sessions where patients appeared at ease and were comfortable to ask questions. The clinician discussed potential side effects of the treatment, answered the patient's questions and was seen to reassure the patient throughout their consultation.

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 said advocacy could be accessed; the request for an advocate was identified at referral.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Language line telephone and insight video translating services were available to patients, families and carers. Leaflets about the conditions treated and post-operative care recommendations were available in several languages.

Guidance in supporting people with dementia type illnesses was available for staff and carers.

Patients with sight and hearing loss could receive additional support through the eye clinic liaison officer.

Procedures were discussed with patients before and during treatment. The five patients we spoke with all said they understood and had felt fully involved in the discussions about their proposed treatments.

The private patient coordinator ensured that private patients were informed of treatment costs.

Private patients received terms and conditions which included details on fees and payments.

In June 2022, 97% of patients said they were involved in decisions about their care. The remaining 3% of patients answered this question as neither likely or unlikely.

Patients gave positive feedback about the service, which we saw through the thank-you cards, the patient survey and from discussions with patients.

Are Surgery responsive?

Good

Surgery

Good

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. Service provision for the local area was discussed and agreed with the local integrated care system commissioners. Service provision was mainly (99%) for NHS patients. Limited self-funded patients accessed this service.

A protocol was in place with local Trusts for emergency cases and cancer pathways.

Facilities and premises were appropriate for the services being delivered. The facility has six consulting rooms, a patient reception and waiting area and designated theatre providing cataract surgery and oculoplastics.

Free local parking was provided at the local Sikh temple which was walking distance to the clinic.

The service had procured a new telephone system to monitor and improve phone call answering performance.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. From April 2021 to March 2022 316 or 10% of new appointments were not attended; 303 or 12% of patients did not attend their follow-up appointment.

The service relieved pressure on other NHS departments as they could treat patients in a day.

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 complied with the Accessible Information standard.

Staff made sure that should patients living with mental health problems, learning disabilities and dementia, attend the service they would receive the necessary care to meet all their needs. Staff said that where patients had additional needs such as these, they were identified at the initial referral stage and if the patient was accepted, they could bring a carer / relative with them to the appointment. However, where patients had several additional needs, they would often be referred to the NHS to ensure that all their needs could be met.

The service had identified a dementia champion and dementia friendly signage was also in place, for example, a large clock was displayed in the waiting area. Staff said the service had used the dementia friend's environment checklist tool to educate their understanding and ensure that the environment was dementia friendly. This is me documentation was in place for those patients who required it.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff could access interpreters through language line to ensure effective patient involvement, communication and involvement at their consultation.

Patients with a visual impairment could receive information in a braille format and large print information leaflets.

Patients with a hearing impairment could request the use of hearing loops.

Patients could access patient transport when necessary.

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.

In 2021/22, the service delivered 160,649 patient interactions including outpatient appointments, diagnostic testing and eye surgery. (Quality Report 2021-22)

The Leeds service dashboard, governance and quality report for the time period 1 April 2021 to 31 March 2022 confirmed 3813 referrals, 78 of which were secondary care referrals; 2966 new patient attendances and 2180 follow-up patient attendances. In total, 3011patients were listed for surgery.

Newmedica continued to receive a significant number of transfers of patients from acute NHS providers, often inheriting long waits. To ensure equality of access, patients transferred from existing NHS waiting lists were treated in chronological order, with new referrals not disadvantaging those patients waiting the longest for care.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Staff said the service achieved a low referral to treatment time. The percentage of referrals triaged within two working days for 2021/22 was 97%; the average number of days from referral to first appointment was 55.9 days. The average number of days from referral to treatment was 88.2 days. (Leeds service dashboard, governance and quality report 2021/22)

The service statistics confirmed that 94% of patients on open incomplete patient pathways had waited less than 18 weeks. Patients who had waited more than 35 and 52 weeks for treatment was 98 and 48 respectively.

No urgent referrals had waited longer than four weeks for their first appointment.

In May 2022, 358 cataract operations took place over 34 sessions; 27 delivered by clinical directors, one by a salaried surgeon and six by long term regular locum consultants. Following theatre sessions patients had a postoperative triage review which identified what actions if any were required to support the patient's recovery.

In 2021/22 no patients had their operations cancelled.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Good

Surgery

Staff said patients received follow-up calls following their procedure. We reviewed five patient records and observed that two patient records had no record of a follow-up call and one patient record was marked as 'No Answer'.

The policy for discharge and transfer of care guidance ensured a framework was in place to deliver safe, effective and timely discharge or care transfer for patients. Patients we spoke with identified no concern's in this area. The triage form in use also fed back to the GP specific information about the patient.

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 clinic service manager led on complaints management and staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

In 2021/ 2022 the service had received five formal complaints three of which were substantiated and 12 informal complaints. We reviewed one complaint with staff and saw that following the incident and investigation some limited guidance was displayed for staff in the clean utility room. The themes of the complaints over the last 12-months related to administration, behaviour, clinical practice, communication, privacy and dignity and medication.

The Leeds dashboard confirmed the service had received patient compliments from July 2021 to June 2022.

Are Surgery well-led?

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.

Leaders were seen to be visible and approachable.

The senior team comprised of the registered manager (operational manager), nominated individual (lead clinical director) and clinical director.

Good

Surgery

At a corporate level clinical leads for glaucoma, cataract and retinal vitreous disease had been appointed into. These roles are designed to support the medical director to ensure specialist sub-specialty leadership for both clinical safety and innovation.

A patient services manager, clinic services manager, human resource lead, optometrist and lead theatre practitioner reported into the senior team. In addition, clinical accountability was clearly identified, for example, the clinical team included medical, nursing and allied health professionals.

Staff said a monthly leadership meeting took place where priorities were discussed.

The management team covered the Newmedica clinics based at Leeds and Wakefield.

Staff could access leadership development programmes and mentoring through their annual appraisal process. We were told that staff had progressed to careers in nursing and medicine following the support and development opportunities offered through the company.

The 'OJV People Planning Framework for discussion, April 2021' identified staff development, including the development required and succession planning as part of its remit.

The provider confirmed that they ensured that employees involved in invasive procedures had a good understanding and were educated in good safety practice through initial checks on new potential employees and once employed new employees would undertake a competency assessment. The example shared was the competency for the cataract scrub practitioner.

Vision and Strategy

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

The service strategy included reference to the service vision. In addition, it identified 'what drives us, what we promise and our ambitions'. The strategy identified the three Ps – Patients, People and Partners. Each area of the strategy identified the outcomes, for example in Patients two areas included: low wait times and to remain a 5-star provider on NHS choices.

The service vision was 'Changing lives through better sight and eye health'. Some staff were able to describe this vision although, not all the staff we spoke with were aware of the vision or had been involved in its creation. However, we saw this vision displayed throughout the clinic.

The vision also identified 'what drives us, what we promise and our ambitions' as part of this vision. The promise was 'to use our expertise and compassion to help people feel special, reassured and cared for.'

The service business plan identified five-year actions and the progress made. Slides of the partner meeting and future review meeting on the 29 June 2022 confirmed the progress made to date against identified actions, for example, the average wait to first appointment in Leeds was 9.2 weeks and average wait for surgery was 12.6 weeks. The next full five-year review was planned for the 19 October 2022.

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.

Throughout the inspection we observed, and five staff told us how well the team worked together and how supported they felt within their roles. This feedback was captured within the staff survey documents we saw.

Staff described an open culture; staff wellbeing was fostered, and the managers were described as approachable and supportive.

Newmedica has a nominated Freedom to Speak Up guardian and an associated policy. Local and national freedom to speak up guardians were available for staff to access. In 2021/22, Newmedica have had no concerns raised under the Freedom to Speak Up policy.

Staff could also access Duty of Candour policies and were able to describe what this concept was about.

Staff confirmed appraisal processes were in place for all staff. All employees had one to one meetings with their line manager to ensure appropriate support was provided and for ongoing learning needs assessment. Training for staff at all levels was through the service intranet system. The service held a monthly all stop day, allowing team members to attend governance meetings as well as frequent bespoke training, designed around the individual needs of the team or specific colleague groups.

The service confirmed they were committed to ensuring equal opportunities for all and adherence to the Equality Act 2010. All processes, from recruitment to selection are conducted in line with these standards. The service said Workforce Race Equality standard (WRES) returns were previously submitted to NHS England and CCGs. The provider said the collection of WRES data for the independent sector was cancelled for 2021 and is not expected to resume until 2023. In the absence of a formal requirements for WRES for 2022, work has commenced on reviewing the Equality Strategy across the business.

The provider had launched a new quarterly Colleague Engagement Survey for 2022 which requests equality and diversity data to be completed. This will provide a current data source and will enable analysis of engagement and colleague satisfaction across all protected characteristics, which includes but is not limited to Race and take action, as required.

Governance

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

There were structures, processes and systems of accountability to support the delivery of the service strategy and ensure good quality and sustainable services continued to be delivered. Sub-committees fed into the main four committees below.

The governance structure included reporting to the board through the:

- Executive committee
- Medical Advisory Committee

- Quality Management Committee
- Information Governance Committee

Newmedica governance methodology monitored quality through structured audits and assurance processes to ensure that best practice and national standards were achieved. The patient safety team worked across national services to identify risks and issues, analyse patient feedback and share learning to continually learn and improve care and effectiveness.

A cloud-based reporting and safety monitoring system supported the improvement of safety and outcomes through monitoring risk, quality, and compliance. The system promoted real time reporting and was embedded throughout the team. The system also facilitated management of policies, ensuring colleagues access the most up to date version of policies and protocols, supporting consistency of practice and ease of access at a local level. Oversight of policies and their review dates, to reflect changes in best practice and legislation took place. Random policies and procedures were reviewed and noted to be in date and reflect current practice.

The roles and responsibility of the Medical Advisory Committee (MAC) were available and information from the MAC was shared with staff. Minutes of monthly MAC meetings confirmed discussions included, proposed new consultant staff, policies and procedures, incidents and complaints, local governance reports, audit outcomes and ongoing and outstanding actions.

Due diligence took place when locum medical practitioners applied to work within the service. New medical practitioners were discussed at the medical advisory committee before being offered the opportunity to work within the service and see the patients. In addition, locum medical practitioners' indemnity insurances were checked, recorded and monitored by the service and were all seen to be current.

The staff we spoke with were aware of the governance agenda, how governance worked within the service and their role in ensuring effective governance. Staff said they were kept informed of audits, complaints and incidents outcomes and this learning was shared across the company. We saw an example of this learning being shared for the time period 1 January to 30 June 2022. The information was displayed on a 'Governance Summary' poster which fed back changes to practice following the incidents and complaints received during this time period.

A service level agreement existed with the local integrated care system (ICS) commissioners. Staff said face to face contract reviews had not re-commenced since COVID. Reports were submitted monthly and the service was in regular informal contact with the ICS in respect of performance and potential service developments. The last meeting with the ICS took place on the 13 July 2022.

Management of risk, issues and performance

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

A formal risk management structure, internal audit and monitoring provided the Board of Directors information relating to audit, performance and risks that may affect the organisation and the actions taken to mitigate these. The local risk and performance lead was the registered manager.

Performance, risk and issues were discussed at board level and at the meetings with the integrated care system commissioners. Staff said the organisational chart was regularly reviewed to ensure it still met the needs of the business and the key performance indicators were sent to the integrated care system to monitor performance and identify trends that required improvement. The last meeting with the ICS took place on the 13 July 2022.

The Leeds dashboard (June 2021 to June 2022) recorded interactions which related to incidents, risks, complaints, compliments, complications, infection prevention control, information requests and audits. The service used a red, amber and green system to identify risks. The ratings criteria were red (immediate action required), amber (of concern) and green (on target). We saw that most of the information given was rated green. We observed two consent audits were rated amber for November 2021 and April 2022 as their percentage score fell below 90% at 87% and 75% respectively.

The service audit schedule; confirmed a series of clinical and non-clinical audits had taken place throughout 2021/2022. These audits included handwashing, infection control and surgical safety audits. Infection prevention and control discussions were documented in the May 2022 Bitesize clinical governance, quality and compliance feedback document and in Medical Advisory Committee minutes.

Staff could access internal policies and procedures which related to risk and performance processes, for example, the Central Alerting System (CAS) policy. Central alert system alerts were circulated to staff and discussed at monthly governance meetings.

The risk register identified individual accountabilities, the controls and measures in place against identified risks which were scored. The risk register's last review was on the 10 March 2022 which identified 13 of the 15 identified risks were now low risk, having scored between 1 – 3 on the risk score. Two risks had scores of four; control measures were identified to monitor both risks.

The Board received an annual safeguarding report to review our response to continually protect vulnerable children and adults across Newmedica. (Quality Report 2021/22)

Business continuity and recovery plans (v3) were in place and were reviewed in May 2022. The corporate business continuity policy (v3) was past its review date of the 8 September 2021.

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.

Newmedica complies with the United Kingdom Data Processing laws in the General Data Protection Regulations and the Data Protection Act 2018. (Quality Report 2021/22) All services are registered with the Information Commissioners Office.

The NHS Digital Data Security and Protection Toolkit was submitted on 30 June 2021 with all standards being met. Information management processes are monitored through the Information Governance Committee and reported to the Board.

Staff confirmed they had completed data security awareness (level 1) training; the mandatory training report for June 2022 confirmed compliance was at 96%.

The patient services manager led locally on clinical records keeping, patient data and general data protection.

Good

Surgery

Electronic patients' records and administration computer systems were used at the clinic which were password protected. The service used a mixture of electronic and paper records. The paper records were locked away in lockable cabinets within a lockable room.

Local and national Caldicott guardians were identified.

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.

We saw that the service had openly engaged with patients, staff and local organisations to plan and manage their service. Meetings with the local integrated care system and quarterly meetings with the consultant led ophthalmology delivery network (CLODN) took place. The operational director worked closely with the ICS, CLODN and various charities to ensure the needs of the population were being met.

The last carers and patients' participation group meeting took place prior to Covid. Staff said these meetings had not been well attended. Staff said the carers and patients' participation group would be restarted but as yet future dates were not identified.

Patient feedback was collected through the NHS Friends and Family Test (FFT); the NHS Choices website confirmed that 100% (117 responses) of patients recommended this hospital.

The outcome of the May 2022 patient experience exercise confirmed a mixture of positive and negative comments of the service provided from the 906 patient feedback responses from the 9 February to the 9 May 2022 at Leeds. An action plan was not provided to confirm how the negative responses were managed.

In June 2022, 86% of patients said they were extremely likely; 14% were very likely to recommend the service to friends or family.

Staff feedback was collected through staff surveys. In 2022 staff surveys had taken place in January and April. Staff engagement scores for both was identified as 9.1. Participation rates ranged from 63% (15 of 24 employees) in January 2022 to 71% (22 out of 31 employees) in April 2022. Both staff surveys confirmed staff satisfaction in working for this provider. However, at both surveys the question 'Working here, I feel I can lead a physically healthy lifestyle' was just below the benchmark at 7.2. In response to this the provider has spoken with the human resource network and wellbeing ambassador forum. Following the actions put in place the health driver has come in at 8.5 which is 0.8 points above the true benchmark.

Staff said monthly staff meetings took place. We reviewed seven staff meeting minutes dated from 4 June 2021 until 20 April 2022 and saw that staff had been regularly engaged in what was happening within the service.

Learning, continuous improvement and innovation

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

Good

Surgery

In 2021/22 for the first time, the service welcomed the first cohort of trainee doctors into the services. The service worked closely with neighbouring Trusts and regional deaneries to aid in the training of trainee ophthalmologists working under the supervision of the Newmedica on-site clinical directors to gain valuable cataract surgery and outpatient experience.

The provider e-Referral Service (ERS) integration with the clinical system had taken place which meant that all the patients' details, and specific needs were shared through the booking process.

The provider said roll-out of the IST programme had taken place where key staff members had completed training to deliver in-house training to colleagues within the service. The information provided did not confirm how successful this programme had been to-date at Leeds.

Good

Outpatients

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

Are Outpatients safe?

Good

Mandatory training

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

Staff of each grade received and kept up to date with mandatory training. We reviewed training records which confirmed staff completed training modules appropriate to their roles.

Training needs analysis is in place which identified the staff groups and the training they were required to complete.

Training for the year started when the employee commenced employment. Initial online training is completed within four weeks and face to face training within eight weeks of starting and then updates following this are completed annually to three-yearly dependent on topic. Staff are informed by email when their mandatory training subject is due.

The mandatory training target for the provider was 95% for employed staff, with staff achieving an overall level of 98.5% compliance, and 80% for bank staff.

Staff we spoke with were up to date with their mandatory training and confirmed they were allocated time at work to complete training.

Staff completed IPC training level 2 which includes sepsis, PPE, HCAI, and antimicrobial resistance. Resuscitation basic life support training for adults was fully completed. A clinical director and one member of nursing staff had received intermediate life support training and additionally six members of bank staff. Two senior consultant staff have advanced life support training.

Autism awareness training is being introduced for staff from July 2022. Currently, this is not a mandatory subject. Clinical staff completed additional training on recognising and responding to patients with mental health needs and dementia.

Safeguarding

Good

Outpatients

Staff understood how to protect people 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. This was included in induction and annual mandatory training and staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

A review of mandatory training statistics confirmed that all staff had completed safeguarding training, which included employed and bank staff training and showed 98.52% compliance

Patient facing staff complete level 2 training, whilst admin staff complete level 1 training for both adults and children (although no paediatric patients are seen in the clinic) Two members of staff are trained to level 3 adults and children. There is a recognised safeguarding lead.

Staff approach the registered manager if they have any concerns. A recognised process was followed to submit concerning information to the local authority duty safeguarding team. Staff could access the safeguarding contact information in the managers room if needed. The registered manager informed us the provider had few safeguarding referrals and learning was shared across sites. There were no safeguarding issues in the last 12 months.

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.

Staff had received mandatory training in infection prevention and control, and we observed that all areas were cleaned to a high standard and had suitable furnishings which were clean and well-maintained. Patients commented on the high standard of cleanliness.

We noted that flooring and chairs were made from easy clean materials. Protocols and measures introduced as part of the service's response to the pandemic included arrival assessments and temperature checks. The wearing of masks was optional when we visited.

Staff followed infection control procedures including the use of personal protective equipment (PPE). Supplies of PPE items including disposable aprons and gloves were available and these items were being used. Antimicrobial hand-rub dispensers were provided at the reception desk and in each room.

Clinic areas were clean, with suitable furnishings which were clean and well-maintained. Storage facilities were also clean although we observed some items stored on the floor, which would have made cleaning less effective.

Cleaning records were up-to-date and indicted that areas were cleaned regularly. The service used records to identify how well the service prevented infections, where infection control issues arose, they were recorded as incidents. The service had reported zero infection incidents in the last year. We saw that monthly cleaning audits achieved very high scores, within the range 90-100%.

Environment and equipment

Good

Outpatients

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The facilities we observed were suitable to meet the needs of patients. Imaging facilities included ophthalmology testing rooms were located adjacent to consultation rooms and a waiting area with toilet facilities.

The maintenance and use of equipment kept patients safe. The service confirmed it had enough suitable equipment to help them to safely care for patients. The service had in place a contract for annual equipment testing. We reviewed equipment records that demonstrated testing and servicing followed manufacturers' specifications. We reviewed electronic records that confirmed the service had clear processes for maintenance of equipment and fault reporting. We observed fire equipment safety checks were undertaken.

Storage areas we checked were visibly clean and well-organised, except for two areas we identified where some items were stored on the floor, which may have prevented thorough cleaning and presented a risk of infection.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys we observed were accessible and records showed safety checks were up to date. The policy for laser safety was in date.

In the minor operations room, we found some items of equipment were out of date.

Staff managed clinical waste well although the storage area for clinical waste outside the building (this may have been beyond the area managed by the service) we observed was untidy and may present a risk of infection.

Assessing and responding to patient risk

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

Staff completed assessments for each patient on arrival to check they were able to have treatment. Diagnostic tests on the patients' eye were completed at the initial appointment to check they were suitable for surgery. The results were shared with the consultant in charge of the patients' care who made the final decision on their suitability.

Staff knew about and dealt with any specific risk issues. Where risks were identified involving complications for surgery, the service liaised with the appropriate NHS trust on behalf of the patient. Staff shared key information to keep patients safe when handing over their care to others. Service agreements were in place for emergency transfer.

The service had guidance in place on managing follow up for patients. The guidance included specific instructions as to the urgency of referral to specialist services if needed.

We saw the risk assessment for the laser room was updated in June 2022. We found the risk assessment did not include the risk presented by reflective taps.

Staffing

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

Managers maintained oversight of staffing levels and skill mix, and gave bank, agency and locum staff a full induction. Managers maintained oversight of professional registrations, mandatory training status and appraisals for medical staff.

Records

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

Patient notes were comprehensive, and staff could access them easily. The service operated a systems of colour coding (blue and pink) for manual records to distinguish each eye. We reviewed records for patients selected randomly for eight current patients. We found consent was completed for seven of those patients. Notes were mainly legible and signed and dated by staff for six records. For some records, the signature was not accompanied by a legible version of the name or the job title or grade of the member of staff.

Notes were stored securely and mainly readily available, but we found notes could also be filed incorrectly and in one instance the file was missing and had been reported as an incident. Although the service recognised and worked to overcome some of the limitations of manual records, we found it did not conduct regular audits of the completion of records.

We observed that stickers were used to identify patients with an allergy, which represented good practice.

Medicines

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

Staff stored and managed medicines and prescribing documents in line with policy and the manufacturers' recommendations.

Prescription and medicine management control were robust. We saw that drugs and medications were stored securely. No controlled drugs were used.

Stocks of medicines that were administered via intra-ocular injection were securely stored in a temperature-controlled environment. We saw fridge temperatures were maintain and regularly checked. With maximum and minimum temperatures recorded.

Records of patient's allergies and drugs prescribed were contained within the patient's clinical notes.

Medicines audits were completed by an external supplier. We saw the service achieved an audit score ranked as 'outstanding' in the most recent audit (8 June 2022).

Incidents

Good

Outpatients

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.

A provider incident policy was in place. An incidents register was maintained within clinical governance and we found incidents were tracked and followed up appropriately. For 2021/22 there were between two and seven incidents monthly, averaging one to three incidents. The service had no never events or serious incidents in the last year, or previously.

The provider's governance meeting reviewed patient safety and operational incidents monthly to identify root causes and to mitigate risk. Patient safety incidents were also discussed at medical advisory and quality management committees at provider level. Any data incidents were reviewed at the information governance committee.

Incidents were discussed with staff through staff meetings and outcomes of some displayed throughout the clinic. We observed that three-monthly learning from incidents was captured and displayed in the registered managers office and within the service using a laminated copy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers stated the incident reporting system was robust, with two-way communications between local governance and the provider's medical advisory committee. Staff received feedback from investigation of incidents, both internal and external to the service.

Are Outpatients effective?

Inspected but not rated

We do not currently rate effective in 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.

The service had a range of policies, protocols and standard operating procedures to support the delivery of services. There were standardised pathways based on guidance issued by the Royal College of Ophthalmology. Other sources of guidance included the NHS and National Institute for Health and Care Excellence (NICE). NICE guidance was an agenda item on the provider's medical advisory committee meetings.

The service undertook regular audits to measure the outcomes of surgery and uses benchmarking data to compare practice.

Good

Outpatients

The service used National Safety Standards for Invasive Procedures (NATSSIPS). NHS England recommends use of NATSSIPS as best practice to improve patient care and safety. Audit compliance (including NATSSIPS compliance) was discussed at monthly governance meetings. Audit data was reported to the provider group.

Staff followed and had access to up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider was responsible for managing policies, so they were consistent amongst each of the provider's services. Staff were provided with updates of changes to policies and policy changes were discussed at governance meetings.

Nutrition and hydration

Refreshments for patients were provided as appropriate.

Drinks and snacks were provided for patients in the waiting area if they required. Staff gave patients enough food and drink to meet their needs. Water was available. Patients attended for day surgery and were offered tea and biscuits following surgery.

Pain relief

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

Patient 's received eye drops but no pain management drugs. Assessments undertaken within outpatient appointments were generally not painful, but staff informed us they would monitor and ask patients if they felt any discomfort.

We found staff checked patients remained comfortable during their appointments. Patients were given information about their treatment and what action to take should they feel pain on discharge from the service.

Patient outcomes

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

Outcomes for patients were positive, consistent and met expectations, both for the local area and nationally. Clinics were used to perform appropriate and necessary pre-testing and treatment prior to surgery.

Outcomes were discussed so staff were aware of how the service was performing. Regular audits were undertaken, and results were within range.

To obtain a more complete picture of patient outcomes for each patient, the service should consider liaising with each of the NHS trusts in its area to track the completion of patients' treatment.

Competent staff

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

Good

Outpatients

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

The service undertook pre-recruitment checks for staff to meet CQC regulation requirements. Managers gave new staff a full induction tailored to their role before they started work. Staff we spoke with described how they received a full induction tailored to their role.

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 well together across the services being provided. We observed effective communication taking place between staff and staff informed us they worked supportively and felt part of a team.

Staff worked across health care disciplines and with other agencies including specialist networks when required to care for patients. GPs and opticians, general practices and NHS trusts to support patients and their treatment with the provider to ensure each agency could care for patients safely and effectively. Protocols were in place with NHS trusts for transfers in emergency and cancer patients.

Seven-day services

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

The provider offered a seven day a week service and evening surgery slots were available. Management cover extended over seven days.

Health promotion

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

The service had information available promoting healthy lifestyles although sharing this regularly with patients had been curtailed during the pandemic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and knew who to contact for advice.

Staff received consent training as part of induction and received mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Good

Outpatients

Patients mental capacity was included in the outpatient's pre-assessment and the service liaised with the relevant NHS trust where any risks or issues with capacity were encountered.

We reviewed records for patients selected randomly for eight current patients. We found consent was completed for seven of those patients. The service had not completed audits for the completion of consent information.

Are Outpatients caring?

Good

Compassionate care

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

Patients were attending outpatients during our inspection and we were able to observe interactions between staff and patients and to interview a selection of five patients. Without exception, patients described the level of care and support provided to them in very positive terms, mentioning specifically the friendliness and courtesy of the staff, and the timeliness of the response they had received.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff speaking with patients in a caring way throughout the service.

We saw patient experience was audited monthly with good practice noted and recommendations for improvement fed back for action.

Emotional support

Staff provided emotional support to patients, families and carers to reduce any distress and understood patients' personal, cultural and religious needs.

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 request 'hand holders' and we were informed most patients took advantage of this service. Patients had a choice of music during surgery.

The service worked closely with sight loss charities, who provided information and support to patients with eye conditions and disease. Eye clinic liaison officers provide emotional support for patients diagnosed with sight loss.

Understanding and involvement of patients and those close to them

Staff gave patients help, emotional support and advice when they needed it.

Good

Outpatients

Staff made sure patients and those close to them understood their care and treatment. Contact we observed with patients showed staff talked with patients in a way they could understand, using communication aids where necessary.

Patients each received a call 24 hours following their surgery.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave very positive feedback about the service. We found 99% of patients said they were likely to recommend the service.

Are Outpatients responsive?

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.

Facilities and premises were appropriate for the services being delivered.

Managers monitored and took action to minimise missed appointments, which were monitored by the service and contact was made with individuals who did not attend. Patients not attending represented six per cent in the two months before our inspection.

The service planned through local commissioners to treat patients who were encountering long waiting lists for NHS services within the Harrogate, Leeds and Wakefield areas.

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 patient-centred care that was aimed at the specific needs of each patient. Patients were offered a choice of appointments and at their initial consultation information was sought from the patient to determine their needs.

The service supported patients living with dementia. Staff complete dementia training and a dementia champion and additional dementia friendly signage was in place. The service used for-get-me-knot label on patients notes to identify patients with dementia.

Patients with complex need were supported to access NHS services in their local hospital. The service confirmed patients with learning disabilities wound normally be referred to the NHS trust.

Good

Outpatients

Translation services were available. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Free local car parking was procured following patient feedback and a new telephone system was procured to monitor and improve call answering performance.

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 better than national standards.

The service monitored waiting times to ensure patients could access services when needed and received treatment within the timeframes set by commissioners. Appointment times for patients were staggered to reduce waiting.

We saw six patients identified on the morning of inspection. We reviewed two of the referrals. We saw that the initial patient referral was recorded on the system. The triage form identified the urgency of referral: within 24 hours, routine or two-weekly.

The service tracked patient progress at key points of the surgical pathway and reported their data monthly to senior managers and commissioners.

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.

The service had a complaints policy which was in date and reviewed on an annual basis.

The service clearly displayed information about how to raise a concern in patient areas. Staff we spoke with understood the policy for complaints and knew how to handle complaints.

Staff were supported with their investigations and the complaint process from governance managers. When the service received a formal complaint an acknowledgment of the complaint was sent within three days and a response was sent to the patient within 20 days.

We reviewed the annual complaints, concerns and compliments report for the year to 31 March 2022 which showed the service received two formal complaints. The report looked at themes and responses taken in response to complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff received mandatory training on complaints handling, customer service and duty of candour.

Are Outpatients well-led?

Good

Outpatients

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 registered manager was also the operational director and responsible for the operational leadership of the locations' services. The registered manager was present at the Leeds location four days per week. The nominated individual was a founding director and senior ophthalmic consultant. A clinical director completed the leadership team.

We observed that managers were visible, and staff told us they were approachable, with no hierarchy. Staff told us there was a clear management structure which made sense and was easy to understand. Staff received good support and teamwork was effective. Managers were approachable and visited regularly. Line management responsibilities were clear, and staff were encouraged to contribute to the development and growth of the service by being involved in discussions and contributing to the on-going review of services.

Staff we spoke with were conversant with the leadership structure. They said leaders were supportive and gave examples of how their development had been encouraged.

Vision and Strategy

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

The vision was clear and linked to defined values including quality and sustainability. A strategy was in place to achieve the priorities and deliver quality sustainable care. The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners.

The providers vision was support by a local (Leeds) vision involving the role of 'patients, people and partners' which we found displayed on meeting boards although we found that not all staff were conversant with the local vision.

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.

The service returned very positive staff survey results and experienced low staff turnover rates. Staff were pleased with the organisation as a place to work and spoke positively of the culture. They told us people were friendly and staff felt respected, supported and valued. We observed the behaviour of managers in interaction with staff was very positive.

Good

Outpatients

The service promoted equality and diversity in daily work and had an open culture where patients their visitors and staff could raise concerns without fear. Staff we spoke with felt confident to raise any concerns with managers and felt listened to. Staff were kept informed of organisational service developments.

The service had a Freedom to Speak Up Guardian and a linked whistleblowing policy and equality and diversity training was included in mandatory training for staff.

Staff suggested that they felt that following the pandemic, the service could do better with cultural events.

Governance

Managers 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.

Policies and procedures were in place for the safe and effective running of the service and were in date. The business had service level agreements with external organisations for the delivery of some of its services.

The service operated an integrated governance framework. Governance and performance management arrangements were regularly reviewed. The governance framework comprised three committees that reported to the board of directors on a monthly basis outlining clinical, safety and quality, risks and trends together with the actions being taken.

Staff teams discussed quality and safety performance issues at regular review meetings. Learning was shared from any incidents, complaints and staff also had the opportunity to comment and ask further questions.

We reviewed minutes from monthly governance meetings and team meetings that confirmed an effective governance framework was in place.

Management of risk, issues and performance

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

The risk register documented risks graded according to severity. Controls to ensure the risks were managed were included in the risk register. The scoring system had scores between twenty (catastrophic) and one (negligible) where twenty described the highest level of risk.

The service operated risk management processes which ensured risks were identified and managed and mitigation measures put in place. Incident or complaint were recorded in the governance recording database. We saw evidence of risks, issues and performance being discussed at management meetings.

The registered manager had oversight of the service's risks and understood the challenge of risks in terms of quality, improvements, and performance.

An example of risk being reflected in an operational change was the introduction of pink and blue recording books where was used for the first eye and blue for the second eye (unless the first eye was treated elsewhere when pink was used.

We found that latex gloves were being used although this was not included in a risk assessment, reflecting HSE guidance. We also found reflective taps in the laser room which were not included in a risk assessment.

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 service used a mixture of electronic and paper records, which were stored securely. Data or notifications were consistently submitted to external organisations as required.

Staff described their use of a combination of paper and electronic records and of plans to upgrade these to a fully electronic system. The current arrangement was for paper records to be stored securely in a separate and lockable room. The system used for the collection and review of management information was supported by the provider.

The service had a data protection policy and had implemented a data retention policy which outlined the purpose for processing personal data and retention periods and disposal methods.

Information security followed national guidance. The information governance committee was responsible for information security.

Engagement

Managers 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 could demonstrate consistently high levels of constructive engagement with patients and staff.

The registered manager engaged with staff regularly including at monthly team meetings. Staff meetings were minuted. Staff we spoke with felt they were involved fully in the day-to-day running of the service. The service obtained very positive staff survey results. The provider's quality report for 2021-22 included the results of a quarterly survey in January 2022, with an overall engagement score of 8.6 against a benchmark of 7.7. for the Leeds and Wakefield locations the most recent staff survey in April 2022. Achieved a 71% participation rate with very positive feedback from staff.

The service encouraged patients to provide feedback. We spoke with a selection of five patients. Without exception, patients described the level of care and support provided to them in very positive terms, mentioning specifically the friendliness and courtesy of the staff, and the timeliness of the response they had received. Patients also used survey forms provided as well as social media, phone and email. Staff felt the proportion of patient survey forms returned could be higher than the 23% being achieved. We saw positive examples of feedback that was consistent with comments made by patients to us.

Good

Outpatients

Staff spoke highly of the carers and patient participation group but also suggested there was opportunity to develop further engagement with external stakeholders.

Learning, continuous improvement and innovation

Managers and staff were committed to continually learning and improving services. They understood quality improvement methods and had the skills to use them. Managers encouraged innovation and participation in research.

The service participated in the provider's strategies for improvement. The provider had five key improvement priorities, and these were monitored quarterly and reported to the board. They were dementia strategy, audit programme, patient and carer engagement and improving staff engagement. Staff we spoke with gave us examples of learning and improving related to these priorities.