Teesside Newmedica Limited

Newmedica Community Ophthalmology Service

Inspection report

29 -30 Market Place
North Ormesby
Middlesbrough
TS3 6HR
Tel:

Date of inspection visit: 02 March 2022
Date of publication: 14/06/2022

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?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location: We rated it as Good because:

- Staff provided good care and treatment, and gave patients enough to eat and drink. Managers monitored the effectiveness of the service and made sure most staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Most key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always use the systems and processes to safely manage medicines.
- The service provided mandatory training in key skills and safeguarding training, but did not make sure everyone, for example, bank staff, completed it.
- Not all staff knew who the safeguarding lead was.
- Laser safety audits were not completed annually in accordance with corporate policy.
- The provider was unable to evidence all bank staff without a substantive NHS role received an annual appraisal, in accordance with the provider's policy.
- We observed eye drops instilled before the correct side of surgery was marked. This was not in accordance with national best practice guidance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service: We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Newmedica Community Ophthalmology Service

Teesside Newmedica community ophthalmic service is an independent provider registered with CQC since 2019, to provide the following regulated activities:

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

The service has a manager registered with CQC.

The service provided a range of ophthalmic treatments for NHS and other funded (insured and self-pay) adults. These included general ophthalmology, cataract surgery and management, ocular hypertension and glaucoma treatment and monitoring, oculoplastics, (which is a broad term for a number of surgical procedures on the eye and the surrounding structures, including the eye socket, eyelids, tear ducts, and parts of the face), medical retina, and yttrium aluminum garnet (YAG) laser treatments. 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 service had one dedicated operating theatre with an anaesthetic room, a recovery area, a dedicated YAG laser room and separate clinic rooms.

Our inspection was unannounced (staff did not know we were coming). This was the first time we had inspected this service.

How we carried out this inspection

During the inspection visit, the inspection team:

- inspected and rated all five key questions
- visited the operating theatre and clinic
- looked at the quality of the environment and observed how staff cared for patients
- spoke with the registered manager
- spoke with 13 other members of staff including medical, allied health professionals, nursing and administrative personnel
- spoke with five patients who were using the service
- reviewed eight patient records
- looked at a range of policies, procedures and other documents relating to the running of the service.

After our inspection, we reviewed performance information about the service and information provided to us by the service.

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

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Surgery

- The service must ensure the expiry dates of emergency medicines are checked in accordance with the provider's policy and these medicines are replaced before the expiry date is reached. Regulation 12 (1) (2) (g).
- The service must ensure all bank staff have completed mandatory training and safeguarding training so they have the necessary skills to carry out their role. Regulation 18 (1) (2) (a).

Action the service SHOULD take to improve:

Surgery

- The service should ensure all staff are aware of the named safeguarding lead for the service.
- The service should ensure correct side of surgery is marked, prior to instilling eye drops, in accordance with national best practice guidance.
- The service should ensure laser safety audits are completed annually in accordance with the provider's policy.
- The service should ensure all bank staff without a substantive NHS role receive an annual appraisal, in accordance with the provider's policy.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Requires Improvement

Our rating of safe: we rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, but did not make sure everyone completed it.

There was a corporate policy for training, experience and qualifications of staff, which applied to all permanent and bank staff employed at the service. The mandatory training was comprehensive and met the needs of patients and staff. For example, staff completed training on recognising and responding to patients living with dementia. Staff accessed training on line, with some face to face practical skills sessions.

Training records were uploaded on to an electronic database and compliance was monitored corporately and locally.

Consultants received and kept up to date with their mandatory training. Managers we spoke with explained consultants with substantive NHS roles attended mandatory training at their NHS trust, and this was monitored corporately through the appraisal process and at review of practising privileges.

Most permanent staff received and kept up to date with mandatory training. Training compliance data we reviewed for January 2022 showed 97% compliance by permanent employees, against an annual target of 100%.

However, the January 2022 training compliance report we were shown for non-permanent staff, indicated a compliance rate of 30% for 20 employed bank staff. One bank staff member we spoke with confirmed they had not completed mandatory training and the registered manager was unable to provide evidence of any safeguarding, infection prevention and control and basic life support (BLS) training for them. This meant we had concerns that some staff may not have the appropriate skills and knowledge to care for patients safely.

We discussed this with the registered manager at the time and were told they would ensure the bank staff completed their training in accordance with policy. The training report for February 2022 received after our inspection confirmed the compliance rate had increased to 42%, increasing further to 49% by March 2022.

Good

Surgery

Safeguarding

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

The service had safeguarding children and adults and chaperone policies in place, which contained references to appropriate legislation and best practice guidance.

Most staff received training specific for their role on how to recognise and report abuse. Compliance for children and adult safeguarding training for permanent staff was 100% for the year against a corporate target of 100%.

However, records we reviewed showed not all bank staff were up to date with safeguarding training. We brought this to the attention of the registered manager and were told they would ensure bank staff completed their training in accordance with policy. The training matrix received after our inspection confirmed improved uptake of safeguarding training by bank staff.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The service had a named safeguarding and PREVENT lead trained to level two and their name was displayed on a poster in the main office. The registered manager told us they shared the safeguarding lead role and had been trained to level three, in accordance with the intercollegiate document guidance. However, this was not apparent on the poster and some staff we spoke with were unclear who the named lead was.

Staff we spoke with knew how to make a safeguarding referral and gave an example of a recent referral made to the local authority safeguarding adults team.

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.

There was a corporate policy in place for infection prevention and control.

Patient waiting and clinical areas were clean and had suitable furnishings which were clean and well-maintained. For example, patient seating was impermeable and could be wiped clean.

Cleaning records we saw demonstrated areas were cleaned regularly.

Staff cleaned equipment after patient contact, and we observed this happening routinely during the inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff complied with arms 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance. We observed staff washed their hands and used hand sanitising gel between patient interactions.

We observed public areas had posters which promoted COVID-19 awareness and walkways were clearly marked to promote social distancing. Patients were requested to provide evidence of a negative COVID-19 test. All patients and visitors had their temperature checked upon arrival and were offered hand gel and a disposable face covering.

The operating theatre had an appropriate air exchange and ventilation unit that had been serviced and recent microbiology test results were all within acceptable range.

We reviewed monthly Infection control and hand hygiene audits, which showed consistently high compliance rates.

Staff worked effectively to prevent, identify and treat surgical site infections. As part of the admission and pre-assessment criteria, patients were asked infection control screening questions. This meant any infection risks could be managed, for example patients could be added to the end of a list so that appropriate decontamination could be completed.

The service monitored infection rates. There were no health care acquired infections and no surgical site infections reported in the last 12 months.

The service participated in mandatory reporting of all alert organisms including methicillin sensitive staphylococcus aureus (MRSA), glycopeptide-resistant enterococci (GRE) bacteria and clostridium difficile infections. The service participated in mandatory surveillance of surgical site infections and these were monitored.

Environment and equipment

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

The service opened in 2019. Although not purpose built, the premises met the requirements for accessibility for all service users. The fabric of all clinical areas was in good order.

All fire extinguisher appliances inspected had been serviced within an appropriate timescale. Fire exits and corridors were clear of obstructions. The service had two named leads for fire safety, who had attended appropriate training. We saw an up to date fire risk assessment.

There were four consulting rooms and three investigation rooms. The theatre department had a pre-surgery preparation area and post surgery recovery area. There was a single operating theatre. The department operated a one-way system to maintain COVID-19 social distancing and promote a smooth transition for patients through the department. There were separate male and female toliets and an assisted toilet for patients living with a disability.

There was a separate room for YAG laser treatments. The service had access to a named laser protection advisor and two management staff were identified as laser leads, to promote laser safety. The YAG laser was last serviced February 2022. We saw a laser safety risk assessment summary letter dated 3 November 2019 completed by the external laser protection advisor. The assessment stated laser risk assessments must be reviewed following significant changes or if controls are not adequate for any reason. YAG laser local rules were last reviewed in 2019.

However, the corporate audit policy stated a laser safety audit should be completed annually. The service provided environmental audits but these did not include an annual laser safety audit.

Staff recorded ambient temperature and humidity readings diligently.

Staff carried out daily safety checks of specialist equipment. For example, the emergency resuscitation equipment trolley was checked weekly in accordance with local policy.

The service had enough suitable equipment to help them to safely care for patients. Most equipment was single use. The exception was re-usable hand pieces which were sent for decontamination off site after use.

There were systems for recording the service and planned preventive maintenance of equipment, identified through a central log and equipment compliance stickers, which indicated the dates tests were due. We inspected several pieces of equipment, which included YAG laser equipment, microscopes and phacoemulsification equipment. All were clean, serviced and maintained appropriately.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

The service ensured there was a member of staff trained in immediate life support (ILS) on duty every day. Individual ILS trained staff were allocated a 'red badge' to identify them as emergency responders and staff we spoke with told us they conducted emergency scenario training periodically.

The service also had two suitably trained first aiders.

Staff we spoke with explained patients referred in to the service were individually risk assessed (triaged) by a clinician. There was a corporate policy in place which described specific criteria for patients to be returned to the commissioner. For example, patients who had complex needs and required a general anaesthetic, were redirected to the NHS trust.

Pre-assessment of patients was conducted face to face and staff conducted follow- up telephone calls after discharge home. If patients could not be contacted after two attempts, there was a process in place to ensure the referrer and patient were contacted by letter.

The service completed risk assessments for each patient, for example, blood tests to assess risks of bleeding were requested in advance of surgery.

Staff knew about and dealt with any specific risk issues. For example, there was recognition of clinical parameters for day of surgery, regarding blood glucose levels and blood pressure readings. The service had policies to identify and manage the deteriorating patient and sepsis. There was a pathway in place for referral to the local NHS trust in the event patients required urgent treatment for postoperative complications. These referrals were made consultant to consultant.

The staff conducted and recorded a team brief at the start of every surgical list, to identify any potential operational risk factors.

The service used a safer surgery pathway which incorporated World Health Organisation (WHO) safer surgery checks. For example, sign-in, timeout (before the start of the surgical interventions) and sign-out (before any member of the team left the operating theatre). We obtained patient consent to observe in theatre and saw staff introduced themselves and three

points of patient identification were checked at the sign-in stage. A white board was used to record patient details, side of surgery and lens power. The surgeon selected the lens and took it into theatre. However, we observed anaesthetic drops were instilled before the correct surgical side was marked, which was not in accordance with best practice guidance and meant there was a risk the drops could be instilled into the incorrect eye.

The service conducted observational and documentation audits of compliance with WHO safer surgery checks for cataract surgery. We reviewed audit data which showed high compliance with completion of documentation and observed practice.

Prior to discharge, patients were given instructions to follow and a contact telephone number to call should they have any concerns. This diverted to an emergency contact number out of hours.

Staffing

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

The service had enough nursing, medical and support staff to keep patients safe.

The service was consultant ophthalmologist-led. All patients were admitted under a named, validated consultant with practising privileges. The term 'practising privileges' means medical practitioners not employed directly by the service, but approved to practise there.

The registered manager could adjust staffing levels daily according to the needs of patients. Actual staffing numbers matched planned numbers. The service offered pre-booked appointments to patients which allowed for effective planning of staffing, to meet clinical needs.

The service had no current staff vacancies.

The registered manager said the service had a higher than expected sickness rate. However, the rate included all COVID-19 related absence, which was the main cause of elevated sickness rate in this reporting year.

Records

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

The service had a patient records policy, referenced to general data protection regulations (GDPR) and data protection act 2018.

Patient notes were comprehensive. For example, we saw an integrated cataract pathway document, which covered administration and bookings, pre-operative assessment, consultant assessment, consent, operation notes, prescribed medicines and follow up arrangements.

Records were on paper and staff could access them easily.

Records were audited monthly and benchmarked against other Newmedica providers. Compliance scores were high.

Good

Surgery

We reviewed eight patient records. They were detailed, with appropriate risk assessments and care plans.

Records were stored securely in a lockable cupboard, when not in use.

We observed the operating theatre register and lens traceability records were completed correctly.

Medicines

The service did not always use the systems and processes to safely manage medicines.

There was a corporate medicine management policy in place.

We saw medicines management audit results for November 2021 and noted high compliance scores.

However, staff did not always follow systems and processes when managing medicines. For example, the policy stated medicine expiry dates must be checked monthly and we found three medicines on the emergency resuscitation trolley had expired. In addition, the 10% glucose solution noted as out of date when checked by the staff in February was not present on the trolley. We brought this to the attention of the registered manager at the time.

Two of the medicines were replaced by the end of the day but one could not be sourced and we were told it would be replaced the following morning. We requested a risk assessment but this was not provided, as the theatre list was cancelled. This meant we were not assured patients that attended clinic appointments would receive appropriate treatment in the event of an emergency. After our inspection we received confirmation the medicines and 10% glucose were replaced.

We saw diligent recording of medicine fridge temperatures.

We saw staff competency documents for administration of eye drops under patient group directions (PGDs). PGDs allow appropriately trained, nominated healthcare professionals to supply and administer specified medicines to pre-defined groups of patients without a prescription.

Cylinder oxygen was stored securely on the emergency equipment trolley.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

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.

Staff we spoke with knew what incidents to report and how to report them on the electronic incident reporting system. They gave specific examples of learning from incidents and changes in practice, which improved patient safety.

Staff raised concerns and reported incidents and near misses in line with the provider's incident reporting policy.

Good

Surgery

Staff reported one serious incident in the last 12 months. Managers debriefed and supported staff afterwards. Managers investigated the incident thoroughly and the patient was involved in the investigation. Staff we spoke with told us how practice had changed as a result of learning.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The service recorded a duty of candour log, to monitor compliance with each stage of the process.

Staff received feedback from investigation of incidents.

Staff met at monthly departmental team meetings to discuss the feedback and look at improvements to patient care. The meeting minutes were shared afterwards with all appropriate staff.

Are Surgery effective?

Good

Our rating of effective: we rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were cascaded from the corporate team and held locally on computer and in files as hard copies. Staff we spoke with knew how to access them.

Clinical policies we reviewed were referenced to best practice guidance, for example Royal College of Ophthalmologists guidance and NHS England guidance.

Compliance against policy was monitored throughout the year using a corporate audit schedule. Audits were completed on an electronic platform. We saw areas that required improvement were clearly identified and the system allowed the addition of action plans which were shared locally and corporately.

Staff we spoke with explained how they accessed the most current best practice guidance on line and intranet, for example NICE guidance and up to date COVID-19 guidance.

Nutrition and hydration

Staff made sure patients were not without food for long periods.

Staff made sure patients had enough to eat and drink. For example, patients attending for same day surgery, were advised to bring their own packed lunch but food and beverages were also provided if patients required them.

Pain relief

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

Good

Surgery

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. For example, on the cataract surgery pathway documentation we saw pain scores were monitored using a one to ten assessment scale. Staff also assessed patient pain levels during follow up phone calls and if pain was not controlled with simple pain killers, they were asked to return to clinic within 24 hours for review.

Patients we spoke with told us their pain was managed well.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service participated in relevant national clinical audits. For example, monthly submissions to the National Ophthalmology Database (NOD).

The annual schedule of clinical audits was described in the corporate policy and oversight was maintained corporately and locally.

Outcomes for patients were positive, consistent and met expectations, such as national standards. For example, we reviewed NOD data for the service for cataract operations performed between 01 September 2019 and 31 March 2021. The total number of eligible operations for this period was 6,075. The data showed complication rates for a rare but serious complication called posterior capsule rupture were significantly lower (0.38%) than the expected rate of 1%.

Infection rates were also monitored locally and benchmarked against other Newmedica providers. Consultants we spoke with told us the benchmark for endophthalmitis was 2% but the service's rate was less than 0.1% for this complication. Audit data was submitted corporately and shared with commissioners monthly.

Managers and staff carried out a comprehensive programme of repeated local audits to check improvement over time. These included for example, hand hygiene, consent, WHO safer surgery checklists and biometry quality audits. All audit results we reviewed showed high levels of compliance.

Managers shared and made sure staff understood information from the audits.

Competent staff

The service made sure most staff were competent for their roles. Managers appraised permanent staff's work performance.

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

Managers gave all new staff a full induction tailored to their role before they started work.

We reviewed the corporate performance and development review (appraisal) policy. This described the requirement for annual appraisals and regular feedback for all employed staff and bank staff were required to provide the date of their last appraisal from their substantive NHS employer.

Good

Surgery

All consultants had substantive NHS roles and had an annual whole practice appraisal at their NHS trust. They were required to provide evidence of their appraisal, scope of practice report, medical indemnity insurance, an enhanced disclosure and barring service (DBS) check, occupational health status and relevant specialist training. We reviewed an appraisal log which indicated consultant NHS appraisals were mostly up to date. The exception was one appraisal that was recently overdue.

Managers supported permanent staff to develop through yearly, constructive appraisals of their work. We reviewed an appraisal log for 2021 to end of March 2022, which indicated appraisals were up to date for 18 named permanent staff. However, the registered manager confirmed there were 25 permanent staff members employed for the same time period. The registered manager confirmed after inspection, four staff were within their probationary period and did not require an appraisal. A further three staff were directors and not required to have an appraisal.

The registered manager confirmed bank staff were required to provide the date of their appraisal in their substantive NHS role. However, some bank staff employed did not have a substantive NHS role and did not have an NHS appraisal. This meant we were unclear how performance of bank staff working exclusively at this service was monitored and recorded.

There was a section on the quality dashboard describing methods of supervision, for example, peer to peer supervision. We saw documented competencies and probationary documentation with objectives identified. In addition, we observed that trainees worked under direct supervision of a consultant.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.For example, several staff we spoke with described how they had been supported to progress their career.

Managers identified poor staff performance promptly and supported staff to improve. We saw examples of additional objectives set for staff to achieve, which were reviewed in accordance with agreed timescales.

Multidisciplinary working

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

Staff of different disciplines worked together as a team to benefit patients. Staff supported each other to provide good care and flexed their working hours to accommodate the needs of patients.

Seven-day services

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

Consultant ophthalmologist-led services were operational 8.30am to 5.30pm, seven days a week. Staff we spoke with told us the laser clinic was held at weekend. After our inspection, we were informed laser surgery lists were also held on Tuesdays and Fridays.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. For example, patients could access informational video clips on the service's website.

Good

Surgery

Staff assessed each patient's health as part of their pre-operative assessment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The consent policy described consent as a two-stage process.

Staff clearly recorded consent in the patients' records. Consent forms stated risks and benefits of surgery. Patients we spoke with told us they were provided with sufficient verbal and written information, to enable them to give informed consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. For example, all referrals were triaged by clinical staff and patients were contacted to discuss any special requirements. Consultants completed mental capacity assessments and documented this on the consent form. Patients could bring carers to support them during consultations.

Are Surgery caring?

Good

Our rating of caring: we rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We saw several positive comments from patients in the patient feedback the service provided.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, we observed patients were asked if they would like background music or religious recitations to be played to help them relax during procedures.

Good

Surgery

We observed staff put patients at ease when they were waiting for surgical procedures and talked with them about their concerns. We also heard examples of additional staff holding patients' hands in theatre to provide support when they needed.

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 made sure that patients did not leave the service unattended so that they were not put at risk.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand.

Staff involved patients in decisions about their care and treatment. Patients we spoke with told us they felt fully informed about their treatment plans and arrangements for discharge.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. For example, by emailed satisfaction survey, friends and family questionnaire, comments on the social media page, NHS choices (search for the service and leave a review) and directly by freepost to the corporate Newmedica governance team. Satisfaction feedback was consistently positive. It was reviewed monthly by the service and quarterly corporately.

Are Surgery responsive?

Good

Our rating of responsive: we rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population.

The registered manager worked hard to promote a positive working relationship with other health providers in the area. For example, a range of services were available for NHS patients where commissioners had identified capacity shortfalls or for patients who wished to exercise their rights of flexibility and choice, under the NHS e-referral system (previously known as choose and book).

Facilities and premises were appropriate for the services being delivered.

The service was near a public car park which provided free parking spaces.

Good

Surgery

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 services for NHS, private-insured and self-funded patients. Patients were referred to the surgeon of their choice where possible and according to their individual clinical needs.

Staff supported patients living with dementia and learning disabilities.Where possible, appointment and treatment times were undertaken at a time suitable to patients and carers. For example, operating lists were flexed to accommodate patients that travelled from out of area.

Patients that required surgery had a consultation and examination in their first visit.

Areas were accessible for patients with limited mobility and people who used a wheelchair. Toilet facilities were available for patients, carers and relatives including those living with a disability.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Pre-assessment staff identified individual needs such as hearing, sight or language difficulties or disabilities. Translation services were available by telephone for patients where English was not their first language. There was a poster displayed in different languages to explain this.

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 the majority of patients were in line with national standards.

Patients were referred to the service by their GP, optician, or NHS referral.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. For example, data we reviewed for the period April 2021 to March 2022 showed no patients classified as urgent waited more than four weeks. The average number of days for referral to first appointment was 19.9 days. The average number of days from referral to treatment (surgery) was 29.8 days against the national standard 18- week pathway.

Managers worked to keep the number of cancelled operations to a minimum. The data we reviewed showed two patients were cancelled by Newmedica, due to overrunning of the theatre list. This represented 0.45% of total cases.

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 clearly displayed information about how to raise a concern, in patient areas. There was also a guide to making comments and complaints on the provider's web site, which could be downloaded. This signposted NHS and self-pay patients to the next steps should they remain dissatisfied with the response from the service.

Good

Surgery

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. According to the service's complaints report 2021-2022, the service received three formal complaints. We reviewed the documentation for the complaints and saw all were managed in accordance with policy. The responses were thorough and addressed the issues raised by the complainants.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Are Surgery well-led?

Good

Our rating of well-led: We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The provider met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role.

A poster showing the organisational structure was displayed. The service was led by two consultant ophthalmologists (clinical lead and nominated individual) and the operational director, who was also the registered manager. The senior leaders had extensive healthcare management and clinical leadership experience.

The service operated as a joint venture model and was supported by Newmedical Systems Ltd corporate management team, which included a medical advisory committee (MAC).

All staff we spoke with considered the leadership team to be visible. For example, they attended departmental meetings, regularly walked round the service and spoke with patients and staff.

Staff we spoke with told us how management had supported them to take on more senior roles and develop their careers, with a view to succession planning. For example, three staff attended an external leadership skills course.

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.

Good

Surgery

Managers we spoke with described their plans for the service. For example, to extend the building to accommodate administrative functions and improve staff rest areas. They also aspired to expand the business to reach community groups and introduce new procedures for the treatment of glaucoma.

The service had a five-year business plan and strategy for what it wanted to achieve and workable plans to turn it into action, which the senior leadership and heads of departments shared with staff .

Staff we spoke with understood the organisational vision and we saw this displayed in the public waiting area.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against strategy and plans.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All corporate policies we viewed included a completed quality impact assessment.

Equality, diversity and human rights was included in the mandatory training modules.

All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. They told us they were given opportunities to attend further training to develop their career.

Staff we spoke with told us they were actively encouraged to speak up and raise concerns. Staff we spoke with described an 'open' culture.

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

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 was a corporate policy for safer recruitment and staffing.

The service's governance structure and arrangements were clearly described in the corporate governance structure and processes policy. The service was supported by Newmedical Systems Ltd corporate MAC, which met monthly. These meetings included, for example, review of complaints, clinical incidents, audit activities and the provision of potential new services. Meeting minutes we reviewed followed a fixed agenda and were thorough.

There was a corporate policy in place for management of consultant practising privileges. Review included General Medical Council (GMC) registration, appraisals, indemnity insurance, and disclosure and barring service checks. The MAC reviewed all applications.

Good

Surgery

At the time of inspection, there were 14 consultants with practising privileges. Consultants with practising privileges for ophthalmology were on the GMC specialist register.

In addition there were monthly quality management, information governance committee and procurement meetings. The service's management team dialled in to a corporate meeting with directors for two hours each week.

Staff met monthly at the team meeting. They discussed, for example, patient feedback, training compliance, incidents, audit activities, operational business and minutes from corporate meetings.

The provider was a members of the Independent Sector Complaints Adjudication Service (ISCAS), a nationally recognised organisation in the management of complaints in the independent health sector, and followed their code of conduct.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated most 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 service had a risk management policy.

We saw most relevant risks were reviewed monthly and escalated appropriately, on a risk register. However, although the registered manager was aware of the low mandatory training compliance for bank staff, this was not included on the risk register.

The service had a business continuity plan (BCP).

There was a full audit plan for the year. These audit plans were in line with the wider group requirements. Audit results were presented to staff at departmental meetings. Individual areas for focus were highlighted with general findings and learning that had taken place.

Information Management

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

Important information such as policies and minutes of meetings were accessible to all staff.

Health records, referrals and diagnostic results were held on paper. The appointment booking system was electronic and uploaded from a paper appointments record. This meant staff could still access theatre lists and clinic appointments in the event of IT system failure.

NHS patient files were colour coded to ensure staff could identify the NHS trust contract that had commissioned their treatment.

Staff completed mandatory data security awareness training and the service achieved high compliance rates for local information security audits.

Good

Surgery

Discharge letters and communications to referrers were sent electronically within two days of treatment.

The service submitted data to external organisations, for example, the National Ophthalmology Database (NOD).

Engagement

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

The service engaged well with patients, staff, the public and NHS trusts to plan and manage appropriate service, and collaborated with partner organisations effectively. It developed services with participation of staff and patients and demonstrated commitment to acting on feedback.

The service's website provided a wide range of information about the referral process, clinical services available and how to leave feedback.

Patient feedback was displayed in the waiting area. Survey results we reviewed for January 2022 indicated high patient satisfaction.

Managers were visible in the departments, which provided patients and visitors with opportunity to express their views and opinions face to face.

Staff we spoke with told us managers engaged with them, were very supportive and visible. Staff said they were encouraged to voice their opinions and speak with managers if they had any concerns. They told us they felt appreciated by their clinical colleagues and service managers. This was reflected in the colleague survey results summary we reviewed.

We saw staff were encouraged to share ideas to improve practice, for example, theatre lists were version controlled and printed in different colours to alert staff when the list order was changed.

The provider's strategy included a focus on building long term partnerships with stakeholders, which included local NHS hospital trusts and community.

Learning, continuous improvement and innovation

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

The service closed on the first Tuesday of every month, for a whole team meeting. This included planned training sessions from the training lead and learning seminars presented by clinicians.

This was also used as an opportunity to discuss local policies to help embed them more effectively

The service was committed to improvement by learning from when things went well or wrong, promoting training, and innovation. For example, staff were asked to contribute ideas for improvements to the service, as part of their performance reviews. Staff we spoke with said they were supported to attend external training, to develop their career.

The service had an agreement with the local NHS deanery to take post-graduate ophthalmology trainees on clinical placement. They worked under direct supervision of a Consultant Ophthalmologist and worked in accordance with a deanery-approved training programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not ensure emergency medicine expiry dates were checked in accordance with the provider's policy and these medicines were not replaced before the expiry date was reached. Regulation 12 (1) (2) (g).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service did not ensure all bank staff had completed mandatory training and safeguarding training so they had the necessary skills to carry out their role. Regulation 18 (1) (2) (a).