Optical Express (Gyle) Limited

# Optical Express - Birmingham Clinic

## Inspection report

16
Corporation Street
Birmingham
B2 4RN
Tel: 08702202020
www.opticalexpress.com

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

## Ratings

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

# Summary of findings

## Overall summary

We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. There was a strong safety system and culture with a focus on openness and transparency. The service managed safety incidents well, learned lessons from them. There was thorough analysis and investigation when things went wrong. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept records to a very high standard. They managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Help and advice was available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients and families.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually and there was a comprehensive and well implemented audit system that was a genuine lever for improvement. Information and record systems were comprehensive and diligently completed. This enabled other systems, such as audit, complaints and incident reporting to operate effectively and in concert with one another.

However:

- Some patients had been sent correspondence with an incorrect clinic address which caused them anxiety on the day of their surgery.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Refractive eye surgery** | Outstanding ☆ | We rated it as outstanding, see the summary above for details: |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Optical Express - Birmingham Clinic

Optical Express, Birmingham Clinic provides refractive, oculoplastic and ophthalmic and surgical procedures to people aged 18 years and above. The service includes pre and post-operative care associated with the procedures. The service is offered to self-paying patients.

The clinic is located across two floors in a purpose-built unit in Birmingham city centre. The clinic was registered and has been operating at the site since April 2021 when it moved from a nearby location.

The clinic is registered to provide regulated activities of:

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

Patients attend for day cases and no patients stay overnight.

A CQC registered manager has been in post since April 2021. There are two individuals registered as a registered manager to ensure sufficient oversight of the service during a planned period of absence for one of the managers.

The provider's track record on safety (September 2021 to August 2022) showed only 1 serious incident, no never events and no incidences of hospital acquired infection.

## How we carried out this inspection

We carried out an unannounced inspection of this service using our comprehensive inspection methodology. We carried out the inspection on 17 August 2022. We spoke with 4 patients, 1 relative and 7 staff, including the registered manager.

The service was inspected by two CQC inspectors. We looked at information about the service before the inspection. During the inspection we looked at the environment of the clinic, we reviewed the policies and procedures of the service, and we reviewed 4 patient records. We followed up the inspections by requesting further information from the service.

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

## Outstanding practice

We found the following outstanding practice:

- The service had a sustained track record of safety.
- A comprehensive safety system was in place which was strongly managed and well run. There was a culture of openness and transparency when things went wrong and a genuine desire to learn from mistakes.
- There was effective, inspiring and compassionate leadership at all levels in the service.

# Summary of this inspection

- The culture and working relationships in the service were healthy. There was open, honest and courteous challenge between staff who were proud of the service.
- There was a well-developed governance system which was completely embedded in the location's management and day to day operations.
- The audit system was comprehensive, under continual review and development, and was a genuine lever for improvement.
- Information and record systems were always comprehensive and diligently completed. They enabled other systems, such as audit, complaints and incident reporting to operate effectively.

## Areas for improvement

**Action the service SHOULD take to improve:**

- The service should ensure that correspondence with patients contains the correct address for the clinic.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Refractive eye surgery | ☆ Outstanding | Good | Good | Good | ☆ Outstanding | ☆ Outstanding |
| Overall | ☆ Outstanding | Good | Good | Good | ☆ Outstanding | ☆ Outstanding |

Outstanding

# Refractive eye surgery

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

## Are Refractive eye surgery safe?

Outstanding

### Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Mandatory training figures showed that 13 out of the 16 modules had 100% compliance with the other 3 at 90% against the provider's target of 85%. Where these small numbers of staff were out of date with their mandatory training it was only by a few weeks.

A new member of staff confirmed that they had completed all their mandatory training as part of their induction. Staff told us they were given time to carry out their training.

The mandatory training was comprehensive and met the needs of patients and staff. There were 16 modules covering clinical, health and safety training, and the care and protection of patients. Training was provided both face to face and through the provider's Optical Express Academy education platform.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. We were provided with documents that showed that mandatory training compliance was continually monitored, and staff were required to be up to date.

### Safeguarding

**Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training specific for their role on how to recognise and report abuse. Staff were trained to adult safeguarding level 3 which was suitable for the patients that met the admission criteria of the service. Compliance for safeguarding training was 100%.

Staff knew how to identify adults at risk of, or suffering, significant harm. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to give examples of what safeguarding issues might arise in the service and how they would deal with them. Although there had been no safeguarding referrals at the inspected location the registered manager was able to describe incidents they had been involved in at other locations.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could tell us how they would make a safeguarding referral and there were lists of contacts for safeguarding available in staff areas. Nationally, the provider had 3 level 4 trained staff available to provide advice and support.

The service did not treat children, nor did children visit, but all staff had level 1 safeguarding training to identify abuse outside of the service.

The service had suitable procedures for the recruitment of staff including enhanced Disclosure and Barring Service checks, identification checks and the taking up of references. When we looked at a sample of 4 staff records, we saw that these were all recorded as completed.

### Cleanliness, infection control and hygiene

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

All clinic and treatment areas were clean and had suitable furnishings which were clean and well-maintained. Domestic cleaning was carried out to a specification and schedule and records were kept.

The service performed well for cleanliness.Infection Prevention and Control (IPC) practices and the clinical environment were subject to weekly audit. We saw samples of recent audits and these were very comprehensive, detailed and when shortfalls were identified action plans were monitored until completion. Compliance was always greater than 95% and the issues raised as a result of the audits did not generally represent significant risk but rather high standards.

Air testing was done every 6 months in accordance with the relevant Heath Technical Memorandum for specialised ventilation and results were satisfactory. Legionella testing of water supplies was regularly carried out and we noted that the associated risk assessments were carried out to a high standard.

At the time of inspection patients were screened for COVID-19 infection prior to admission. Patients received a screening call 3 days beforehand and answered a questionnaire. Following this, patients were given advice on hand hygiene and what to do when they attended. Patients to whom we spoke confirmed that this happened. This screening was recorded in the patient's record.

Staff completed a COVID-19 questionnaire every day and took lateral flow device tests twice a week.

Staff followed infection control principles including the use of personal protective equipment. Regular hand hygiene audits demonstrated 100% compliance with the standards. There were plenty of handwashing and sanitising facilities for both staff and patients. Posters were displayed reminding staff and patients how to clean their hands effectively.

Relevant staff were required to have inoculation against hepatitis B for their own and patient's protection. When we looked at a sample of personnel records, we saw that this was done and recorded.

Staff wore disposable scrubs which were thrown away at the end of each shift. All clinical staff were seen to be bare below the elbow and to be complying with hand hygiene and mask wearing.

Deep cleaning took place according to a schedule or when circumstances dictated, and this was carried out by an external company. We confirmed this when we looked at the records kept on file.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Antibacterial wipes were available for staff to clean equipment between patients. High frequency touchpoints were cleaned throughout the day as a precaution against COVID-19.

Staff used records to identify how well the service prevented infections. Staff worked effectively to prevent and identify surgical site infections. There had been no surgical site infections since the service had opened.

### Environment and equipment

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

The design of the environment followed national guidance.Clinic and treatment areas were purpose built and well maintained. There was sufficient storage space and all areas were tidy and unobstructed. There were suitable arrangements to prevent unauthorised patients and staff accessing the laser treatment area when the device was in use.

The service had enough suitable equipment to help them to safely care for patients. Equipment was maintained to manufacturer's recommendations by suitably qualified staff, usually from the manufacturer. A folder contained service logs for the medical devices in the clinic. This was comprehensive, complete and accurate.

There was a "damaged equipment log" for medical devices, including instruments. We saw equipment labelled "out of service" which corresponded with the log and empty oxygen cylinders were also labelled. This meant that patients were protected from the use of faulty equipment.

A general equipment maintenance folder contained comprehensive, detailed and accurate records for all equipment other than medical devices, as well as the building infrastructure. Examples included fire extinguishers and alarms, portable appliances, fixed wiring and lifts. There was a comprehensive and detailed fire risk assessment in place from December 2021. Comprehensive and up to date Control of Substances Hazardous to Health (CoSHH) risk assessments were on file.

We saw comprehensive and meticulous records of lenses that were in stock and implanted and the surgical storage areas for these and other devices were tidy and well organised. A monthly stocktake took place. There was a system in place to response to manufacture alerts as to when stock was approaching expiry.

"Local Rules" were in place to ensure that the laser equipment was operated safely. Those who could act as the laser protection supervisor were identified as were authorised operators and the laser protection advisor. The laser protection advisor was responsible for undertaking risk assessments and providing advice and training on laser safety. They also drafted local rules and investigated laser incidents. The laser protection supervisor role and these staff supervised all optical radiation protection at the clinic in line with the local rules. There was a room diagram clearly indicating the laser-controlled area and there was an accident and incident procedure. The Laser Protection Supervisor for the day was identified at the daily briefing.

Staff carried out daily safety checks of specialist equipment.Daily team briefs ensured that daily safety checks of equipment and other tasks, such as intraocular lens counts, were adhered to by allocating tasks to designated members of staff and we saw that compliance with this requirement was audited. There were different checks in use dependent on the surgical activity each day.

The service had one resuscitation trolley located in a suitable position. The trolley was suitably equipped, regularly checked and the checking was subject to audit.

The service had suitable facilities to meet the needs of patients' families. There were comfortable areas where people accompanying patients could wait and obtain refreshments.

Staff disposed of clinical waste safely.Contracts were in place with suitable companies for the disposal of household, clinical and cytotoxic waste. Clinical waste was stored safely in a locked room and the small quantities of low-level cytotoxic waste generated were stored in a separate bin in the operating theatre. All waste transfer records from the contractors were stored on file. Compliance with the management of waste was subject to a weekly audit.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.There was a suitable emergency policy and a resuscitation policy that addressed medical and surgical emergencies. The service undertook unannounced emergency scenarios as a training method for staff. Staff told us that if there was any deterioration in a patient's condition during their time at the hospital then they would contact the emergency services so that the patient could be transferred to an acute hospital.

Patients had access to a 24-hour emergency line which was staffed by the provider's central clinical services team. They would take over the management of the patient from the local clinic and refer into a suitable private hospital as necessary through a network of surgeons with admitting rights.

Staff completed risk assessments for each patient on arrival and reviewed this regularly, including after any incident.The service had admission criteria to ensure that patients were safe to receive treatment under the facilities available at the clinic. There were no "blanket" policies excluding people with a disability, including a learning disability and mental health needs but all patients were assessed for capacity and ability to cooperate with the planned procedure.

We saw from the patient records we looked at that pre-existing conditions were recorded as part of the patient's assessment and allergies or absence of allergies was recorded.

Patients had their blood pressure, oxygen saturation and pulse checked prior to going to theatre. Observations were re-recorded during surgery as required and after surgery were complete.

The service adhered to the World Health Organisation's 5 steps to safer surgery checklist and was subject to regular audit. We looked at the most recent audit results for the surgical and laser theatres and these demonstrated 98% and 100% compliance respectively. We saw that the issues found had been raised with the individual responsible. When we looked at patient records ourselves, we found that the requirements for the checklist had been adhered to in all those cases.

There was a post-operative checklist that ensured that take home medicines were supplied and that the patient had an escort home. This was signed by a member of staff and the patient.

Shift changes and handovers included all necessary key information to keep patients safe. Daily team briefings noted any risks specific to individual patients. On the day of our inspection, the daily brief noted that a patient had a pre-existing condition. We tracked how this was managed and noted that it was covered in the patient's assessment, their consent for surgery, and their individual risk assessment and plan for surgery. This included having their own medicines available in the operating theatre should they be needed.

### Staffing

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

The service had enough nursing and support staff to keep patients safe. The service was fully staffed for all roles as they were increasing staff numbers for forthcoming NHS contract work. The service had no vacancies.

Managers limited their use of bank staff and made sure all bank staff had a full induction and understood the service.No agency staff were ever used by the service. "Bank staff" were used but these were referred to as "travelling staff" who moved between services to accommodate the changing demand at different clinics. When a member of staff worked at a clinic for the first time they were given a full introduction.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift. There was a central scheduling team who planned and deployed staff such as surgeons, nurses and technicians to clinic locations dependent on the planned surgery for each day. The numbers of staff matched the planned numbers.

The service had low turnover rates. Where staff had left in the recent past it was during their probationary period and at the instigation of the service. Exit interviews had indicated that the most common reason for staff leaving was the need to travel between sites because services were not offered on all sites on all days. This was being addressed through the establishment of full base teams at each location.

The service had low sickness rates. Staff received back to work interviews.

### Records

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

Patient notes were comprehensive, and all staff could access them easily. The service used an "in house" electronic patient record system which ensured that all records were integrated in one place and accessible.

Records were stored securely. There were systems in place to ensure records that were no longer needed were shredded. Staff were required to ensure their work areas were free of confidential information when they left them, either by disposal or filing. We observed staff adhering to this principle.

Patient records were subject to audit. The most recent was in June 2022 found all to be compliant except for one consistent shortfall in 5 of the 6 records audited. The cause was identified and traced to a single person who was informed.

Record keeping, both clinical and ancillary, electronic and paper, was to a high standard. Filing was well organised, documents were fit for purpose and completed fully and accurately. This meant that the inspection team were able to carry out their work quickly and effectively which indicated that would also be the case for staff using those records.

Implantable medical devices were accurately recorded in the patient's and manufacturer's records to assure traceability. This recording was subject to audit through both an internal system and in cooperation with the manufacturer.

## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines. Compliance with medicines policy and procedure was routinely monitored and action plans were always implemented promptly.**

Staff followed systems and processes to prescribe and administer medicines safely. Patients were usually given take home eye drops. Patients were given information about the medicines including side effects and staff ensured that the patient was able to administer the drops.

For controlled drugs there was a policy and system in place to manage the Midazolam and Diazepam used in the service, including the use of a controlled drugs book. There was a paper-based system for drug ordering through an order book. The records were noted to be comprehensive and accurate. There were 4 members of staff authorised to manage controlled drugs. We saw that there was an in-date Home Office licence on file for the ownership and use of the controlled drugs. There was a designated key holder identified at each day's team brief. Adherence to the controlled drugs policies and procedures was subject to regular audit.

Staff completed medicines records accurately and kept them up-to-date. When we looked at patient's records, we saw that drugs charts were completed correctly in all cases and included a signature and the time administered. Medicines processes were audited, and we saw examples of when shortfalls were identified that action plans were promptly implemented to prevent reoccurrence

Staff stored and managed all medicines safely. Medicines that needed to be stored cool were stored in fridges. Room and fridge temperature checks were carried out daily and records showed that no issues had arisen.

Medical gases were stored correctly, full and empty cylinders were separated and labelled.

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and there was a genuinely open culture in which safety concerns raised by staff and people who used the service were highly valued as being integral to learning and improvement. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff knew what incidents to report and how to report them.Staff raised concerns and reported incidents and near misses in line with provider policy. Staff told us incidents were taken seriously and escalated immediately. One member of staff described them as "learning opportunities".

The service had had no never events.

Outstanding ☆

# Refractive eye surgery

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. There was a duty of candour process in place which met the requirements of the relevant regulation. If the process was triggered the responsibility would be taken over by the provider's national clinical services team. There had been no incidents requiring the duty of candour to be implemented at the location. Staff to whom we spoke were aware of the duty and the provider's processes.

There was a comprehensive incident log which we inspected and noted that the service had a low threshold for the definition of an incident. The manager told us that they encouraged staff to report everything and then filter to decide whether or not it was an incident. We saw that this approach had been emphasised in recent team meeting notes.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers debriefed and supported staff after any serious incident. We saw from records of incidents, and notes of team meetings and daily briefings that lessons learned were communicated to staff to prevent reoccurrence. Where incidents were as a result of individual error this was clearly communicated to them and we saw recorded discussion of how performance might be improved.

The use of the "Clinical Services Directive" system, which is described later in this report ensured that lessons learned, and actions required from incident investigations were implemented.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.We looked at the service's most recent serious incident and saw that it had been subject to a formal root cause analysis which resulted in an action plan. This plan addressed shortfalls in the performance of individual team members who one of whom was retrained and reassessed for their competency for a particular task.

We saw that the service analysed incidents for themes and we noted that in 2021, 4 "near misses" had resulted from individual staff failing to adhere to policies and procedures. From further records we examined it was clear that this had been taken up both with the individuals and the teams as a whole.

Incident reporting and investigation systems worked well alongside other systems such as complaints and staff training. For example, we saw that following a complication during surgery the patient had told the service how it felt from their point of view. The service responded by reviewing processes and introducing scenario training where staff practiced how to react under these circumstances to ensure not only that the situation was dealt with safely, but the patient was reassured.

## Are Refractive eye surgery effective?

Good ●

### Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Polices and processes were developed and implemented under the guidance of a medical advisory board which advised the provider's clinics across both the UK and internationally.

# Refractive eye surgery

Guidance was obtained from best practice guidelines from organisations, such as the Royal College of Ophthalmology and the provider's own outcome data which was provided by an inhouse biostatistical team.

Staff were aware of policies and they could be accessed through the service's systems. We saw that staff adhered to policies and procedures and this was assured by the service's own audit and quality assurance systems.

## Nutrition and hydration

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

Staff made sure patients had enough to eat and drink. Patients did not spend a long time at the service, but refreshments were available to them and people accompanying them at any time.

## Pain relief

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

Staff assessed whether patients experienced pain throughout their operation but did not routinely use a recognised tool. Patients told us that they experienced discomfort rather than pain, but advice was given as to what over the counter remedies could be used once they got home. Patients received local anaesthetic eyedrops before the surgery commenced and could ask for additional eye drops during the procedure if they felt any pain or discomfort.

## Patient outcomes

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

Outcomes for patients were positive, consistent and met clinical expectations. Complication rates were low at around 1% for 2021.

Managers and staff used the results of outcome monitoring and audit to improve patients' outcomes. Outcomes for patients were closely measured and monitored for each surgeon and this was overseen by the provider's dedicated biostatistical team based in the UK and by the parent company's team based in the USA.

The service provided detailed clinical outcome data for each of the employed surgeons that demonstrated that there was a rich source of information to support not only the analysis of the clinical efficacy of the surgery but also the appraisal of performance.

The outcomes for the Birmingham Clinic were in line with the performance across the rest of the provider's clinics. This is turn had been demonstrated to be better than comparable surgery by recent benchmarking study against NHS performance as calculated by the Royal College of Ophthalmologists.

There had not been any surgical site or other hospital acquired infections up to our inspection.

## Competent staff

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

# Refractive eye surgery

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff underwent competence-based training based on their individual roles. We saw the relevant training records for a sample of staff records we looked at. The service provided a competency matrix that demonstrated every member of staff was trained and assessed as competent for the modules required for their role. The staff files that we examined contained certificates and competency assessments.

The service took up references and required certificates to be produced during staff recruitment and when we looked at a sample of personal records, we saw that this was adhered to.

Managers gave all new staff a full induction tailored to their role before they started work. All staff told us that they had been given an induction. Those “travelling staff” said that they were given an induction to any clinic they had not worked at before and were kept up to date for the clinics they usually worked at.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff received regular appraisals. When we looked at a sample of personnel records, we saw that these appraisals addressed their performance and there were actions to both address shortfalls and to support staff in developing their skills. The compliance with appraisal for the service was 100% meaning all staff due an appraisal had received one.

Surgical staff were directly employed by the service and they received appraisal and revalidation within the provider organisation.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meeting notes were comprehensive and detailed. They were distributed to all staff and there was a space for staff to sign that they had read them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff took part in resuscitation scenarios where they practiced their skills in an unannounced event lead by the organisation’s clinical services team. Scenarios included cardiac arrest, asthma and anaphylaxis.

Managers identified poor staff performance promptly and supported staff to improve.We saw several examples where audits had identified issues with staff performance, and this had been followed up.

## Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed good teamworking between the different staff groups. The daily briefings involved all the health care disciplines.

## Seven-day services

**Key services were available seven days a week.**

The service offered appointments at the weekend and on bank holidays to meet the preferences of patients. There was a 24-hour emergency line available to all patients which was staffed by the provider’s central clinical services team.

Outstanding ☆

# Refractive eye surgery

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.**

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. A post-operative patient told us that before their operation they had a booklet about it, a telephone call where the risks were explained to them and that they met with their surgeon to further discuss things. They said they signed to give their consent and that they thought everything had been explained very well. Other patients to whom we spoke confirmed that this happened.

Nursing staff told us that surgeons had plenty of time to spend with patients. We noted that some complaints had been from patients who had higher expectations of the surgery than was attainable. The registered manager demonstrated how this had been addressed through better information and discussion and this had significantly reduced complaints and feedback about the issue.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received consent training as a mandatory training module. The compliance rate for the training was 100%.

Staff clearly recorded consent in the patients' records. We looked at a sample of 4 patient records and saw that capacity and consent was recorded each time. This aspect of the patient record was audited by the service.

Staff received and kept up to date with training in the Mental Capacity Act. Staff received Mental Capacity Act education as part of their mandatory training. Deprivation of Liberty Safeguards training was not provided as it was not relevant to the client group. The service did not treat anybody who did not have capacity to consent.

## Are Refractive eye surgery caring?

Good

### Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We noted that the interactions between staff and patients were professional but friendly and supportive.

Patients said staff treated them well and with kindness. The patients to whom we spoke, and the feedback we reviewed were almost always positive. A post-operative patient told us that the nursing staff had been supportive and described them as "fantastic". Other patients to whom we spoke reported similar positive experiences.

Staff followed policy to keep patient care and treatment confidential. The service had policies to ensure that records were not left unattended and we saw staff reminded of this in team briefings.

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress.**

Outstanding ☆

# Refractive eye surgery

Staff gave patients and those close to them help, emotional support and advice when they needed it. The organisation had a suitable chaperone policy which was on display and stated that patients could ask for a relative, friend or staff member to be with them. It also defined the role of the chaperone that the patient was expected to agree to.

Staff supported patients and helped them maintain their privacy and dignity. All consultations took place in private.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. However, one patient told us that they had received correspondence asking them to go to the service's old address and they had found this a distressing start to the day. When reviewing complaints, we noted that this had happened before.

### Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment and they supported patients to make informed decisions about their care. People enquiring about treatment were given information verbally and in writing about the treatment and choices. Patients were given additional information about their treatment to allow them to make decisions and give informed consent.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient satisfaction surveys were regularly carried out. The service also made use of "patient conversations" where more detailed information was gained through face to face engagement with a sample of patients.

Patients gave positive feedback about the service.The local performance in patient satisfaction surveys was benchmarked against the provider's national performance. The service received consistently high scores which were comparable to the national benchmarks.

## Are Refractive eye surgery responsive?

Good

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served.**

Managers planned and organised services, so they met the needs of the local population. The clinic was in a central location in Birmingham City Centre and was easily visited by public transport both locally and nationally. There was public car parking close by.

They service took account of the needs of people within the catchment area and recognised the specific cultural and religious needs of these communities.

Facilities and premises were appropriate for the services being delivered.The clinic was located in a block of business and retail units opening directly onto the high street. The clinic was spacious, and pleasantly decorated with comfortable waiting areas.

Managers monitored and took action to minimise missed appointments.Managers ensured that patients who did not attend appointments were contacted, however the rate of nonattendance was negligible as patients payed for their treatment beforehand.

## Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.**

Staff made reasonable adjustments to help patients access services. The service had admission criteria to ensure that patients were safe to receive treatment under the facilities available at the clinic. There were no "blanket" policies excluding people with a disability, including a learning disability and mental health needs. All patients were assessed for their ability to cooperate with the procedure which involved conscious surgery on the eye.

The clinic was wheelchair accessible and there was a lift between floors.

We saw that the service took account of individual's preferences and beliefs in that they could offer medicines that did not use products from certain animals or alcohol. We were told that they had tried to meet some individual preferences, such as having all female or all male surgical teams, but these could not reasonably be accommodated and so these clients had had to be turned away.

The service had information leaflets available in languages spoken by the patients and local community. There was signage in the reception area indicating that documentation could be provided in other languages and this was stated in 11 different languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service required that interpretation services were provided by a professional interpreter from a subcontractor and not a friend or relative and this was detailed in their interpretation service policy. The languages offered included sign language. The manager told us that there had been problems with the subcontracted service, such as lateness or the wrong language being booked, and we saw that this had been recorded in the complaints and incident logs.

The organisation had a suitable chaperone policy which was on display and stated that patients could ask for a relative, friend or staff member to be with them. It also defined the role of the chaperone that the patient was expected to agree to.

## Access and flow

**People could access the service when they needed it and received the right care promptly.**

Managers and staff in the provider's central operations team monitored waiting times and made sure patients could access services when they wished to. Patients were normally able to access the service quickly because the provider adjusted the capacity to meet demand by moving staff from one clinic site to another.

The time between consultation and surgery was usually by the choice of the patient who selected a day suitable to them. Patients were able to book surgery quite soon or some time ahead to suit their personal circumstances.

Managers and staff worked to make sure patients did not stay longer than they needed to. The time spent at the clinic was a performance criteria and the clinic was benchmarked against other sites. The figures for the Birmingham Clinic were comparable to the national scores.

# Refractive eye surgery

Managers worked to keep the number of cancelled operations to a minimum. The service provided figures and reasons for cancelled surgery. These were low in number and were for clinical reasons.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**

Staff understood the policy on complaints and knew how to handle them. There was a suitable complaints policy in place which was in-date and was suited to the service provided. Complaints could be raised in a variety of ways as detailed in the policy including less traditional methods, such as social media.

We noted that the complaints log recorded that for the year 2022 up to the date of the inspection all formal complaints had been resolved within the provider's target of 20 working days.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Complaints leaflets were prominently in the reception area of the clinic as well as in consultation rooms.

Managers investigated complaints and identified themes. The manager told us that a common theme was that patients had higher expectations of some aspects of surgery such as the chosen laser treatment improving some aspects of their vision which it could not or not expecting their eyesight to fail again over a number of years. The provider had addressed this through improved information which had resulted in a reduction in these complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There was a complaints log and we saw that in addition to formal complaints this also recorded informal complaints and negative comments. We looked at a sample of recent complaints in detail and we noted that each point made by the patient was responded to well and patients were signposted to the Optical Consumer Complaints Service if they still had concerns.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw from the notes we reviewed that recent complaints and negative feedback were discussed in team meetings. Patient satisfaction surveys were done every month and we saw through the records that were kept that the service responded to both positive and negative feedback.

Staff could give examples of how they used patient feedback to improve daily practice. The use of the "Clinical Services Directive" system, which is described later in this report ensured that lessons learned, and actions required from incident investigations were implemented. As an example, we saw how an incident involving a patient who left a clinic unaccompanied had resulted in a directive being issued to ensure that it did not happen again at any of the provider's clinics.

We saw an example of how the service had responded to a patient's concern about how staff reacted to a clinical complication in theatre. The service had responded by introducing clinical complication scenarios so staff could practice how to react in a simulated environment.

## Are Refractive eye surgery well-led?

Outstanding ☆

# Refractive eye surgery

Outstanding ☆

## Leadership

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

While the clinic was a newly registered location it had moved from a nearby location and so the team and leadership were the same. The staff team had had the same local registered manager for some years in the clinic's previous location and they were highly regarded both by the national leadership team and their own staff.

We saw through documentation and interviews with staff that local leadership demanded high standards from the staff at the service and inspired people to meet this shared purpose. They were also well respected, visible and approachable. Staff were proud of the organisation and told us that it was a good place to work. In turn the leadership were proud of their staff and what they achieved.

Leaders articulated well the plans for the service and how these had been adapted from the provider's national vision and strategy to deal with local issues.

There were opportunities for staff to develop and achieve promotion within the service and we saw, through appraisal records that these involved individual personal development plans.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.**

The provider had clear vision and strategy at a global and national level. This was translated into local initiatives through a quality improvement plan for the cluster of midland clinics of which the Birmingham Clinic was a part.

The plan identified the priorities for the current improvement cycle as being education and opportunities for staff, quality improvement, dashboard systems and improved risk management and quality assurance.

There were clear year end targets and an assessment of where the individual initiatives were in terms of achieving these goals.

When we spoke to the registered manager it was clear that the improvements that they wanted us to know of, and the improvements we saw being developed and delivered were those from the quality improvement plan. This was echoed in the conversations we had with team leaders and staff.

## Culture

**Staff felt respected, supported and valued. They were proud of the organisation and spoke highly of the culture. They were focused on the needs of patients receiving care. The service had an open culture where patients and staff could raise concerns without fear.**

# Refractive eye surgery

Staff told us they felt supported and inspired by local managers and those with a national role. There was a positive atmosphere and staff were complementary of their local leaders.

There was strong collaboration, team-working and support across the service and a common focus on improving the quality of care and of people's experiences.

It was notable that when there were lessons to be learned from complaints or incidents the service made sure individual performance was addressed no matter what the role or seniority of the person.

Staff were relaxed and open with the inspection team. They were proud of the service and were honest about the occasions when things had not gone well and keen to tell us how changes had been made.

We saw, through the records of complaints and feedback from patients that patients took the opportunity to raise concerns and that this was encouraged through the information provided on making complaints and comments

## Governance

**Leaders operated very effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There was a comprehensive and well implemented audit system that was a genuine leverage for improvement. The audit system, like other governance arrangements, was proactively reviewed and improved.**

There was a clear governance structure. Staff worked in identified roles to job descriptions with identified lines of accountability and responsibility.

Clinical governance and oversight was provided through a group clinical governance committee that met at a national level.

Clinic managers held regular team teleconferences with their peers at other sites and senior managers. We inspected notes from the last 3 of these meetings and saw that they were used to ensure, amongst other matters, the consistent implementation of changes, the sharing of learning from incidents and complaints and the promotion of improvement.

The service operated against a comprehensive set of policies and procedures largely supplied at a national level but also locally. Policies were clearly issued through a formal process of sign off and had review dates. Although we did not review all policies, none of those we did see had expired. The policies and procedures were written to a high standard.

A key part of the service's governance were the daily team briefs where tasks were allocated, and issues and risks were raised. An agenda, notes and checklists were used to ensure that the briefing ran as prescribed and adherence to this was audited.

We reviewed the notes of the last 3 team meetings and saw that they represented an open and well-structured discussion between staff and managers. Notes of the meeting were clear and detailed, and the meetings appeared run to a strong agenda. The issues discussed correlated well with recent complaints, incidents, risks and changes that we had noted through our inspection activity.

There was an overall audit plan for the service which was adhered to and compliance with the audit plan was itself audited. Any issues were addressed through an audit action plan which identified the current status of the action and compliance with the actions was too audited. The audit system, alongside the investigation of incidents and complaints was a genuine lever for change and improvement.

An example of recent individual audits included, personnel records in May 2022, patient records in June 2022 and infection and prevention control in July 2022.

As an example of how audit was used to promote improvement. We saw that that in a recent audit of controlled drugs practice, an issue had been picked up which resulted in a directive being issued to staff and the audit frequency being increased. These audits demonstrated that practice had improved, and a recommendation had been made that the audit schedule be returned to normal.

Despite the audit system being effective the provider was transitioning to an improved "centralised audit system" to allow and encourage more staff to carry out audits. The rationale was that as well as introducing more audits by encouraging one per week, the system would improve "ownership" of audit and action plans and the "fresh eyes" were more likely to spot concerns. Because the new system was IT based it would also allow better oversight of audit and performance by the provider's senior team and make benchmarking between sites easier. The introduction of a national improvement director and team meant that there was a dedicated group of staff responsible for quality improvement and audit.

The audit tools we saw, particularly those that were being newly introduced or revised were comprehensive, detailed and written to a high standard. We saw through examination of a sample of audits that they were carried out diligently and that any resulting actions were monitored until completion.

The audit tools had an issue date and an expiry date before which the audit system required they be reviewed.

We noted the use of "Clinical Service Directives" which were notes and memos drawing attention to incidents, complaints and changes to practice across all the provider's sites, often as a result of audits. These were kept in a file and all relevant staff were required to read, action and sign that they had done so. It was clear that this was carried out diligently at the Birmingham Clinic.

We noted that an issue identified with resuscitation equipment at a recent CQC inspection of another site had resulted in a national audit and changes had been made as a result at this location.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. There was a demonstrated commitment to best practice in performance and risk management systems. They openly identified and promptly escalated relevant risks and issues. Actions to address risks or reduce their impact were done quickly.**

At corporate level, there was an audit team who were responsible for the management of corporate risk including financial, insurance and health and safety. The clinic manager and the surgery manager were responsible for the practices within their departments. They were supported by the clinical services director, the clinical compliance manager and the surgical services manager at corporate level. The corporate clinical services department, led by the clinical services director was responsible for risk management associated with the pre-operative, peri-operative and post-operative patient pathway including consent, monitoring of outcomes, review of incidents and surgical outcomes.

The service had 3 "risk registers", one each for activities in the theatre, the laser room, and the general clinic. These were presented in a common format of an initial risk score derived from a likelihood and impact score followed by any control actions and a subsequent revised risk score.

Individual risks were aligned with issues we had seen in our inspection activity. The documents were available and updated on the service's intranet and were clearly up to date and being used to manage risk within the service.

Health and safety risk assessments were comprehensive and detailed and covered the general environment, medical devices as well as other aspects such as security.

Issues addressed through audit, complaints and incident investigations fed into the risk management systems and were not treated in isolation.

### Information Management

**The service collected accurate, reliable and timely data and analysed it. Staff could always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.**

The service relied on both paper and electronic systems although it was moving towards more electronic information systems through investment and the development of bespoke systems. The core patient record systems were electronic. The information was seen to be accurate, reliable, timely and relevant.

Clinical data was collected, analysed by a national and international biostatistical department and was made available to staff to allow them to monitor an improve performance.

For some aspects of information management, the service was small enough for paper records to be effective and because they were legible, comprehensively and consistently completed and filed it was easy for the inspection team to understand the performance of the service.

Electronic and paper systems were secured, and the inspection team needed support from the clinic staff to access the documents and systems.

### Engagement

**Leaders and staff actively and openly engaged with patients and staff. Constructive challenge from people who use the service and staff was welcomed and seen as a way of holding the service to account.**

The service communicated with staff through team meetings and a weekly bulletin.

Every patient was given the opportunity to feedback views on their treatment. Patient satisfaction surveys were regularly carried out and the local performance was benchmarked against the provider's national performance. The service received consistently high scores which were comparable to the national benchmarks.

The service also made use of "patient conversations" where more detailed information was gained through face to face engagement with a sample of patients.

# Refractive eye surgery

There was a staff survey every year which was benchmark against the provider's other locations. Staff completed training in equality and diversity as part of the mandatory training schedule. There were newsletters for staff containing information about issues, such as mandatory training, patient stories, profiles of surgeons and new clinics. The newsletter included "Perkbox" which was offers and discounts that were available to staff. The newsletter promoted health and well-being for staff.

## Learning, continuous improvement and innovation

**The service was proactive in questioning their practice and encouraged improvement and innovation. All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.**

The service had stopped doing intraocular lens surgery under conscious sedation in 2020 to reduce risk to patients. This was being validated though a trial being carried out at another site to measure patient experience between sedation and topical anaesthesia. The results were promising and indicated there was no increase in discomfort while reducing risk to the patient.

We saw an example of how the service had responded to a patient's concern about how staff reacted to a clinical complication in theatre. The service had responded by introducing clinical complication scenarios so staff could practice how to react in a simulated environment.

We heard of other interesting innovations, such as an exercise to strip down the resuscitation trolley during a team meeting so that all staff understood what each item was and was used for.