

Optegra UK Limited

Optegra London

Inspection report

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Date of inspection visit: 20 & 21 October 2020
Date of publication: 15/12/2020

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

Inspected but not rated



Are services safe?

Inspected but not rated



Are services effective?

Inspected but not rated



Are services responsive to people's needs?

Inspected but not rated



Are services well-led?

Inspected but not rated



Summary of findings

Overall summary

We conducted an unannounced, focussed inspection to see that improvements made after our comprehensive inspection in 2017 had been sustained. At that time, we required improvements to be made as we had concerns about the quality of services.

We also wanted to review changes in systems and processes made in response to the coronavirus pandemic and how the hospital was managing the consequent backlog of cataract cases since NHS contract work resumed in October.

As it was a focussed inspection, we were unable to review the rating of the service. However, we did not identify any significant risks and we found aspects of good practice, which are detailed below.

Overall, we found that the improvements we required after our last inspection had been implemented and sustained.

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Surgery

Inspected but not rated



As it was a focussed inspection, we were unable to review the rating of the service. However, we found that the improvements we required after our last inspection had been implemented and sustained.

- The hospital had actively addressed the backlog of patients for cataract surgery, which arose from COVID-19 restrictions. This was being progressed when we visited and we saw evidence that patients were being prioritised in line with Royal College of Ophthalmology guidelines. We saw that the hospital had the operating capacity to resolve the backlog within a short period of time and could open a second theatre if required.
- During the “lockdown”, senior managers had accelerated competency training and implementation of a new cataract surgery patient pathway. The pathway had already demonstrated early improvements in patient flow and included refinements in patient consent and education as well as enhanced safety through standardised equipment and medication along with reduced time in surgery. The introduction of the pathway was partly achieved through the creation of extended roles for optometrists and nurses.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Managers monitored the effectiveness of the service and made sure staff were competent.
- Leaders ran services using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities.

Outpatients

Inspected but not rated



As it was a focussed inspection, we were unable to review the rating of the service.

Summary of findings

The main services provided by this hospital were surgery and outpatients. Where our findings on surgery also apply to outpatients, we do not repeat the information.

- Overall, we found that the improvements we required after our last inspection had been implemented and sustained.
- The outpatient department had actively participated in the programme to reduce the backlog of patents waiting for cataract day surgery. We were satisfied that patients were being contacted to inform them of the situation with the backlog and alert them about the possibility of vision changes.
- Optometrists reassessed patients and facilitated virtual clinics held by consultants for patients whose vision had changed. We were assured that clinical oversight had been maintained and patients on the waiting list were being stratified according to risk.
- Other improvements noted since our last inspection included the management of medicines and learning lessons from incidents. Staff collected safety information on a new computer software application and used it to improve the service.

However,

- While the hospital generally managed infection prevention well, we saw the use of cloth-covered chairs in the outpatient waiting area. At the time of our visit, no mitigating action had been taken and this aspect was not on the hospital risk register. This indicated that while we saw improvements in governance, work was still needed to identify and manage risk.
- We saw temporary signage in use that was unsuitable for visitors with visual impairment.

Summary of findings

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Summary of this inspection

Background to Optegra London

Optegra London is an independent eye hospital, based in north London and registered with the CQC to provide the following regulated activities:

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

The hospital primarily offers cataract surgery to NHS patients, under contract with London and Hampshire clinical commissioning groups (CCGs). Privately funded patients are also seen for eye tests prior to treatment being undertaken at the Optegra Eye Hospital in central London.

Following our last inspection in August 2017, the hospital was rated as 'requires improvement'. Warning notices were issued for breaches of Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance). These notices were addressed and resolved by the organisation prior to publication of the report in November 2017.

As part of our focussed inspection, we interviewed the medical director and three members of the senior management team. In addition, we spoke to three optometrists and nurses, two health care technicians, an administrator, and three patients. We also examined 10 sets of patient notes and 17 documents including policy and risk papers, audit reports and training summaries.

How we carried out this inspection

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

Areas for improvement

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

Action the service SHOULD take to improve:

1. The service should ensure that risk in relation to the use of fabric chairs for patient seating is reviewed across the estate and controls implemented. The service should consider the implications of this finding for the other hospitals in the Optegra group:
 - At the time of our visit, senior managers responded to our observations by reviewing their risk assessment and completing a survey of all seating in public-facing areas of the hospital. We were subsequently shown evidence of quotations for selected chairs to be removed and recovered with easy-clean material.
 - We also saw a purchase order for disposable covers to be used as an interim measure. While this indicated that action had been taken, it remained unclear why this had not been identified as a risk on earlier assessments.
2. The service should ensure that all temporary signage is suitable for visitors with visual impairments:

Summary of this inspection

- We saw signs reminding visitors about COVID-19 symptoms attached to the front door, but these were not prominent enough for patients with sight limitations to read. Although we were told the triage station was staffed at all times, the information should be available in a range of formats given that the hospital provides care and treatment for people with visual disturbances.
- We accept that the hospital also included this information in their public website, pre-appointment letters and a reminder text on the day of their attendance. However, as a hospital providing care and treatment with people who have visual disturbances, all signage should be in 'easy read' formats.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inspected but not rated	Inspected but not rated	Insufficient evidence to rate	Inspected but not rated	Inspected but not rated	Inspected but not rated
Outpatients	Inspected but not rated	Not inspected	Insufficient evidence to rate	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated

Surgery

Safe	Inspected but not rated 
Effective	Inspected but not rated 
Caring	Insufficient evidence to rate 
Responsive	Inspected but not rated 
Well-led	Inspected but not rated 

Are Surgery safe?

Inspected but not rated 

- The service provided mandatory training in key skills to all staff and made sure everyone completed it annually. The organisation provided statutory and mandatory training using a combination of commercial training providers and e-learning. Some topics such as basic life support (BLS) and manual handling were ‘face to face’ sessions while the rest of the mandatory training programme was delivered using a digital system. We saw records from three staff files, selected at random, that showed training certificates issued by external providers and competency check lists that supported this.
- At our last inspection we found that many staff did not have BLS training, in contravention of Optegra policy and Regulation 12 (Safe care and treatment). On this occasion, we asked staff about their mandatory training status and compared their responses with the latest records provided by senior management.
- We found staff received BLS training to enable them to respond to a potential emergency. Designated clinical staff received intermediate life support training. We saw records that showed compliance rates for staff who were not on extended leave (furlough) met Optegra targets (85%). We noted these records were now produced using an electronic quality management system (QMS). This system had been introduced since our last inspection and managers told us it had improved oversight of training and competency checks.
- 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. In 2017 we found that, contradictory to corporate policy, senior members of staff had not received level three safeguarding training. During this inspection, the training records we examined showed that staff and senior staff were appropriately trained to level 2 and level 3 respectively.
- We saw there were ‘in date’ safeguarding policies and procedures to follow and staff knew who their safeguarding lead was should they have any concerns. In addition to the local safeguarding lead (clinical services manager) there was a corporate safeguarding lead available to provide advice and oversight.
- Safeguarding training was included as part of the mandatory training package and staff told us they knew where to find information should they need to. None of the staff we spoke with could recall the need to raise a safeguarding concern in the last year.
- We saw that the organisation had well-defined recruitment pathway and procedures to help ensure that the relevant recruitment checks had been completed for all staff. This included a disclosure and barring service (DBS) check; photo-ID, occupational health clearance, references and qualification and professional registration checks.

Surgery

- The service controlled infection risks. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. We reviewed risk assessments, protocols and assurance frameworks introduced as part of the organisation's response to COVID-19.
- Managers said that only essential staff were scheduled to work each day and all others had been working from home. Patients were not allowed to bring in visitors unless there was an essential medical need. Staff told us that symptomatic patients or visitors were not admitted and added that the triaging process commenced with letters sent to each patient prior to admission.
- We observed staff wearing personal protective equipment (PPE) in line with current guidance. Managers explained that infection prevention and control guidance was monitored by the corporate clinical governance team and any changes communicated to managers and staff via the electronic quality management system.
- Optegra provided information on safe COVID-19 practices on their website and administrators explained that patients were given information in writing prior to their appointment asking them not to attend if they showed symptoms of the virus. Patients were also asked to practice social distancing and minimise contact with other people in the two weeks prior to attendance. A text reminder was also sent on the day of attendance reminding patients about any likely symptoms and not to attend if they had these.
- Managers explained that targets had been set to reduce "exposure time" (time spent in the building) for all patients to reduce risk. For cataract patients this was a "door to door" target of under 60 minutes. Staff told us this was being achieved, although we did not see data to support this. Patients we spoke with indicated that they had been on the premises for less than an hour.
- Day surgery times had been adjusted to help limit time on site. Patients were issued with disposable gowns in the ward before entering the theatre and the regime of eye drops to dilate the pupils in preparation for the procedure had been changed to an interocular injection. Staff had been trained and assessed as competent to administer this injection instead of the usual eye drops, thereby reducing time spent in close proximity to a minimum.
- Managers stated that all staff had been risk-assessed to identify individuals with increased vulnerability to infection or at risk of poorer outcomes from COVID-19. These included people with specific long-term health conditions, older age and later term pregnancy. In addition, the organisation had responded to evidence linking ethnicity, gender and obesity with higher risk. Control measures implemented for this population group included home working, redeployment to less risky work environment or enhanced PPE along with additional training.
- We saw that the emergency equipment included a portable defibrillator along with adult and child resuscitation bags. These were checked weekly and recorded on log sheets, which were collected by the clinical manager and audited.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Since our last inspection, a new electronic quality management system had been introduced. This computer software package included modules for incident reporting and recording of investigations as well as remedial actions taken. Managers and staff felt positive about the improved systems and we saw examples of shared learning taken from incidents and near-misses.
- There were two serious incidents recorded in the last year, both relating to the prescription of implant lenses. We reviewed the root cause analysis reports for both incidents. We saw that investigations was methodical, clearly written and clearly identified areas for improvement. In each case, action plans had been implemented and progress reviewed to reduce the risk of similar occurrences happening again.
- Lessons learned were disseminated to hospital staff through team briefings and to the wider organisation through senior manager meetings (latterly by videoconference) and quality notices sent via email. Managers explained that these briefings and notices were also supported by alerts published on the quality management system.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Surgery

Are Surgery effective?

Inspected but not rated 

- The hospital provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The hospital did not routinely offer food or drink to patients attending for day surgery and coffee facilities in the reception area been closed to help preserve social distancing. Staff told us they kept bottles of water behind the reception desk if patients requested water to drink.
- The provider 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. During our previous inspection, we found staff did not have the required competencies to safely manage medicines. In October 2020 we saw the local management team had assessed staff competencies and record of staff training and competencies was kept in the clinic. Staff had appropriate knowledge to allow them to manage medicines safely in line with guidelines and written prescription.
- Medicine use was authorised by a doctor and staff administered it in line with a written prescription. Prescriptions were specific for each patient recorded in the patient's care plan. However, we noted that record-keeping was not always of good quality. When we reviewed a random selection of patient records, we noted one consultant had an illegible signature nor used a name stamp in the prescription section.
- We asked to see copies of the last two medicines prescribing and administration audits. Managers supplied copies of the audits dated March and July, 2020. These were completed using they electronic quality management software adopted by Optegra. We saw that each audit required 262 items to be checked and reported. The July audit scored 98% compliance and the March audit scored 97%. We learned that the individual responsible for the earlier error no longer practised at the clinic.

Are Surgery caring?

Insufficient evidence to rate 

As a focussed inspection, we did not inspect this aspect.

- However, we noted several interactions between staff and patients in the outpatients department as well as before and after cataract surgery and we spoke with three patients following surgery.
- We saw staff talking to treating patients courteously and the patients we spoke with confirmed this. They were all positive about the care provided and felt they had been treated respectfully. They told us staff were kind, answered any questions they had and respected their privacy and dignity.
- Patients told us they felt comfortable with the COVID-19 procedures in place and said that staff wore masks at all times during their stay.

Are Surgery responsive?

Inspected but not rated 

- The hospital was a two-story building and the surgical unit was located on the first floor. Access was by stairs or a lift and facilities upstairs included the theatre suite, day-patient rest area, offices and storage areas.
- We did not visit every area of the unit to help reduce the risks associated with any coronavirus contamination.

Surgery

- The service planned and provided care in a way that met the needs of local people. It also worked with others in the wider system and local organisations to plan care. Senior managers showed us the protocol for cataract services designed to address the backlog of patients arising from the COVID-19 pandemic. Agreed by the leading CCG, the document (dated 1st October 2020) followed the prioritisation protocol issued by the Royal College of Ophthalmology.
- The priority list included those patients who had severely limited binocular vision, inability to work or drive or had significant limitations to activities of daily living. Priority patients also included those who required surgery to support the management of sight-threatening diseases such as diabetic retinopathy.
- Managers stated that Optegra had assigned people from the central analytical department to review and 'stratify' the backlog of patients according to the priority criteria above. This list was forwarded to the medical director, who had oversight of the prioritisation process. The process had recently commenced in line with the resumption of surgery on the 13th October. The medical director stated that the hospital had the capacity to deal with the backlog within four to six weeks, and that this could be reduced further if a second theatre was opened.
- We saw the second theatre and ward area which was currently being used as a location for bulk storage of PPE and consumables as part of preparations for the UK leaving the European Union.





Are Surgery well-led?

- At our last inspection, we had concerns about consent, patient information and governance. On this occasion, we saw evidence of improvement.
- For example, the hospital had introduced a 'patient information for consent' leaflet which had been commissioned from a company specialising in this type of service. The document we saw was in use for both London eye hospitals. Managers stated the advantages of a specialist provider was that the documents could be quickly obtained in multiple languages as required. The document we saw explained clearly what the operation involved and possible complications as well as instructions about recovery, who to contact if concerned and advice on returning to normal activities.
- We saw an example of improved governance in relation to a medication designed to prepare a patient's eye for theatre. This was a single injection into the tissue of the eye instead of a series of drops. The medical director explained that Optegra commenced a pilot trial in 2019, which led to the medication being approved for use in other hospitals in the group. With the onset of the pandemic the medication was further discussed as a way of reducing "touch points" and lowering the risk of viral transmission.
- We saw medical advisory meeting papers recording the approval process as a variation in the new cataract patient pathway. Senior managers stated that the modified pathway will be formally reviewed in November 2020.
- We saw how the organisation had used the interruption caused by the coronavirus restrictions to accelerate competency training and preparations for a new cataract surgery patient pathway.
- Senior managers showed us documents supporting the new cataract pathway, and explained how the process had been reviewed and re-designed "from end to end". Managers and clinical staff we spoke with told us the pathway had already demonstrated improvements to patient flow, patient consent and education as well as enhanced safety through standardised equipment, medication regime and time in surgery. We were unable to corroborate this aspect, but accept that the pathway had just been launched and staff were giving us first impressions.
- The introduction of the pathway was achieved through the creation of extended roles for optometrists and nurses. This was supported by additional competency training combined with a consolidation in the number of surgeons holding practising privileges. We saw documents showing that all clinical staff had been assessed as competent for their roles.

Surgery

- The service collected reliable data and analysed it. The service kept clear electronic records using digital systems specially designed for healthcare providers. 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 submitted to external organisations as required.
- Staff we spoke with 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.
- However, we were concerned to see the use of cloth covered chairs in the waiting areas in outpatients and outside the day ward. At the time of our visit, no mitigating action had been taken and this aspect was not on the hospital risk register. This indicated that while we saw improvements in governance, work was still needed to identify and manage risk.
- While we accept that patients had received reminder letters and texts, signage was not in a format that all patients could read.

Outpatients

Safe	Inspected but not rated 
Caring	Insufficient evidence to rate 
Responsive	Inspected but not rated 
Well-led	Inspected but not rated 

Are Outpatients safe?

- We saw that all patients and visitors were greeted at the front door by a member of the clinical team standing at a triage desk. This comprised of a table with trays for exchanging items; hand sanitisers, disposable cleaning cloths, masks and a poster display. The display included laminated alert and information signs as well as NHS Test and Trace 'QR code' posters so visitors could identify the location on their NHS COVID-19 Apps.
- We saw patients and visitors undergoing temperature checks, hand decontamination and given surgical face masks to wear while attending the hospital. Patients were given instructions about the use of masks, the 'one way' flow system and social distancing. We saw COVID-19 risk and consent forms being completed and included in the patient records.
- We saw that floor markings had been installed in the reception area to remind patients and visitors about social distancing requirements, Staff explained that appointment times for clinics and day-surgery cases had been spaced apart to reduce the number of people in the building at any one time. During our inspection the hospital was uncrowded and we saw that staff and patients alike observed distancing requirements.
- We saw evidence that staff had been trained in identifying the symptoms of COVID-19 and the procedures undertaken at the hospital to reduce risk. Staff had temperature checks on arrival each day and those coming into direct contact with patients had been issued scrubs. We saw staff frequently using hand sanitiser and were 'bare below the elbow' in accordance with good practice standards and national institute for health and care excellence (NICE) Clinical Guideline 139.
- We noted the reception area had been fitted with transparent screens to help minimise risk of contact contamination and these were used. We saw additional spacing between chairs.
- Managers explained other controls in use, such as restrictions on the number of contractors and delivery drivers arriving at the hospital. Larger delivery quantities were used to reduce the number of deliveries and where possible, deliveries were met outside the building by staff who decontaminated the boxes, then set them aside in the store area to allow a time gap before the boxes were being opened.
- Managers and staff explained that virtual consultation clinics were being used to reduce the need to visit in person and for appointments, patients were asked to wait in their cars or time their arrival to avoid any unnecessary waiting. Reception staff explained that patients requiring follow-up appointments were being called once they had left the hospital to reduce the need for them to wait in the building.
- In the outpatient areas of the hospital, staff workstations had been altered to allow for a two-metre gap and we saw safety signs and hand sanitiser available in all areas. Windows were left open where appropriate to allow for fresh air to circulate. Rooms such as kitchens and toilets had signs limiting the number of people who could enter.
- During our inspection, we observed housekeeping staff moving around the building cleaning frequently-touched areas such as door handles and handrails.

Outpatients

- We reviewed the COVID-19 risk assessment for staff (June 2020) and saw that the hospital had implemented control measures such as arranging for staff to work from home, providing enhanced cleaning, conducting safe systems of work reviews and training and fit testing of PPE.
- We noted the use of fabric covered chair in use in the outpatient waiting area. We discussed the risk in relation to the use of fabric chairs for patient seating. At the time of our visit, no mitigating action had been taken. Senior managers responded to our observations by reviewing their risk assessment and completing a survey of all seating in public-facing areas of the hospital. We were subsequently shown evidence of quotations for selected chairs to be removed and recovered with easy-clean material. We also saw a purchase order for disposable covers to be used as an interim measure.
- While this indicated that action had been taken, it remained unclear why this had not been identified as a risk on earlier assessments. This raises the possibility that other hospitals in the group are in a similar situation.
- This indicated that action had been taken to improve compliance with Department of Health and Social Care guidance contained in the 'Health Building Note 00-09 'infection control in the built environment' (Section 3.133). However, it remained unclear what mitigation action had been taken in the meantime.
- Consultation rooms were well-equipped, air conditioned when appropriate and had enough furnishings for their intended purpose. The building, owned by Optegra, was kept in good decorative order and we saw fire safety and evacuation equipment present throughout. We saw that external contractors had completed fire equipment safety checks.
- In 2017 we found the hospital was failing to manage medicines to provide safe care and treatment. Since then, the hospital developed systems to ensure appropriate prescribing, handling and administration medicines. The hospital had allocated staff to oversee the management of medicines, who were trained and had good knowledge of the local medicines management system.
- Medicine use was authorised by a doctor and staff administered it in line with a written prescription. Prescriptions were specific for each patient recorded in the patient's care plan. However, we noted that record-keeping was not always of good quality. When we reviewed a random selection of patient records, we noted one consultant had an illegible signature and had not used a name stamp in the prescription section. Managers explained that the prescriber concerned no longer practised at the hospital.
- We asked to see copies of the last two medicines prescribing and administration audits. Managers supplied copies of the audits dated March and July, 2020. These were completed using the electronic quality management software adopted by Optegra. We saw that each audit required 262 items to be checked and reported. The July audit scored 98% compliance and the March audit scored 97%. This indicated that the omissions we saw in older records had been addressed.
- The hospital employed a pharmacist who carried out regular audits. Where an audit indicated that action needed to be taken staff followed protocols to address concerns. For example, when a room temperature, where medicines were stored, was found to be out of the medicines' safe storage temperature range staff moved medicines stored in that room to a more suitable area with appropriate temperature. This was an improvement to what we had found during the inspection in 2017.
- During our previous inspection, we found the provider did not manage cytotoxic medicine safely. Since then the hospital had stopped procedures that required the use of this type of medicine.

Are Outpatients caring?

Insufficient evidence to rate 

As a focussed inspection, we did not inspect this aspect.

Outpatients

Are Outpatients responsive?

Inspected but not rated 

- The design, maintenance and use of facilities, premises and equipment kept people safe. The hospital was a two-story building sited in a technology park in Colindale, North London. Outpatients was located on the ground floor and included a patient reception area along with consulting and optometry rooms.
- Off-street parking was available immediately outside the premises and automated doors were provided to assist people with limited mobility enter the building. Toilets and consultation rooms were spacious enough to accommodate people using wheelchairs.
- We saw signs reminding visitors about COVID-19 symptoms attached to the front door, although these were not prominent enough for patients with sight limitations. One of the three patients we spoke with explained they had difficulty reading the sign. Although we were told the triage station was staffed at all times, the information should be available in a range of formats given that the hospital provides care and treatment for people with visual problems. While we accept that the hospital also included this information in pre-appointment letters sent to patients, our observation was consistent with the feedback we received from the patient concerned.
- We did not visit every area of outpatients to help reduce the risks associated with any coronavirus contamination.

Are Outpatients well-led?

Inspected but not rated 

The main services provided by this hospital were surgery and outpatients. Where our findings on surgery also apply to outpatients, we do not repeat the information.