Leeds Newmedica Limited

Newmedica Wakefield

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	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 processes to manage safety incidents and lessons learned. Records were stored securely and easily available to all staff providing care.
- 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Governance processes were in place. 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.
- 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.

However:

Surgery:

- Staff training did not include announced and unannounced emergency simulation drills.
- Eight patient records were reviewed which showed shortfalls in information, legibility, dates, absence of staff grading and medical staff General Medical Council numbers.
- Patients' follow up calls were not completed for all patients. Following a call when the patient was not reached there was no evidence that another follow-up call had taken place.
- We saw limited evidence that attention was given to the range of complications and the visual outcome.
- Where patients were referred post operatively to other hospitals for follow-up this was not recorded by 'Newmedica' as a complication which could be used to inform current practice and patient outcomes at the hospital.
- All risks should be identified on the service risk register.
- The onward referral clinical support (December 2020) document confirmed which Trust the patient would be referred to for specific concerns. Staff said this agreement was reviewed with the local NHS Trust verbally, however, no written minutes existed of these conversation

Outpatients:

- Consultant and nursing records were not completed fully.
- The service did not undertake audits for the completion of consultant and nursing records including the signing and dating of entries.
- The clinical team did not have consistent access to current information related to patients existing medical conditions and treatments.

Summary of findings

- When an incident occurs, details are not always fully documented in the patients notes, in the patient's electronic record or in the incident reporting system.
- Audits are not undertaken for the completion of consent information.
- Post-operative checks are not consistently undertaken for each patient.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Newmedica Wakefield

Newmedica Wakefield is an independent provider registered with CQC since 2020 and this is the first inspection since registration. This service is delivered in Wakefield by Leeds Newmedica Limited, a joint venture partnership company within the Newmedica Group. The registered manager is registered across two locations in Leeds and Wakefield.

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 alternate weekends and Wednesdays, whilst 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.
- Ocular hypertension and glaucoma treatment and monitoring
- 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 and two members of the senior management team.
- Spoke with 9 staff members including bank and consultant staff.
- Reviewed eight patient care records and treatment records.
- Observed three patient surgical pathway sessions from admission to discharge.
- Attended three theatre briefings.
- Spoke with 9 patients.
- Spoke with one carer.
- Looked at a range of policies, procedures and other documents which related to the running of the service.

You can find information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

Summary of this inspection

Surgery:

- The provider must 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. Regulation 17(1)(2) (c)
- The provider must ensure that the patient's referral initial triage includes checks on the patient's medical history and medication and ascertain whether surgery exclusion criteria apply to the patient's referral. Regulation 12 (1) (2) (a) (b)

Outpatients:

- The provider must ensure that the clinical team have access to current information related to patients existing medical conditions and treatments. Regulation 17 (1) (2) (c)
- The provider must ensure that dates for each entry within the patient's pathway and the signature of the clinician involved at each stage of the patient's care is legibly recorded to enable the accessibility of information within each record sheet. Regulation 17 (1) (2) (c)

Action the service SHOULD take to improve:

Surgery:

- The provider should ensure that announced and unannounced emergency simulation drills take place.
- The provider should ensure that all ongoing risks are documented in risk registers and reviewed as agreed by policy.
- The provider should ensure that patient follow up calls are completed and documented for all patients.
- The provider should ensure that where patients are referred post operatively to other hospitals for follow-up this is recorded by as a complication and audited; the outcomes of which are used to inform current practice and patient outcomes at the hospital.
- The provider should ensure that minutes are taken of meetings held with NHS Trusts and other providers.

Outpatients:

- The provider should consider the availability of an additional resuscitation trolley.
- The provider should consider how to support the clinical team with up to date and accurate information as to the patient's medical conditions and treatments.
- The provider should consider introducing a clear management plan for patients to support reviewing clinicians involved in the patient's care.
- The provider should ensure that audits are undertaken for the completion of records, including the signing and dating of entries and the recording of post-operative calls.
- The provider should ensure that when an incident occurs details are fully documented in the patients notes, in the patient's electronic record and in the incident reporting system to support identifying root causes and to mitigate risk.
- The provider should ensure post-operative checks are undertaken for each patient to provide a more complete picture of patient outcomes linked to the completion of each patients' treatment.
- The provider should ensure that patient follow up calls are completed and documented for all patients.

Our findings

Overview of ratings

Our ratings for this location are:

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

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 complete IPC training level 2 which includes sepsis, PPE, HCAI, and antimicrobial resistance. Resuscitation training basic life support 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 was introduced for staff from July 2022. Previously, this was 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% 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. Recognised process is followed to submit concerning information to the local authority duty safeguarding team. Staff could access the safeguarding contact information if needed. The registered manager informed us the provider had few safeguarding referrals and learning is shared across sites.

The clinical governance meeting minutes for September 2022 showed one safeguarding incident was recorded and action taken to mitigate the risk to the patient.

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 wellmaintained. Patients commented on the high standard of cleanliness.

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. We noted that flooring and chairs were made from easy clean materials. Storage facilities were also clean and well maintained. 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.

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 90100%.

Environment and equipment

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

Good

Outpatients

The facilities we observed were suitable to meet the needs of patients. Imaging facilities included ophthalmology testing rooms were located adjacent to consultation and waiting areas with toilet facilities. Storage areas we checked were visibly clean and well-organised. We also observed space was quite limited, so that patients may need to transfer several times between examination chairs during their visit.

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.

Staff carried out daily safety checks of specialist equipment and records showed safety checks were up to date. The clinical governance meeting minutes for September 2022 showed the decontamination audit for Wakefield identified where equipment decontamination was incomplete and the action taken to address this.

The policy for laser safety was in date.

The availability of resuscitation trollies we observed was limited with no couches available, apart from the theatre table which may present an issue in the event of a patient collapse.

Staff managed clinical waste well.

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 most 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 this was required.

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.

Good

Outpatients

Records

Staff kept detailed records of patients' care and treatment. Records were stored securely and were usually available to staff providing care although we found consultant and nursing records were not always completed fully.

The service operated a system of colour coding (blue and pink) for manual records to distinguish each eye. We observed patient notes were recorded both on the computer system and in a manually written folder. We reviewed records for patients selected randomly for current patients. Notes were not always legible or signed and dated legibly by staff. 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 but we found notes could also be filed incorrectly. The service did not ensure the clinical team consistently had access to current information related to patients existing medical conditions and treatments. The management plan and pathway for the patient was not always clear in current records. We found some information about events in the clinical pathway were missing from care records. For 6 records, no telephone post-operative check was recorded.

Although the service recognised and worked to overcome some of the limitations of manual records being operated alongside computerised records, we found it did not undertake audits for the completion of records including the signing and dating of entries or the recording of postoperative calls.

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 in place. We observed that patients were requested to present their prescription slip.

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.

Incidents

Good

Outpatients

The service managed patient safety incidents. Staff usually recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and responded to patients with 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. For the most recent month (August) the provider had recorded 325 appointments, for which two of these involved an incident being recorded. 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 in the service.

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

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 used benchmarking data to compare practice.

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.

Good

Outpatients

Nutrition and hydration

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

Drinks and snacks were provided for patients whilst waiting if they required. 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.

Patients receive 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. Patients we spoke with confirmed they had not needed pain relief.

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 that 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.

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

We reviewed the annual appraisal data for consultants and other staff that worked in the service which confirmed that appraisals were up to date or had been scheduled. Appraisals supported staff development linked to induction and probationary periods for new staff. We spoke with some staff who had recently joined the service and they were very positive about the support they had received and the career development opportunities this presented.

Good

Outpatients

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. The service worked with GPs, opticians 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. We found Newmedica Wakefield had moved to seven days operation from 1 September 2022 in response to patient demand. 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 saw that consent for surgery was audited and action needed was identified and monitored.

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 six patients. Without exception, patients described the level of care and support provided to them in very positive terms, mentioning specifically the friendly and courteous support 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.

Policies for chaperones and other aspects of policy supporting a caring service were in place. Patient experience was audited monthly with good practice noted and recommendations for any improvement fed back for action.

Patient feedback results for August 2022 were 99% positive.

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. Patients we spoke with confirmed they were pleased with the emotional support they received.

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

Good

Outpatients

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

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 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.

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. Did not attend patients represented 5 per cent for the most recent month (August 2022).

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 forget-me-knot labelling on patients notes to identify patients with dementia.

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

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

Good

Outpatients

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 during the inspection visit. 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 in place which was in date and reviewed on an annual basis.

The service clearly displayed information in patient areas about how to raise a concern. 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. 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

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 nominated individual was a founding director and senior ophthalmic consultant. A clinical director completed the leadership team.

Managers were approachable and visited the Wakefield site regularly. We observed that managers were visible, and staff confirmed they were approachable, with no hierarchy. We noted the high visibility of managers present including for weekend working. Staff told us there was a clear management structure which made sense and was easy to understand and the manager was 'very people-focussed'.

Staff received good support and teamwork was effective. 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. All Wakefield staff attended Leeds for an 'all stop' day held monthly.

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 supported by a local vision which focussed on the role of 'patients, people and partners' which was displayed in the service. The registered manager explained that the Wakefield site was opened in response to patient demand.

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 and the interaction with staff was very positive.

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 said they were happy with the way the clinic is run, felt confident to raise any concerns with managers and felt listened to. Staff were kept informed of organisational service developments. We spoke with some staff who had recently joined the service who spoke positively about the welcoming attitude they had experienced and the open attitude of managers.

The service had local and national Freedom to Speak Up Guardians and a linked whistleblowing policy and equality and diversity training was included in mandatory training for staff. A health and well-being ambassador was available who received any duty of candour incidents directly.

The service had in place a current policy for being open and duty of candour. The service confirmed it had not had any patient related incidents which had required a Duty of Candour letter being sent to the patient.

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.

The service operated an integrated governance framework which treated Leeds and Wakefield effectively as one organisation. Governance and performance management arrangements were regularly reviewed. The governance framework comprised of 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.

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. For Wakefield, a quarterly meeting was held with commissioners.

Staff teams discussed quality and safety performance issues at regular review meetings. Learning was shared from any incidents or 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 service operated risk management processes which ensured risks were identified and managed and mitigation measures put in place. A policy was in place to support identifying patients as 'high risk' to ensure risk was managed appropriately and to support deciding on appropriate urgent action.

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.

Incidents or complaints were recorded in the governance recording database. We saw evidence of risks, issues and performance being reviewed 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. Processes were in place to manage current and future performance. A monthly governance and quality report including key performance indicators specific to Wakefield was shared with commissioners. A business continuity and recovery plan which included Wakefield we saw was most recently reviewed in July 2022.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance and to make decisions and improvements. The service used a mixture of electronic and paper records, which were stored securely. Data or notifications were 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. Although the service recognised and worked to overcome some of the limitations of manual records being operated alongside computerised records, we found some information about events in the clinical pathway was missing from care records.

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.

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

The service contributed to the provider's annual governance and quality report which included summarised performance information with identified areas for improvement.

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 recorded. 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 six patients. Without exception, patients described the level of care and support provided to them in very positive terms, mentioning specifically the friendly and courteous support of the staff, and the timeliness of the response they had received. Patient feedback results for August 2022 were 99% positive.

Good

Outpatients

Patients also used survey forms provided as well as social media, phone and email. We observed the notice board with a 'You said, we did' poster which included examples of appropriate action being taken in response to concerns raised.

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 gave us examples of learning and improving related to these priorities.

The service set aside one day a month as an 'all stop' day with no clinical commitments in order to focus on staff meetings and training. We found evidence of active participation in learning from reviews and sharing information and learning. Innovation included plans for the service to 'go paperless'.

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.

Mandatory training was comprehensive and met the needs of patients and staff.

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. Training statistics for 2021/22 confirmed 97.5% of employed staff had completed their mandatory training for this year. Bank staff compliance was at 88%.

The mandatory training report dated 16 August 2022 confirmed the majority of mandatory training module compliance was 100%. We observed two dips in compliance for dementia training at 78% and level two patients manual handling training at 81%. Staff said the dementia training was not a mandatory training and the level two patient handling training was completed by clinical staff only and this was why compliance was not at 100%.

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. Consultant completion of mandatory training subjects were recorded on the bank staff training matrix document.

New standalone sepsis training had been introduced and was completed by staff on the 22 July 2022. The infection control policy also contained a section detailing how to spot the signs of sepsis. The sepsis presentation to staff took place on the 'all stop day' and staff said this training had also been introduced as part of new starters inductions.

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

Mandatory training matrix updates had taken place. The August 2022 mandatory training matrix report identified the changes to the current matrix. Staff said, although, not currently included as a mandatory training subject online autism awareness training from e-learning for Health was offered to staff from the 1 July 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 that 80.72% of bank staff had completed their mandatory training subjects to-date.

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. The training matrix for permanent and bank staff groups confirmed completion of this training and due dates for each staff member of their next training session. The training matrix confirmed that six bank staff members was colour coded amber or red which identified update training in Equality, Diversity and Human Rights level 1 was required. In addition, staff complete training in the Mental Capacity Act and Consent training. The provider has observed that

Standard nine of the Care Certificate included a module on 'Understanding Learning Disabilities' and were reviewing the content of the certificate to see whether there was additional information in this area that can benefit staff.

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.

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 manager's room. In addition, all permanent staff had completed Prevent training, the preventing radicalisation level 3 adults training and conflict resolution training. Bank staff completion of this training confirmed some shortfalls in completion as 24 of the 33-bank staff had completed this training.

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. The bank staff training matrix confirmed two bank staff safeguarding adults training and three bank staff members safeguarding children's training sessions were due for completion.

The clinical governance meeting minutes for September 2022 showed one safeguarding incident was recorded and action taken to mitigate the risk to the patient.

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.

The service dashboard confirmed that there were no reported cases of MRSA, MSSA or Clostridium difficile within the Newmedica Wakefield from April to July 2022.

The mandatory training matrix confirmed that all staff had completed level 1 and level 2 infection prevention and control (IPC) training.

In response to Covid-19, 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 and all were temperature checked.

Staff generally 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. Staff cleaned the local environment and equipment, after patient contact. We observed three patient's surgical pathway experiences from arrival to discharge.

We noted a potential infection risk to the theatre area. Staff changed into scrubs and theatre shoes and walked through public areas without changing shoes or having overshoes placed over existing footwear. We also observed that patients entered the theatre without overshoes protection on their footwear.

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

Cleaning services were provided through a property management company. Cleaning schedules identified daily and weekly cleaning regimes. Completed cleaning checklists for July and August 2022 confirmed the necessary checks were completed.

The quarterly thematic report dated 20 June 2022 identified compliance against audits from January to June 2022. We saw 100% compliance was achieved for the following audits at Newmedica Wakefield - IPC, Infection Control during Pandemic Audit, Waste Management, Cleaning, Scrub, Hand Hygiene and Decontamination.

Hand hygiene, infection control and cleaning audits compliance from, July to September 2022 was between 99 and100%.

Staff confirmed that weekly checks included flushing taps and the shower which were documented. The Quarterly Thematic Review Report dated 15 August 2022 for Wakefield Newmedica confirmed that water checks and legionella checks were completed as part of the service daily and weekly checks. Health and Safety Executive Legionella risk assessments had taken place on the 22 August 2022. The conclusion of the risk assessment was that the overall risk associated with the domestic water services was currently Low. Due to the risk rating of the building, it is advised the next Legionella Risk Assessment was completed by August 2024. There were no high-risk actions identified at the time of inspection.

Good

Surgery

Reusable instruments were sent to an external Independent Health provider for decontamination and were managed effectively. Decontamination policy guidance was also available to advise staff.

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 facilities were suitable to meet the needs of patients. The patient area was located on the ground floor of the clinic and accessible access by a small lift was in the car parking area to the rear of the clinic.

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.

Two consultation rooms although small allowed for patient privacy, the third consultation room was larger. We observed space was quite limited, which meant patients may need to transfer several times between examination chairs during their visit.

The theatre was small but adequate for the service being provided. There was no clean prep room, so instruments were prepared in theatre between cases.

The staff area and storage space were located on the first floor of the building. We observed that the storage space door was locked when not in use. Storage areas we checked were visibly clean and well-organised. Parking was available for both staff and patients.

We observed close circuit television in the car park area of the premises and saw entry to clinical rooms was generally through a keycode system. Patients and visitors were greeted by a staff member and the necessary checks made prior to being allowed entry into the clinic and waiting area.

Portable appliance testing, positive pressure ventilation systems used in theatre and lift servicing records confirmed checks took place and equipment passed these checks.

We undertook a random check of the medicines and equipment in the resuscitation trolley and found all to be in-date. The resuscitation trolley was sealed with a plastic tie. Resuscitation equipment records check lists confirmed weekly checks had taken place.

Business continuity plans were in place.

Clinical waste was tagged and disposed of safely through an external provider. However, we also observed that one large external clinical waste bin was not locked despite being lockable. The provider was informed. Later the same day we checked the external clinical waste bins again and found all bins were locked.

Controlled substances hazardous to health (COSHH) were locked in a separate cleaning cupboard which could only be accessed by designated people at the clinic.

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 onward referral clinical support (December 2020) document confirmed which Trust the patient would be referred to for specific concerns. Staff said this agreement was reviewed with the local NHS Trust verbally, however, no written minutes existed of these conversations. The discharge of care policy (v4) included guidance on patient emergency discharge processes.

Pre-operative screening and clear patient categorisation guidance 'Newmedica Leeds Cataract

Categorisation' guided staff in the pre-assessment stage of the patients' journey as to whether the patient should have their cataract surgery at Newmedica Wakefield. Preoperative assessment documentation confirmed the patient's suitability for treatment at Newmedica Wakefield.

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

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.

The policy for medical emergencies gave clear direction as to what to do should a patient deteriorate, and guidance followed Resuscitation Council (UK) guidelines. We saw that discussion with the Medical Advisory Committee had taken place on the 31 March 2022 with respect to the draft policy and the importance of standardising this policy and follow-up audits across services.

We saw a call bell system in place 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.

Training statistics confirmed staff had completed training to enable them to respond to the deteriorating patient. Two consultants were advanced life support trained. Relevant permanent staff, consultant staff and bank staff were immediate life support trained. All staff had completed adult basic life support training. Training records confirmed that 21 of the 33-bank staff had completed ILS; the other bank staff either had completed this training and were due to update, whilst five bank staff were identified to complete ILS training.

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 described one incident where a patient deteriorated and the outcome of this investigation. It was confirmed staff did not always receive information which related to the patients past medical history at the initial referral stage which meant individual patient risks were not always identified. We looked at the online referral triage process with one staff member and saw no reference on this electronic document to check the patients previous medical or medicine history. Staff told

us that unless the referral came from the patients GP no past or current medical and medicine history was provided and as such were reliant on the patient providing this information at their first face to face appointment. Following this investigation, although this issue still existed, and some actions implemented the service had not identified this risk on the local risk register.

Staff said and we saw through observation of the patient journey, health problems were generally 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.

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 and surgical team brief's took place in theatre prior to surgery commencing.

Evidence 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. Quarterly local safety standard for invasive procedures (LocSSIPs) audits from December 2021 until September 2022, average performance was 93%. The oculoplastics consent audit action plan from these audits identified actions and monitoring accountabilities. The service had also audited cataract and minor operations, the outcomes of these audits are documented in the consent section of this report.

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.

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 accessible.

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 senior management rotas for March, June and August 2022 confirmed the presence of a senior management on the Wakefield site when the service was operational.

The manager could adjust staffing levels daily according to the needs of patients. The July 2022 - Leeds People's Report confirmed that 30 employees worked across the service.

On the day of inspection theatre staffing included one scrub nurse, an operating department assistant and one runner which staff confirmed was normal practice. One registered nurse saw the patient preoperatively; whilst the operating department practitioner was available for postoperative patient support.

Ongoing recruitment throughout the service continued with between zero to three employed joiners per month from July 2021 to July 2022. The staff appointed worked between the Leeds and Wakefield Newmedica sites. Five staff had left the service in this same time period.

We reviewed the personnel files and the recruitment checks undertaken for two new staff members and noted that all the necessary checks were completed prior to them starting in post.

The July 2022 Local People Report confirmed sickness levels from July 2021 to July 2022. The total number of days per month ranged from zero (July 2022) to 14 (January 2022). The highest sickness levels of 13 – 14 days per month were between December 2021 to January 2022 which would have coincided with the resurgence of the COVID-19 pandemic.

Bank staff were employed to provide additional support where needed. Managers limited their use of bank staff and requested staff familiar with the service. Bank staff said they had completed local inductions.

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 preemployment 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 – July 2022 confirmed that in July 2022 there were 13 locum consultants including one associate specialist who worked within the service. We reviewed two consultants' personnel files and noted that all the necessary pre- and post-employment checks were completed.

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 service triaged patient calls to ensure that the patient was directed to the right person. An agreement was in place with a local NHS Trust to see patients overnight should concerns be raised.

Records

Good

Surgery

We found gaps in the information contained in the patients records we reviewed. Records were 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 used at the clinic. Staff confirmed paper records such as the 'cataract pathway' were kept and archived.

We reviewed eight patient records for evidence of consent processes, pain relief, legibility, dates, signatures and pre-operative and post-operative checklists. The issues noted in these records included:

- Several had a blank 'Postop Telephone Call' sheet.
- A few had 'no answer' recorded, but there was no indication if any other follow up was to be undertaken apart from the standard six-week review.
- Not all notes were legible
- Most entries were illegibly signed, most did not have staff grading and none had the surgeon's General Medical Council numbers identified
- Because of the duplex written and computerised systems, not all entries were dated.

The service dashboard, governance and quality report for July 2022 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 monthly review visit, on the 11 March 2022 confirmed from January 2021 until December 2021, the cataract WHO checklist average performance was 100%.

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.

Medicines management policies and procedures were in place. Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed all medicines and prescribing documents 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.

FP10 prescriptions were locked away when not in use.

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. Patients' prescriptions were prescribed on site and patients were given the necessary medicines to take home.

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.

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.

A medicines thematic review took place on the 18 May 2021. The outcome of the external medicines audit in March 2022 was confirmed as part of this review. The initial recommendations for the Wakefield Newmedica crash trolleys and medicines audit identified the following:

- Some items on the emergency trolley were missing and no efforts were made to replace them despite regular checks
- FP10s must be strictly monitored and tracked.
- Room and fridge temperatures were not always recorded daily (Jan 2022).
- Theatre fridge minimum temperature recorded was below 2C on a few occasions. The fridge should be serviced and calibrated if needed.
- The big sharps bin in the theatre had a loose lid and posed a risk if knocked over.

It was noted that Wakefield Newmedica had started completing these actions and monitoring would continue through identified managers and as part of the governance action plan. We did not see the outcome of the further monitoring as this information was not provided. During the inspection we checked monitoring of the fridge temperatures and saw this had taken place and the results documented. All results seen were within normal temperature ranges.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents although we observed that further actions were required in one incident, we reviewed to reduce overall risk. 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 learning could be identified and shared. 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. Incident learning were displayed throughout the clinic.

An incidents register was in place. We tracked one incident with staff as described in the

'Assessing and Responding to Risk' section of this report and saw two actions were implemented as part of the incident review process. Following this investigation, one issue which related to staff not having collected patients medical and medicine history data still existed as part of the triage process. Some actions were implemented however, the service had not identified this risk on the local risk register or engaged with the local integrated care board (ICB) to try and resolve this potential risk. This incident had been discussed with the staff on the monthly staff meeting day where learning was identified, support and supervision was also offered to staff.

Good

Surgery

Incidents learning was captured and displayed in the clinic. For the 2021/2022 period Wakefield had identified 33 incidents, no themes were identified.

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, Royal College of Ophthalmologists and local guidance was in use. We selected random policies, protocols and procedures and we found they were in date and were reviewed three-yearly.

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. We observed that postsurgery patients were 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. However, we saw from patients notes that on some occasion's patients had not been contacted and there had been no further attempt at contact.

Good

Surgery

Pain relief

Staff assessed and monitored patients to see if they were in pain.

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. However, we saw from patients notes that on some occasion's patients had not been contacted and there had been no further attempt at contact.

Patient outcomes

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

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.

We found no evidence which confirmed that complication rates were higher than expected. The cataract patient pathway outcome graph confirmed from April to July 2022 there had been no complications. However, where patients were referred elsewhere due to complications this information was not collected by the service. This meant that this outcome data was lost to Newmedica who should use this data when auditing patients' outcomes which would inform on the patient's final visual outcome.

Patient experience was monitored through patient feedback. In July 2022, 76 patients completed the survey for Newmedica Wakefield. The extremely likely ratings included: 84% recommended the service to friends and family, 88% said they were treated with dignity and respect, whilst 85% said they were involved with decisions about their care. We also saw the positive feedback that was given as part of this process.

Good

Surgery

In 2021/22 information taken from the Quality Report 2021/22 confirmed the three additional monthly clinical audits had good levels of compliance.

In addition, the Quarterly Thematic Review Report dated 15 August 2022 for Wakefield confirmed the additional audits which had taken place and compliance levels. The audits included: cleaning audit (100%), monthly hand hygiene (100%), monthly theatre scrub (100%), decontamination audit (100%) and infection control during the pandemic audit (100%). Managers shared and made sure staff understood information from the audits. The service participated in relevant national clinical audits. We saw 100% compliance achieved consistently for these audits which were undertaken monthly from January to June 2022.

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

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.

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. New staff to the clinic completed specific workbooks, for example the clinic assistant workbook as part of their induction and ongoing learning.

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, the service 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. Three of the 13 doctors were overdue a clinician appraisal which had been due in 2021/2022.

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. 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.

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. Examples of the training completed were safeguarding of vulnerable adults – level 3 and immediate life support 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 NHS Trust 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.

The service worked closely with and supported pre-registration optometrists and medical trainees.

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 Wednesday's surgery took place from 8am until 4.30pm.

Patients were reviewed by consultants prior to surgery and postoperatively.

Staff could call for support from doctors and other disciplines seven days a 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, for example dementia champions were identified, smoking, falls and weight management leaflets associated with visual defects.

Patients and carers were recently invited to a coffee morning to help shape how the organisation could ensure best care for eye health.

Staff meeting minutes from June 2022 showed that discussions had taken place around dementia awareness and learning from incidents which involved vulnerable patients.

We saw documentation which confirmed that patient's other health needs such as high blood pressure were followed through with their GP to ensure that they received the necessary treatment to assist with their condition.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Discussions with staff and the mandatory training matrix confirmed all permanent 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.

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 preoperative 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 saw exclusion criteria was clarified at the patient's initial referral. Should the patient have mental capacity shortfalls they were referred to the NHS.

Good

Surgery

Cataract Pre-assessment and Consent Audit from January 2021 till December 2021, the service (St. Martin's and Wakefield) had an average performance of 98% with consultants completing the confirmation of consent. The service had improved on the signing of the confirmation of consent on the day of surgery; the consultant who completed the surgery, signed the confirmation.

The minor operations consent and World Health Organisation (WHO) checklist audit from January

2021 until December 2021, the service's average performance (St. Martin's and Wakefield) was 87%. This audit was completed quarterly or depending on the availability of activities per month. Confirmation of capacity to consent remains the reason why the service performance on mentioned remains to be under 100%. The service had regularly discussed the gap with consultants who complete minor operations activities.

Oculoplastics Consent and WHO Checklist audit from January 2021 until December 2021 average performance was 86%. This audit was completed quarterly or depending on the availability of activities per month. Confirmation of capacity to consent remains the reason why the service performance on mentioned remains to be under 100%. The service had regularly discussed the gap with consultants who complete minor operations activities.

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.

Patient feedback for July 2022 confirmed that 88% of patients said they were treated with dignity and respect by staff, whilst 12% of patients answered neither likely or unlikely.

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

We spoke with three patients and one carer who confirmed they were 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 four patients and observed the clinician was respectful and respected the patient's dignity.

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

Training records confirmed that all permanent 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.

Good

Surgery

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 three patient sessions and saw that patients appeared at ease and 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.

Advocacy support could be accessed and was identified at the patient's initial referral.

Procedures were discussed with patients before and during treatment. The 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.

The July 2022 patient feedback confirmed that 85% of patients said they were involved in decisions about their care.

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

Are Surgery 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.

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 for NHS patients.

Good

Surgery

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 had three consulting rooms, a patient reception and waiting area and designated theatre providing cataract surgery and oculoplastics.

Free local parking was provided in the clinic / car park.

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 84 or 6% of new appointments were not attended; 49 or 10% 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, attending the service received the necessary care to meet all their needs. Staff confirmed patients with additional needs were identified at the initial referral stage. If the patient was accepted, they bought a carer or relative with them to the appointment. However, where patients had several additional needs, they would be referred to the NHS to ensure their needs were met.

The service had identified a dementia champion. 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 braille and large print formats.

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

Guidance for staff regarding patients discharge and transfer of care was available.

Patients could access patient transport when necessary.

Access and flow

Good

Surgery

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.

The Leeds service dashboard, governance and quality report for the time period 1 April 2021 to 31 March 2022 confirmed 1334 referrals. There were 1213 new patient attendances and 445 followup patient attendances. In total, 627 patients were listed for surgery.

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.

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 Leeds service dashboard which included referral information about the Wakefield service, governance and quality report for the time period 1 April 2021 to 31 March 2022 confirmed the percentage of referrals triaged within two working days was 98%; the average number of days from referral to first appointment was 41.2 days. The average number of days from referral to treatment was 58.5 days.

The service statistics confirmed that 97% 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 13 and 2 respectively.

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

In 2021/22 24 patients' operations were cancelled due to consultant availability. All patients were rebooked within a week of the cancelled clinic.

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

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 concerns 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.

Good

Surgery

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.

The service had received no complaints since they opened in December 2020.

Patient feedback was also collected through 'You said, we did'. We saw examples of changes implemented described in the February and May 2022 thematic reports which resulted from monthly visits to the service.

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.

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

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.

At a corporate level there were clinical leads for glaucoma, cataract and retinal vitreous disease. These roles supported 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.

Staff could access leadership development programmes and mentoring through their annual appraisal process.

Good

Surgery

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

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. 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/Wakefield 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.

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 12 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.

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

Staff confirmed appraisal processes were in place for all staff. All employees had a one to one meeting with their line manager to ensure appropriate support was provided and for ongoing learning needs assessment. 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.

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. Subcommittees 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.

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 and Wakefield dashboard (April 2022 to July 2022) recorded interactions which related to incidents, serious incidents, complaints, surgical site infections, the percentage of staff who received infection, prevention and control, critical medicines training and monitoring of formulary compliance 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.

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. We saw discussions relating to audits and outcomes had taken place in the local governance and Medical Advisory Committee minutes we reviewed.

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 registers documented risks which were graded according to severity, using the red, amber and green traffic light system. 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.

Good

Surgery

The Board received an annual safeguarding report to review our response to continually protect vulnerable children and adults across Newmedica.

Business continuity and recovery plans were in place and were reviewed in July 2022.

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. 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.

The training matrix confirmed that all permanent staff had completed data security awareness (level 1) training.

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

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.

Patient feedback was collected through the NHS Friends and Family Test (FFT); the NHS

Reviews website confirmed that 100% (six responses) of patients scored the service five stars.

Good

Surgery

Patient feedback shared in the May 2022 Wakefield Thematic Report identified a mixture of positive and negative comments of the service. Some of the negative comments included: scheduling, waiting times and appointments, information and communication and the signage was confusing on the ground floor. We did not see actions produced from the negative comments.

Annual patient feedback from 1 August 2022 to 13 September 2022 described positive experiences.

In July 2022, 84% of patient feedback said they were extremely likely; 16% were 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 staff meeting minutes which confirmed staff were informed in what was happening within the service.

Engagement through the Consultant Led Ophthalmology Delivery Network (CLODN) took place. Meetings were arranged for June, September and December 2022 via Teams. The June 2022 meetings discussions included audit and changes to guidance.

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.

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 In-Service Trainers 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.

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 17 HSCA (RA) Regulations 2014 Good governance • The provider must 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. Regulation 17(1)(2) (c) • The provider must ensure that the clinical team have access to current information related to patients existing medical conditions and treatments. Regulation 17 (1) (2) (c) • The provider must ensure that dates for each entry within the patient's pathway and the signature of the clinician involved at each stage of the patient's care is legibly recorded to enable the accessibility of information within each record sheet. Regulation 17 (1) (2) (c)

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that the patient's referral initial triage includes checks on the patient's medical history and medication and ascertain whether surgery exclusion criteria apply to the patient's referral. Regulation 12 (1) (2) (a) (b)