

Optical Express - Sheffield (Meadowhall) Clinic

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Overall summary

Optical Express - Sheffield (Meadowhall) Clinic is operated by Optical Express Limited. It is a nationwide company offering general optometric services. The clinic provides laser correction procedures for adults aged 18 years and over. The clinic is based in a shopping centre in Sheffield. The service provides general optometric services, which are outside of the scope of registration and refractive eye surgery. We inspected refractive eye surgery only at this service.

The refractive eye surgery service has dedicated clinical space, located on the first floor of the Optical Express optometric shop, and is accessible either by stairs or by lift. Both services share some facilities on the ground floor, including a scan room.

We inspected this service using our comprehensive inspection methodology. The inspection was announced and took place on the 1 December 2017.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us, and how the service understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate refractive eye surgery services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- The service had systems in place for reporting, monitoring and learning from incidents. Staff knew how to report incidents.
- Staff used an adapted 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in treatment, by carrying out a number of safety checks before, during, and after each procedure. During our inspection, we observed three patient procedures where the WHO checklist was used correctly, and we reviewed other patient notes that showed the WHO check had been completed.
- There was sufficient, experienced and skilled staff to provide care and treatment to patients. Additional training was provided to staff that used laser eye equipment, which ensured patient procedures were carried out safely.
- Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were in line with national guidelines and standards.
- The service had a clear leadership structure, which mirrored the organisation's leadership structure. There was effective teamwork and good local level leadership, which created a positive culture.
- There were governance, risk, and quality systems in place, and staff we spoke with understood governance and risk arrangements.

- The service had systems in place for the identification and management of adults and children at risk of abuse.
- Staff we spoke with and training records viewed showed staff had completed mandatory training.
- Staff were aware of their responsibilities in relation to infection prevention and control. We observed that staff followed Infection prevention and control procedures and the clinic was visibly clean.
- There were systems in place that ensured clinical outcomes of surgeon were measured and monitored on an annual basis.
- We observed consistent positive interactions between patients and staff. All patients we spoke with were very happy with the care they had received. There was a system in place for obtaining patient feedback; this enabled staff to benchmark the service against other clinics across the organisation. The clinic had not received any specific feedback highlighting the need for changes to the service; but they had used feedback from other clinics to improve the service offered.
- Medicines were stored safely and staff administered medicines in accordance with the clinic's policy.
- The service had systems in place for the reporting, monitoring and learning from complaints. Complaints about the clinic were dealt with in a timely manner and information relating to complaints was shared with staff.
- Equipment we reviewed was serviced regularly and electrical tests had been completed and were in date. There were measures in place to manage the safety of lasers.
- The organisation recognised and rewarded staff through their weekly staff reward scheme.

However, we found the following issues that the provider needs to improve:

- The consent policy did not reflect Royal college of Ophthalmologists guidance 2017 for a seven day cooling off period between the initial consent meeting with the surgeon and the final consent by the surgeon.
- Patient information leaflets were not available in different languages.
- The organisation did not conduct staff surveys.

Summary of findings

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details of these are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Refractive eye surgery

Rating

Summary of each main service

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Optical Express - Sheffield (Meadowhall) Clinic

Services we looked at

Refractive eye surgery

Summary of this inspection

Background to Optical Express - Sheffield (Meadowhall) Clinic

Optical Express - Sheffield (Meadowhall) Clinic is operated by Optical Express Limited. The clinic opened in March 2008. The service primarily serves the communities of the Sheffield It also accepts referrals from outside of this area.

There is no registered manager at present. However, the manager has applied for registration with CQC. At the time of inspection, this application was being processed and the manager had been invited to attend an interview.

Our inspection team

The team that inspected the service included a CQC lead inspector, another CQC inspector, and a specialist advisor. The inspection was overseen by Lorraine Bolam, Interim Head of Hospital Inspection.

Information about Optical Express - Sheffield (Meadowhall) Clinic

Optical Express - Sheffield (Meadowhall) Clinic is registered to provide three regulated activities:

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

The clinic is based at Meadowhall shopping centre. Patients are self-referring and self-funding. The clinic provides laser vision corrective procedures using Class 4 and Class 3b lasers. The clinic provides the service for patients over the age of 18 years.

Surgery is carried out two to four times per month, according to patient need; and follow up aftercare is provided. The service opens at 8am and closes when the clinic has finished and the last patient leaves.

The service does not offer any other services other than refractive (laser) eye surgery. If a patient required further care, or surgery using anaesthesia or sedation (for example, lens replacement surgery), they are referred to other clinics. The service also provides pre and post-operative care for patients referred for surgery at alternative clinics.

Following an initial consultation with an optometrist, the patient has a consent appointment with the operating surgeon.

The clinic does not directly employ any resident team members. However, they do employ a regional surgical team covering the geographical area.

As part of our inspection, we visited the patient waiting area, examination rooms, pre and post-operative rooms, laser treatment room, and dirty utility room. We spoke with seven members of staff, including the service manager, senior managers, and surgeon, and asked them to share their views and experiences. We spoke with six patients in total, who were attending for pre and post-operative assessments and laser eye surgery. We reviewed six sets of patient records and two staff files.

There were no special external reviews or investigations of the service by the CQC at any time during the 12 months before the inspection.

The service was last inspected in 2013, where it was found to be meeting all the standards of quality and safety it was inspected against.

Activity

- In the 12 months prior to the inspection, there were 1,005 episodes of care recorded at the service. Of these: -
 - The service carried out 818 laser-assisted in situ keratomileusis surgeries. A procedure where the surgeon reaches the mid-layer of the cornea using a

Summary of this inspection

different laser- a femtosecond laser and a corneal flap is created. This is the most commonly performed laser eye surgery to treat myopia (near-sightedness), hyperopia (far-sightedness), and astigmatism.

- There were 187 laser assisted sub-epithelium keratomileusis laser surgery procedures performed during this period. This is where corneal flap is not created.

Track record on safety (in the last 12 months):

- No never events
- No serious injuries
- Two incidents with no harm
- No incidences of healthcare associated infections, such as Methicillin-resistant Staphylococcus aureus (MRSA) or Methicillin-sensitive staphylococcus aureus (MSSA), E. Coli or Clostridium difficile (c.diff).
- Twelve complaints, one of which was upheld.

Services provided at the location under service level agreement:

- Clinical and or non-clinical waste removal
- Laser protection service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate refractive eye surgery where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- There were systems in place for reporting, monitoring, and learning from incidents.
- Staff used an adapted 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in treatment. During our inspection, we observed three patient procedures where the WHO checklist was used correctly, and we saw other patient notes that showed the WHO check had been completed fully.
- There was sufficient, experienced and skilled staff to provide care and treatment to patients.
- The service had systems in place for the identification and management of adults and children at risk of abuse.
- Staff we spoke with and training records viewed showed that staff had completed mandatory training.
- Staff were aware of their responsibilities in relation to infection prevention and control (IPC); and we observed they followed IPC procedures and the clinic was visibly clean.
- Medicines were stored safely and staff administered medicines in accordance with the clinic's policy.
- Equipment we reviewed was serviced regularly and electrical tests had been completed and were in date. There were measures in place to manage the safety of lasers.

Are services effective?

We do not currently have a legal duty to rate refractive eye surgery where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines had been developed in line with national guidelines and standards.
- Surgeon clinical outcomes were measured and monitored on an annual basis.

Summary of this inspection

- Staff we spoke with and records we reviewed showed staff were experienced and competent to carry out their role. Additional training was provided to staff that used laser eye equipment, and this helped ensure patient procedures were carried out safely.

However:

- The consent policy did not reflect Royal college of Ophthalmologists guidance 2017 for a seven day cooling off period between the initial consent meeting with the surgeon and the final consent by the surgeon.

Are services caring?

We do not currently have a legal duty to rate refractive eye surgery where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- We observed consistent positive interactions between patients and staff. All patients we spoke with were very happy with the care they had received.
- Patients we spoke with said that they had been fully involved in their care decisions. Patients said they were given realistic expectations of the outcomes of their surgical procedure, and the potential risks and benefits of the treatment.

Throughout our visit, we observed staff reassuring patients with additional support when needed.

Are services responsive?

We do not currently have a legal duty to rate refractive eye surgery where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- Services were planned to meet the needs of patients, based on preferences and choice.
- Patients were offered follow up care at a time and clinic to support their needs.
- The service had systems in place for the reporting, monitoring, and learning from complaints. Complaints about the clinic were dealt with in a timely manner and information relating to complaints was shared with staff.

However:

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- There were no formal interpreting services available; and patients were asked to bring a family member, carer, or friend to their consultation to translate, if required. This meant that staff might not be clear if patients have fully understood the potential risks and benefits of surgery.
- Patient information leaflets were not available in different languages.

Are services well-led?

We do not currently have a legal duty to rate refractive eye surgery where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- The service had a clear leadership structure, which mirrored the organisation's leadership structure. There was effective teamwork and effective local level leadership, which created a positive culture.
- There were governance, risk, and quality systems in place; and staff we spoke with understood governance and risk arrangements
- There was a system in place for obtaining patient feedback. This enabled staff to benchmark the service against other clinics across the organisation. The clinic had not received any specific feedback highlighting the need for changes to the service; but they had used feedback from other clinics to improve the service offered.
- The organisation recognised and rewarded staff through their weekly staff reward scheme.

However, we also found the following issues that the service provider needs to improve:

- The organisation did not monitor staff motivation or job satisfaction in the form of staff surveys.

Detailed findings from this inspection

Refractive eye surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are refractive eye surgery services safe?

Incidents and safety monitoring

- The service had systems in place for reporting, monitoring, and learning from incidents. The clinic had an incidents and near miss policy, dated January 2017. This provided staff with information about reporting, escalation, and investigation processes.
- Staff knew the procedure for reporting incidents. The manager reported incidents to the surgical services manager via email, and the surgical services manager reported them to the clinical director. Reported incidents were then graded and added to the central register, located at the provider's head office. The surgical services manager said that they followed up and actioned surgical service incidents and the clinical director followed up and took action on clinical related incidents.
- The service had not reported any never events in the 12 month period prior to the inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were no serious incidents reported in the clinic during the last 12 months. Serious incidents are incidents that require further investigation and reporting.
- There had been two minor incidents reported in the preceding 12 months; both incidents involved inaccurate completion of consent forms, and both incidents had been investigated.
- Staff we spoke with explained how they reported incidents, and confirmed that incidents were discussed at team meetings for lessons learnt. Staff were able to

describe a change of practice as a result of learning from an incident, for example, not over-ordering consent forms and checking that the latest version of the consent form was used.

- Surgical services directives were sent to each location, these were directives from the senior clinical team at head office regarding important changes. The surgical services manager and clinical services director reviewed incident reports for the North region, and shared any learning that was required with other locations. Incidents were discussed at regional team meetings and within the team brief.
- A duty of candour policy was available; and a review of records and information supplied prior to the inspection showed that the service had no duty of candour concerns. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The staff we spoke with were aware of their responsibilities in relation to duty of candour concerns. The service had made no duty of candour notifications in the previous 12 months prior to inspection, as no incidents reported met the duty of candour requirements.

Mandatory training

- Training data we reviewed confirmed that mandatory training was undertaken in order to develop and maintain staff skills. Mandatory training included areas such as safeguarding, duty of candour, and infection prevention. New staff received a corporate induction, which included some aspects of their mandatory training, such as fire, health and safety issues.

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- The manager provided up to date records that demonstrated all staff had completed mandatory training; and that they monitored this information in order to make sure that staff had the training to maintain the safety of patients, visitors and themselves.
- Mandatory training was delivered via e-learning programmes.
- Records showed that all staff (100%) working at the clinic had completed their mandatory training. The corporate target for mandatory training completion was 100% compliance.
- The surgical services manager monitored compliance with mandatory training and reviewed training compliance records on a monthly basis to ensure compliance.
- Records reviewed reflected that all staff members were trained and up to date with basic life support (BLS). This training was in place to ensure that if a patient required life support staff would have the skills to intervene appropriately until emergency services arrived.

Safeguarding

- The service had systems in place for the identification and management of adults and children at risk of abuse.
- The service had a safeguarding policy, which detailed the different types of abuse, and how staff should report safeguarding concerns. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern, and how to raise them. The policy referenced the Care Act 2014, which included key changes to information relating to adult safeguarding. The safeguarding policy included information on the PREVENT strategy, which is a government anti-radicalisation directive.
- The laser protection supervisor was the designated safeguarding lead for the unit; part of this role was to report any safeguarding notifications.
- Safeguarding training was part of mandatory training, and information we received showed that 100% of staff had completed adults safeguarding training. The surgical services manager said that nursing staff were trained to children's safeguarding (level three); however, we did not receive information to support this. Information we reviewed showed that 100% of staff were trained to level one children's safeguarding. The

service had limited contact with young people as they did not treat patients under the age of 18 years old, and young people accompanying parents were not allowed into the treatment area.

- The surgical services manager and the safeguarding policy informed us that in the event of a safeguarding concern, staff would access the local council's safeguarding team for advice and support.
- Safeguarding contact details for the local authority were available within the policies and procedures file. The service had not reported any safeguarding concerns and there were no safeguarding notifications logged with CQC. The manager confirmed there had not been any safeguarding concerns in the service during the last 12 months.

Cleanliness, infection control and hygiene

- The unit had an infection prevention and control (IPC) policy, dated January 2017; this directed staff to other policies and protocols for guidance about cleaning, decontamination, and IPC practices.
- During the inspection, we observed that staff were compliant with 'bare below the elbows' and personal protective equipment practices. Staff we spoke with were aware of their responsibilities in relation to infection prevention and control, for example, bare below the elbows and decontamination of their hands before and after patient contact.
- Records we reviewed and conversations with staff confirmed that staff received and completed training in infection control. Staff also completed competency assessments following their training to confirm they understood the training, and were able to put the training into practice.
- There was a lead person for infection prevention and control who had overall responsibility for providing infection prevention and control advice.
- The surgical services manager audited standards on an ongoing basis. The audits identified what actions the service needed to take in order to reduce any potential risk of infection.
- The organisation carried out individual hand hygiene audits. We reviewed recent hand hygiene audit results, which showed 100% staff compliance. Where staff did not comply with hand hygiene standards, they were regularly monitored until they received 100%

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compliance. Once they attained this, they were audited on a yearly basis. Expectations for hand hygiene and infection prevention and control were discussed as part of the daily team brief.

- The clinic had a policy for dealing with patients that were known to be carrying methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA).
- The health questionnaire asked the patient to declare whether they work in healthcare and whether they had ever been diagnosed with MRSA. If patients declared a previous history of MRSA carriage at the time of the consultation, the Optometrist requested evidence of clearance results from the patient or prescribed prophylactic treatment as necessary.
- The clinic had reported no cases of MRSA, MSSA, or Escherichia-Coli (E. Coli) blood stream infections or Clostridium difficile (c.diff) infections in the 12 months prior to inspection.
- During our inspection, we observed good aseptic (no touch) technique processes by staff. The manager confirmed and we saw that the service utilised “single” usage surgical equipment. These were appropriately disposed of following surgery.
- We observed staff performing cleaning and disinfection of equipment between each patient, which followed manufacturer and organisational guidance.
- We inspected equipment in the treatment room, and all items were found to be visibly clean and ready for use. We saw that daily checklists took place on the day of surgery. These included, checking equipment was ready for use, and ensuring staff were wearing the appropriate uniform.
- An external company cleaned the clinic on a daily basis.
- The head office had overall responsibility for managing the domestic contract. We observed the cleaning schedules for the clinical areas and we reviewed the cleaning records and found them to be completed correctly.
- Sharps bins were used by staff to dispose of used disposable instruments, such as sharps, needles, and glass ampules. Sharps bins in use were secure, dated and signed, and off the floor in all areas we visited. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.

- The surgical service manager was knowledgeable about the surveillance of water systems for the presence of bacteria, and staff we spoke with were able to explain the procedures required to ensure water systems were safe to use. An annual test for the presence of bacteria, including legionella (a water-borne bacteria that can be harmful to people health), was available. This annual water test complied with the Approved Code of Practice and guidance on regulations for Legionnaires’ disease: the control of legionella bacteria in water systems (L8). The water log book was completed correctly.
- Staff had access to clinical and non-clinical waste facilities; and staff were able to dispose of waste at the point of use.

Environment and equipment

- The clinic was spacious, visibly clean, well maintained, and free from clutter. The clinic was accessed through the Optical Express store. The service was located on the first floor, and facilities included a laser treatment room, an examination room, discharge room, and consultation room.
- There was good access, with parking just outside the premises and disabled bays near to the entrance.
- There were two types of laser used in the clinic and the laser machines had a backup supply in the event of a power failure. This equipment was maintained under contract and we saw service checks had been carried out. Optical Express held a maintenance spreadsheet recording, detailing when equipment had been serviced. An emergency call out service was available, and staff confirmed they knew who to contact if they had any concerns about the safety of the laser equipment. Staff we spoke with said that the maintenance team attended in a timely manner to respond to any issues within the clinic.
- The location had a contract with an external Laser Protection Advisor (LPA), who was responsible for undertaking risk assessments, and providing advice and training on laser safety. They also drafted local rules and investigated laser incidents. Records we reviewed showed us the LPA carried out site visits every three years, or when any equipment or rules changed. The surgical services manager and clinic manager reviewed the visit reports, and any issues for action were addressed. We viewed the local rules for the laser

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machines. The rules contained information on the control of hazards, responsibilities, risk assessments, laser hazards, and gas hazards. Staff signed the rules to show they had read and understood all the information.

- The manager at the location was the Laser Protection Supervisor (LPS) and directly supervised all optical radiation protection at the location in line with the Local Rules.
- The laser technicians were LPS trained and assumed the role when the LPS was not available. The laser technician performed safety and calibration checks before each use, the machines also had safety warnings and failsafe cut offs built into the laser software. The checklist for checking the equipment was recorded.
- There was a laser warning light on the laser treatment room door, which was in working order and informed individuals not to enter the room. Appropriate warning signs were also on the door to advise staff when the room was occupied.
- Records recorded that humidity and temperature in the laser room was checked on a daily basis, which was in line with recommended guidance. Evidence we reviewed demonstrated that the air handling unit in the operating room was checked on a regular basis.
- Electrical safety checking labels were attached to electrical items showing they had been tested and were safe to use.
- We observed equipment stock in storage areas was CE marked, for example, protective eyewear, needles, and other surgery devices. This ensured that all equipment was approved and compliant with relevant safety standards. Ophthalmic diagnostic equipment that was not in use had appropriate covering to keep the machines clean and dust free.
- Emergency equipment, including an anaphylaxis box, contained all the relevant equipment that was needed, Other equipment was available such as spillage packs and eye wash packs. Staff at the clinic checked the contents and expiry dates. All items were correctly stored and ready for use. Staff we spoke with said they would contact emergency services if they needed to escalate a deteriorating patient.
- We noted that fire extinguisher checks were routinely carried out. All fire exits and doors were kept clear and unobstructed. Emergency exits were clearly signed and easy to access.

- Staff we spoke with said there were adequate stocks of equipment, and we saw evidence of good stock rotation. The system for segregating supplies of fluids for treatment was very good.
- There were risk assessments in accordance with control of substances hazardous to health (COSHH) regulation 2002, for a variety of chemicals; including gases, chemicals, cytotoxic medicines, and cleaning products. COSHH are regulations employers need to abide by to prevent or reduce their workers' exposure to substances that are hazardous to their health.
- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01 Control of Substances Hazardous to Health, and the Health and Safety at work regulations. All waste was kept appropriately in bulk storage bins on the clinic premises, which was collected by a specialist waste company on a weekly basis.

Medicines

- The clinic had a medicine management policy in place from January 2017, for review in three years. This described the handling, storage and security, ordering, and disposal of medicines.
- Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register. No controlled drugs were stored or administered at the clinic. The clinic had a narrow range of eye drops held at the location. At a local level, the surgery manager was responsible for ensuring that handling medicines policy and processes were followed and adhered to.
- The manager, who was a registered nurse, was responsible for the ordering, receiving, recording and storing of medicines; and pharmacist support was available by telephone. One pharmacy supplied all medicines for the clinic.
- We reviewed the clinic's drug order stock book and the medicines we checked were in date and reconciled with the records.
- We found medicines were stored securely and appropriately. Medicines were ordered, on average, every four weeks from an external supplier. Medicines requiring cold storage were stored in locked fridges and the temperature was monitored daily. We observed the

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logbook, and all checks had been completed. Staff we spoke with were aware of the action to take if the temperature recorded was not within the appropriate range.

- Staff completed competency assessments for managing medicines. We noted from staff records, that staff had been assessed for competencies for dispensing of medicines prior to discharge.
- Medicines to take home were prescribed by the surgeon that carried out the surgical procedure. We saw prescription labels attached to each medicine package, with the patient's name, the date, and instructions for dosage visible.
- We observed a patient being discharged by a technician. The patient was provided with clear and concise instructions on how to use and store the medicines prescribed. The patient was provided with opportunities to ask questions, and the patient was not discharged until they confirmed they understood all the instructions. Staff we spoke with said there was minimal need to access out of hours support.
- The gas cylinders, which contained various gases to re-fill the main laser machines, were kept in a storage room in an upright position and stored securely.
- We looked at the prescription and medicine administration records for five patients on the unit, which detailed current medicines, any allergies, and a medical history - in order to make sure that any medicines prescribed by the consultants were safe to be given. These records were fully completed, clear, and legible.
- Staff identify patients formally prior to medicines being administered.
- The service had a policy regarding the use of cytotoxic medicines, which included the management of risk. These are medicines that contain chemicals which are toxic to cells, preventing their replication or growth. There were appropriate risk assessments, policies and protocols associated with the handling of the cytotoxic medicines. We spoke with the surgical manager and the manager of the service regarding management of these toxic medicines. The service purchased these medicines before surgery, for single use only. We were shown how these medicines were safely disposed of in line with the policy.
- Mitomycin-C is used to decrease haze after surface abrasion procedures. The clinic did not use Mitomycin C regularly; however, when it was required, it was ordered

in for the specific patient from central support services for the company. It was then delivered to the clinic already prepared and ready for use. We looked at the operations register when Mitomycin C was used, and found details recorded, such as patient's name, the expiry date, and batch number. If patients were required to have Mitomycin C administered during surgery, this was consented for by the patient within the relevant section. This was due to the medicine being used off license, and patients were required to be aware of this before it was used. Staff were aware of this, and showed us within the consent document where this needed to be completed.

Records

- The service used both hard paper copy surgical notes and an electronic medical record, storing the hard copy off site. This contained all the patients' details; including assessments, consent forms, and instrument traceability records for the surgery and medicines given. Both copies were integrated following the surgery.
- We looked at this system, which recorded information such as: full details of the patient's medical history, previous medications, consultation notes, treatment plans and follow-up notes - in order to keep the patient safe and determine the suitability of surgery.
- Copies of post laser surgery letters were given to patients to provide to other healthcare professionals as they wished.
- We noted instrument traceability sheets were kept in an ordered fashion. These showed information on single use items used within the treatment.
- We reviewed records of the World Health Organisation WHO five steps to safer surgery checklist, which included, sign in, sign out, and time out.

Assessing and responding to patient risk

- Patients were assessed for their suitability for treatment at the clinic, prior to treatment. Checks included health questionnaires and eye examinations. Patients with epilepsy had to confirm they had been seizure free for three months, and had to have a letter from their GP to confirm this. Lifestyle questions and psychological health assessments were asked, so the clinic could make an informed decision about the use of different laser treatments.

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- The risks and benefits of treatment were explained to patients, and we observed consultations where health checks and eye tests were undertaken.
- After the initial eye examination was conducted, the patient was provided with information on likely outcomes; but it was explained they would need to see the surgeon who would make the final decision, discuss everything again, and review examination results.
- We saw records that showed patients have an appointment with the ophthalmologist prior their laser surgery and staff and patients confirmed this; however, this appointment could be over the telephone and not face-to-face. Patients also had a first appointment prior to the ophthalmologist appointment, with an optometrist.
- Staff used an adapted 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in treatment, by carrying out a number of safety checks before, during, and after each procedure. During our inspection, we observed three patient procedures, where the WHO checklist was used correctly and we saw other patient notes, which showed the WHO check had been completed fully.
- The clinic used an operating theatre register. The registers were used to provide an on-going record of patients that had undergone treatment at the clinic, and included the following information: patient name, age, address, diagnosis, names of attending doctors and assistants, date and time of procedure, and the anaesthetic used.
- Staff provided patients with an emergency telephone number for out of hours use. The information was written on the aftercare advice leaflets, which staff discussed with patients. This information was also available on the company website.
- Observations of vital signs such as blood pressure and pulse were recorded before treatment.
- Staff informed us patients remained in the service after surgery and reviewed by the surgeon to ensure they were well enough to go home. Once discharged and aftercare information had been discussed with patients, and they were confirmed as visually well, they were supported to leave with appointments for follow up confirmed. As the surgery did not involve general anesthesia or sedation, patients did not require any observations post operatively. However, a staff member explained that they were aware of what actions to take if

a patient became unwell. Information provided as part of the Optical Express assessment of their services showed that the most common issue post-surgery was fainting. Staff described how they would address this, and if necessary, they would call an ambulance for the patient.

- The clinic did not provide treatment that required local or general anesthetic. The surgeon remained on site until the last patient left the clinic on the day of treatment. Staff we spoke with confirmed they had access to medical advice out of hours; the service had a system where the optometrist had access to the operating surgeon, internal optometrist support, and a clinical services team.

Nursing and medical staffing

- Nursing staff arrangements were dependent on when the clinic opened, which was dependent on patient demand. Therefore, there were no set days that the clinic opened.
- The clinic employed a registered nurse who was the surgery manager. A regional surgical team provided the staff for this clinic; these staff included a consultant ophthalmologist, a scrub assistant, a laser technician, a clinical coordinator, and a discharge coordinator. These staff also covered other Optical Express clinics in the area.
- The organisation's central scheduling team managed staff rosters, so that sufficient, suitably qualified staff were in place to cover clinic days. Rosters were allocated one to two months in advance. The surgeon was allocated first, and other staff were rostered according to treatment needs at the clinic.
- The surgery manager reviewed rosters to ensure suitably trained staff with an appropriate skills mix covered all clinic days.
- There were no staff vacancies at the time of our inspection, and the clinic had not used agency staff in the three month period prior to our inspection visit.
- On surgery days, staff from the roaming team would attend the clinic; this consisted of four or five staff members, with the inclusion of a registered nurse.
- The roaming team was comprised of 13 staff that covered all locations in the North of England; these areas included Sheffield, Leeds, Manchester, Newcastle, and Liverpool.

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- A certified laser technician undertook the role of laser protection supervisor (LPS) during surgical procedures. They were responsible for ensuring the machines are calibrated, safety checks were complete and lasers were closed down appropriately at the end of the session.
- Staff and the manager said all new staff shadowed a senior member of the team until they felt confident. Staff worked independently once all their competencies were signed off. There was no time period for competencies to be completed by, but all new staff had a six-month probation period.
- A review of two staff files showed that all staff had received a disclosure and barring service (DBS) check to identify if the staff had a past criminal record. Additionally, all staff had completed a healthcare check and immunisation check to minimise the risk to patients. Two references were also available in the files.

Major incident awareness and training

- Fire escapes were clearly marked throughout the clinic, and were unobstructed and easy to access. Fire extinguishers were in date and last serviced by an official external company in November 2017.
- Each member of staff had a personal emergency evacuation plan (PEEP). We saw the manager's plan, which identified their responsibility in the event of an evacuation. Staff members we spoke with were aware of the action to take in the event of a fire. An in date fire policy was seen with a review date of January 2018.
- The service had a fire warden and fire drills were recorded. They took place each year as part of the Meadowhall fire drill programme. Records showed the last drill response time for the service was less than three minutes.
- The clinic had a business continuity plan; this detailed the plans for the prevention and management of potential emergency situations, such as fire, loss of electricity, or water leaks. All staff were aware of this plan, and there was a requirement within it for training and site evacuation drills.
- The business continuity plan included defined roles and responsibilities; emergency contact details for emergency services, public services and utilities, key headquarter personnel, and neighbours. The plan addressed a number of situations that could arise including fire, loss of services and systems.

- The clinic had backup generators in the event of a power supply failure, which allowed procedures that had already commenced to be completed.

Are refractive eye surgery services effective?

Evidence-based care and treatment

- Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines had been developed in line with the Royal College of Ophthalmologists (RCO) Standards for laser refractive eye surgery and the National Institute for Health and Care Excellence (NICE) guidelines in relation to refractive eye surgery. Policies and procedures were in date, and staff were able to access these online and in paper form.
- Records reviewed, and discussions with management, demonstrated that the service utilised both national policies and procedures developed by Optical Express and included safeguarding, infection prevention, and consent. Clinical guidance that was incorporated in policy was reviewed at a company national level as well as at local level to maintain continuity of care and support, and ensure consistent implementation.
- Policies were stored on an online system and staff we spoke with said they were able to access them.
- Suitability guidance and treatment criteria were subject to annual critical review by the International Medical Advisory Board (IMAB). The IMAB was comprised of refractive eye experts who had no link to the company. Guidance and any recommended changes were discussed and reviewed internally via the medical advisory board (MAB). Any changes in guidance or protocols were disseminated to staff. The MAB meeting minutes of 2016 included recommendations to follow General Medical Council (GMC) guidance pertaining to cosmetic procedures, which went live on June 2016 and applied to refractive eye surgery.
- Individual care pathways and treatment prescriptions were available for patients, and these were based on relevant national guidance.
- The service followed NICE Interventional Procedures Guidance IPG64 guidelines on photorefractive eye

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surgery. The surgeon undertook appropriate tests and pre-treatment checks, and ensured robust consent was obtained. Patients were supplied with information on the potential risks of treatment.

- Pre-operative tests for elective surgery were in line with NICE guideline NG45. The patients' medical history was discussed and appropriate tests and scans were undertaken to help determine treatment pathways.
- We saw that the service had a policy that patients start their laser surgery following a clinical assessment, which involved a review by an optometrist prior to being seen by the ophthalmologist. Where a patient was deemed unsuitable for laser surgery, an explanation in writing was provided to them. This was undertaken in line with best practice guidelines in order to maintain patient safety.

Pain relief

- Local anaesthetic eye drops were prescribed prior to treatment. Patients were asked if they were in any discomfort during surgery.
- Patients were advised to purchase over the counter analgesic to help cope with any pain.
- All patients were given discharge information including a 24-hour helpline number that advised if pain was severe, they should attend their local accident and emergency department.

Patient outcomes

- The clinic was not required to contribute to the National Ophthalmic Database Audit (NODA), as this only collected data relating to NHS cataract procedures. Optical Express had a fulltime biostatistician based overseas who collated data for each surgeon's outcomes; each year the surgeon was presented with their outcome data, as part of the annual appraisal process. This data included data on number of treatments, improvements in vision, number of complications and number of attempted versus achieved results.
- We viewed a surgeon's clinical outcome data. The data collected included patient feedback of a positive and negative nature, and a score of patient satisfaction with surgeon care was collated.
- The data collected enabled the service to monitor the demographics of patients, in terms of their age, gender, treatment type, procedure type, and ablation profile.

The surgeon's efficacy and safety data were rated. The surgeon scored 52 for efficacy (corporate 50) and 59 for safety. A score of 50 represented outcomes that were on par with expected Optical Express levels.

- From August 2016 to July 2017, 21 patients experienced complications following refractive eye surgery. The surgeon's complication rates and overall performance were monitored and reviewed annually at their appraisal. The surgeon's overall complication rate was slightly higher at 0.60% when compared to Optical Express' average score of 0.52%. Each surgeon's outcomes were assessed at the IMAB meeting, where any necessary changes were reviewed, and recommendations were made and discussed at the national medical advisory board (MAB).
- The service expected to enhance approximately 5% of treatments. This meant that these patients might have needed to return to the clinic to correct their vision or to achieve an outcome with which the patient was satisfied. Patients were made aware of the potential need for corrections before the start of their treatment, so they were not unexpected. Information sent to us before the inspection recorded that out of the 1005 patients treated in the previous 12 months, they had completed 97 enhancements. We discussed this with the surgical services manager who said that some of the enhancements undertaken at the location were for patients who had treatment at another location, and maybe several years after their primary treatment. The service monitored individual surgeon enhancement rates, the resident surgeon for Sheffield Meadowhall had a rate of 1.7%. This rate was not significantly higher than the expected rate.
- The service informed us that 12 patients experienced complications following refractive eye surgery at this location in the 12 month prior to the inspection. The service had an effective system in place for reviewing patients and referring for additional services, if required.
- Incidents and outcomes were attributed to the individual surgeon, rather than the individual location; as patients had the choice to attend other clinics for follow-up appointments rather than the location they had their treatment at.

Competent staff

- Staff we spoke with said they had good access to training regarding their professional development. Training records reflected a variety of training, including

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health and safety, safeguarding, and laser safety. All staff working at the clinic had completed all training required; this showed that the service were invested in providing suitable training for staff.

- Staff we spoke with said they felt they were experienced and competent to carry out their role. The unit used competency assessments. All competencies had been completed, such as screening, infection prevention and control, and assisting in theatres.
- In the 12 months reporting period prior to inspection, 100% of staff had received an appraisal; staff we spoke with said they found this useful, and there was ongoing informal supervision that assisted them in identifying areas of skill they wished to develop. All registered nurses had their professional Nursing and Midwifery Council (NMC) registration checked by the clinic manager. Registered nurses we spoke with said they had been supported through the revalidation process.
- The clinic manager was the Laser Protection Supervisor (LPS), with overall responsibility for the safety and security of the lasers. Records reflected that the service ensured that all the laser technicians had undertaken laser safety training, and this was renewed every two years at a minimum. An external Laser Protection Advisor (LPA) was available for training, advice and support, as needed. All staff we spoke with confirmed that they knew how to contact the LPA. Staff attended core laser protection knowledge training every three years with the LPA. The LPS provided both training and support on a yearly basis.
- The provider informed us, and records confirmed that 100% of surgeons that performed refractive eye surgery held the Royal College of Ophthalmologists (RCO) certificate in laser refractive surgery. They also confirmed that ophthalmologists had successfully completed three phases of training prior to using the lasers unsupervised. They must also be observed following training by the company medical director.
- Staff informed us there was always at least one member of staff on duty during surgery days that were BLS (basic life support) trained.
- There was an induction programme, which lasted four to six weeks - dependent on staff role. After competency assessments, which were signed off by the staff member's line manager, staff had a week of observations which covered the entire patient journey, from initial assessment to discharge.

- The medical director completed the surgeons' GMC revalidation and appraisal. The ophthalmologist held the Certificate in Laser Refractive Surgery; this was evident in their employment file.

Multidisciplinary working

- We saw good multidisciplinary working between the team at the clinic. There was good communication and each staff member knew their role within the service.
- There were monthly team meetings and we saw minutes of the meeting of August 2017; where there was good attendance from all staff. There was time allocated within the meeting for staff to raise any concerns, or discuss any other issues they wished to raise.
- With patient consent, the service communicated with GPs for relevant information and patients' GPs were able to contact the service through the out of hours telephone line.

Access to information

- We looked at how information needed for staff to deliver safe treatment was made available. The service used both hard paper and electronic medical records. We saw that patient files were accessible for each appointment during laser eye surgery, and for staff to monitor patients after their laser surgery. Staff we spoke with said they had access to all the relevant information they required to look after patients safely. Staff we spoke with did not report any concerns with the system or gaining access to it.
- Records showed information was given to patients that they could provide to any external professionals that they wished to be informed about their surgery.
- Patients were given written discharge information detailing when and how to take the prescribed medicine.
- We saw electronic records that enabled those patients attending for assessment and after care to have these records accessed from another Optical Express branch; when, for example, they had surgery at that service. This assisted the consultant to review the records for an individual following surgery and enabled the service to provide continuity of care.
- We saw that information available for patients complied with guidance from the Committee of Advertising. Patients received a statement that included, terms and conditions of the service being provided, the cost, and method of payment for the laser eye surgery.

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Consent and Mental Capacity Act

- There was a consent policy dated January 2017, which provided staff with guidelines on obtaining patient consent. The consent appointment was made at least three days before any treatment took place. The service did not consent patients on the same day as treatment; however, the new Professional Standards for Refractive surgery (April 2017) recommends a 'cooling off' period of one week.
- Nursing and medical staff obtained consent using both verbal and written routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients; and their representatives, if appropriate. We observed staff obtaining verbal consent before undertaking clinical procedures. We reviewed patient consent forms and saw that these were completed accurately and in line with professional guidance.
- Staff we spoke with said for those patients who did not speak English, they were asked to bring somebody with them who could translate information. This was usually a family member or friend. However, for consent procedures, it is best practice for an independent interpreter to explain treatment and assist with consent; to minimise the risk of coercion and to ensure medical information is translated correctly.
- We reviewed six sets of patient records and saw consent forms were signed and legible. Consent forms provided patients with information relating to potential risks associated with the procedure.
- The booking consultation included psychological testing, which asked about the patient's motivation for having treatment. We saw informed discussions between the surgeon and patients' were in-depth, with outcomes, expectations, risks, and recovery discussed.
- We observed records that demonstrated that the mental capacity of a patient to consent to laser surgery was reviewed by the Ophthalmologist and staff during the consultation and the pre-operative assessment stage.
- Training records for the clinic for October 2017 showed 100% of staff had undertaken mandatory training, including Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

Are refractive eye surgery services caring?

Compassionate care

- We spoke with six patients during the inspection. We observed consistent positive interactions between patients and staff. Staff members were kind towards patients, and smiling with them and putting them at ease. All patients we spoke with were very happy with the care they had received.
- We observed three surgical procedures. The surgeon explained the treatment and asked the patient if they felt comfortable at every step of the procedure.
- Patients we spoke with said they were treated with dignity and respect by all staff members, and said they found the staff polite, friendly, and approachable.
- Staff respected patient confidentiality and ensured discussions took place in private laser rooms.
- We reviewed patient feedback data for January to October 2017. The feedback showed 398 patients responded and the clinic scored same or better than provider-level benchmarking scores for all of the eight criteria. Questions asked included, "Overall how satisfied are you with the care that was provided by the Surgeon" and "Did the surgery team make you feel comfortable and at ease?"
- Patients we spoke with were happy with the standard of care they received and call buzzers were located within easy reach.

Understanding and involvement of patients and those close to them

- Patients we spoke with said they had been fully involved in their care decisions and they were given realistic expectations of the outcomes of their surgical procedure and the potential risks and benefits of treatment.
- Patients informed us they were given sufficient time to consider the information provided about their proposed surgery, including any potential risks and benefits; and patients said they "felt supported" during their surgery.
- We observed staff taking time to clearly and carefully explain instructions to patients and to answer any questions patients had following surgery. This included how to insert eye drops at home, cleaning around the eye to prevent infection, and activities following surgery.

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- Patients said they would know who to approach if they had concerns regarding their care, and they felt able to ask questions; however, they were clear about having no concerns.
- The patients we spoke with were aware of their discharge arrangements and actions that were required prior to leaving the unit.

Emotional support

- We spoke with patients who told us they felt supported and staff members were warm and welcoming. Records showed that patients were given verbal information and support regarding their laser surgery, and patients confirmed this.
- Throughout our visit we observed staff giving reassurance to patients with additional support provided when it required; especially if patients were apprehensive.

Are refractive eye surgery services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service covered laser surgery for the immediate local population and across the Yorkshire region. Staff informed us any patient could attend any of the Optical Express services nationwide, as the service could access electronic patient records from every service.
- Patients could access the service either through self-referral through recommendation, an internet search, or in response to marketing. The clinic did not do any NHS work and did not receive referrals from the NHS.
- The manager said the service had a team of staff that were responsible for undertaking booking for patients, both before and after surgery. Patients were informed of the locations where the surgery was available and offered the opportunity to choose where they would prefer to receive any pre and post-surgery support.
- The provider generally undertook refractive eye surgery as and when patient demand dictated. Rosters were completed on a two monthly basis and extra days could be fitted into the roster if there was a demand.
- Patients who required procedures not performed at this location, such as lens replacement, were supported to access another location.

- All patients we spoke with said they felt comfortable in the waiting areas at the service where drinks facilities, magazines and information leaflets were available.
- Information sent to us prior to inspection and available on the services website showed that surgery was carried out two to four times per month, according to patient need; with follow up aftercare provided. The service opened at 8am and closed when the clinic had finished and the last patient left.

Access and flow

- The service did not provide an emergency eye surgery service. They provided elective and pre-planned procedures only. Any emergency cases were referred to appropriate emergency eye care services.
- Patients were able to self-refer without a GP or optician's referral. Appointments were made to suit patient requirements.
- All staff we spoke with confirmed the service monitored waiting times; both prior to an appointment being arranged and when the patient arrived for their appointment. Staff said it was the provider's policy to try to make sure that patients received an appointment of their choice. The service offered face to face or telephone appointments with the surgeon prior to the procedure.
- Patients we spoke with said they had not had to wait long before they received an appointment.
- Records showed the service did not have anyone waiting for treatment. Records also confirmed the service had not cancelled any surgical procedures in the 12 months prior to the inspection.
- There were no incidences of unplanned transfer of a patient to another health care provider in the last 12 months.
- Records we reviewed and staff we spoke with confirmed that no urgent unplanned returns to theatre had occurred in the 12 months prior to inspection.
- There was a process to manage patients who did not attend their appointment; staff contacted patients within 48 hours of their appointment to follow up and arrange another appointment, if required.

Meeting people's individual needs

- Staff informed us patients with communication restrictions, such as hearing, language, or literacy issues

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were advised to bring someone with them for every appointment. There was a hearing loop system in place at the service; however, this did not extend into the room where surgery took place.

- There was good access for wheelchair users and patients with limited mobility, including a lift.
- The service had a range of patient information leaflets available, which explained the various conditions treated and laser surgeries it offered. These included pre and post care instructions, photographs of medicines required, aftercare, and emergency contact details. However, all patient leaflets and documents, including consent forms, were in English. Staff and management confirmed that different formats, for example, using large print or other languages were available if requested, but were not readily available on site.
- The clinic had acceptance criteria and did not treat patients with complex health and social needs or learning disabilities.
- Screening procedures at the start of the patient's journey ensured those patients who required additional support were referred to alternative services with the support of their GP.
- At the time of the inspection, there was no access to independent translation services or an interpreter. If needed, patients were asked to bring a relative or friend who could translate information for them. For consent procedures, it is best practice for an independent interpreter to explain treatment and assist with consent. This is to minimise the risk of coercion and ensure the correct translation of medical information. Post inspection, the provider confirmed that they use a telephone based translation service and translators are available to attend the service to support individual needs.
- We saw information was given to patients advising them of post-operative care and the 24 hour contact details of the treating surgeon, should they have concerns following discharge.
- In the reception/waiting areas, we saw that there was access to a television and a hot and cold drinks machine was available for patients to use whilst awaiting laser surgery.

Learning from complaints and concerns

- The service had a complaints policy. The policy gave the same level of importance to verbal complaints as it did written. All complaints were acknowledged within two to seven working days and responded to within 21 working days.
- Information regarding complaints was made available as part of the discharge information given to patients. This outlined how to make a complaint and included a copy of the patient survey.
- There were twelve complaints received by the service in the 12 months prior to the inspection; of these, one was upheld. The complaints received included booking errors, quality of vision, and unmet expectations. We saw a response had been made to each complaint, and learning outcomes with associated actions documented, if required.
- On receiving the complaint, the surgery coordinator would attempt to resolve the complaint, if unable to resolve the issue, the clinical services department would oversee the complaints process.
- Complaints were discussed and addressed at senior management meetings and the information also referred to the medical advisory board (MAB), if necessary. Information about complaints was available in the service, and the outcomes discussed at team meetings in order to improve the service.
- Staff we spoke with could describe their roles in relation to complaints management and articulate the need to accurately document, provide evidence, take action, investigate, or meet with patients or relatives, as required. Staff we spoke with confirmed complaints received by the service were shared with staff via team meetings and through individual conversations.

Are refractive eye surgery services well-led?

Leadership and culture of service

- The service had a clear local leadership structure. The location manager ran the clinic on a day-to-day basis.
- The corporate leadership arrangements consisted of the chief executive officer (CEO), optometry directors, operations director, and the clinical services team; comprised of the refractive operation manager, surgical services manager, and location surgery managers.

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- Staff were aware of the corporate management structure and were clear about who they reported to within the structure.
- Staff we spoke with described the leadership in the unit was good.
- Staff we spoke with said they felt supported and were able to raise any concerns with their manager and senior managers.
- The surgery services manager visited the clinic every four to six weeks, and there was positive working relationship between the surgery manager and the surgery services manager. The surgery manager felt supported in their role.
- Staff we spoke with described the morale of the unit as 'good' and said they felt supported.
- Staff described their peers in a positive way and spoke about them supporting each other. The senior management team said they were proud of the staff working within the unit.
- The culture and leadership within the clinic represented the vision and values of the organisation; they encouraged openness, transparency, and promoted quality care. Staff described the culture as open and supportive.
- During and prior to the inspection, we did not receive any whistleblowing enquiries. The service had a whistleblowing policy in place.

Vision and strategy

- The service had a vision for the organisation. Staff were not aware of the organisation's values. However, they were able to tell us the organisation's strategic plans involved opening more clinics across the country and investing in advancements for treatment.
- Staff were aware of the provider's strategy and future plans, as these were discussed at team meetings.

Governance, risk management and quality measurement

- The service had governance structures and systems in place to effectively manage risk and safety. The surgical services manager and clinical services director were responsible for centrally monitoring the unit's governance and quality arrangements.
- All staff members we spoke with were aware of the governance arrangements that monitored and improved the quality of the service. The corporate medical advisory board (MAB) met annually and

reviewed data for all Optical Express locations and clinical protocols. The MAB managed changing practices, to either treatment, surgery techniques, or the introduction of new technology.

- Local monthly team meetings took place. Topics discussed included incidents and any changes to practice, for example, learning from complaints (which had been fed back from the MAB). The meeting allowed time for staff to raise any concerns. Staff from all locations were invited. The agenda/minutes showed they discussed incidents that had occurred within the organisation, and included investigation and learning. We reviewed September, October and November 2017 meeting minutes and saw that these were well attended by all grades of staff. Agenda items discussed included audit updates, MHRA alerts and directives, risk assessments, and infection control.
- Regular quarterly audits were conducted for infection control, incidents, complaints, record keeping, maintenance of equipment, medicines management, and health and safety. We viewed a variety of audits, which showed actions were taken against any areas of concern.
- The location had quality indicators, which covered incidents, complaints, and local audits. This local quality information was fed into the clinical governance committee, which met once a month, and in turn fed into the MAB.
- The clinic has a risk register made up of 22 risks; these were all potential risks to the clinic, such as a needle stick injury, no registered nurse on site, wrong patient treated. Each risk had an impact, likelihood, what needed to be done and agreed actions. Staff had the ability to add specific risks to the location, if this was required.
- We saw that the service had specific location risk assessments that were updated and reviewed monthly; these covered areas such as moving and handling and fire risks. Each risk assessment contained action plans as to how to minimise the risks. Changes to these risk assessments were discussed at meetings.
- Relevant policies were in place to support the governance of the company. These included information governance, medicine management, safeguarding, and consent. The policies provided staff with clear guidelines and processes to follow. The majority of policies and procedures had been reviewed in January 2017.

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- We were informed that alert information from the Medicines and Healthcare products Regulatory Agency (MHRA) or Health and Safety Executive (HSE) were screened as relevant by the surgical services manager and cascaded to the service as necessary. These were further reviewed by the manager and discussed at team meetings. Where actions were needed, the manager undertook a risk assessment and monitored the effectiveness of actions taken. We saw examples where relevant alerts had been cascaded to staff.

Public and staff engagement

- The organisation did not conduct formal staff surveys; however, staff views were captured at team meetings.
- The surgery services manager told us the organisation planned to appoint a Freedom to Speak up Guardian, who would start staff surveys through the organisation in January 2018.
- The service had a website where full information could be obtained about the laser surgery available for patients. This included information about costs and finance. It also outlined suitability criteria, and explained the laser eye surgery procedures offered. The website included information regarding a free consultation and life time after care, as needed.
- Patients were able to leave feedback online at the clinic or through the organisation's website. There were 396 patient responses received between January 2017 and October 2017. The clinic regularly received rating scores of nine and above (scores were given up to 10).
- The service audits on patient experience showed that 9.7/10 patients perceived they had a positive

treatment experience, better than the overall company score of 9.5/10. Satisfaction with the surgeon also showed a slightly better result 9.7/10 than the organisational average 9.6/10. The service had a patient vision satisfaction rate of 9/10, compared to an organisational score of 8.9/10. The results of these findings were discussed at staff meetings in order to monitor the quality of the service provided.

- The clinic had not received any specific feedback highlighting the need for changes to the service; but they had used feedback from other clinics to improve the service offered, for example, in relation to appointment scheduling for surgery, and the terms and conditions of treatment.
- Feedback from patients undertaken as part of their assessment and aftercare was examined and discussed with the surgical services manager; this information was used to improve the performance of the service and inform future developments.
- Information was also available on other social media platforms. The feedback viewed was positive, with patients recommending the service and describing positive results.

Innovation improvement and sustainability

- A staff recognition and reward scheme called 'wonderful Wednesday' took place every week. This was a scheme to recognise valued members of staff. Staff were nominated for the award by colleagues and successful staff members were rewarded with a gift, such as vouchers for a spa day or towards a meal.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The consent policy should reflect Royal college of Ophthalmologists guidance 2017 for a seven day cooling off period between the initial consent meeting with the surgeon and the final consent by the surgeon.
- The provider should ensure that staff engagement surveys are completed.