Optimax Laser Eye Clinics - Manchester

Quality Report

1 Albert Square
Manchester
M2 3FU
Tel: 0161 832 7153
Website: www.optimax.co.uk

Date of inspection visit: 31 July 2019
Date of publication: 01/11/2019

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Optimax Laser Eye Clinics Manchester is operated by Optimax Clinics Ltd. Facilities at the Manchester clinic include a laser treatment room, a recovery room, four consultation rooms and a topography room.

The service provides refractive (laser) eye surgery and pre and post-operative care for patients over the age of 18, who self-refer and pay for their own treatment.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the clinic on 31 July 2019.

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

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

The main service provided by this clinic is refractive eye surgery.

Services we rate

We had not previously rated this service. We rated it as **Good** overall.

We found good practice in relation to refractive eye surgery:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service had suitable premises and equipment and looked after them well.
- Patient outcomes were robustly measured, and the service monitored and implemented changes in best practice guidance and standards swiftly. Pain relief was assessed appropriately, and managers made sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their treatment options and choices.
- Patients could access the service when they wanted to, and services were planned to meet the needs of the individual patients. The service made it simple for patients and their relatives to give feedback or raise concerns.
- Managers promoted a positive culture that supported and valued staff. Staff were clear on their roles and responsibilities. Leaders operated effective governance processes. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Refractive eye surgery	Good 	Optimax Laser Eye Clinics Manchester is operated by Optimax Clinics Ltd which is a nationwide provider. Optimax Clinics Ltd operate 20 clinics across England, Northern Ireland, Scotland and Wales. The provider offers a range of specialist vision correction procedures and treatment across its clinics. Optimax Laser Eye Clinics Manchester provides refractive eye surgery as a single specialty service.

Summary of findings

Contents

Good

Optimax Laser Eye Clinics Manchester

Services we looked at
Refractive eye surgery

Summary of this inspection

Background to Optimax Laser Eye Clinics - Manchester

Optimax Laser Eye Clinics Manchester is operated by Optimax Clinics Ltd. The clinic opened in 1994. It is a private clinic in Manchester city centre. The clinic primarily receives patients from the North West. It also accepts patient referrals from outside this area.

The clinic has had a registered manager in post since May 2019. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations.

This service was last inspected in August 2017, we did not have a legal duty to rate refractive eye surgery services at that time. During this inspection the provider was issued with two Requirement Notices which detailed legal requirements which were not being met in line with the requirements of the Health and Social Care Act 2008 and associated Regulations. During this inspection we saw that the provider had taken action to rectify the issues and the requirements were now being met.

Our inspection team

The team that inspected the service comprised of a Care Quality Commission lead inspector and a specialist advisor with expertise in optometry. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Why we carried out this inspection

We inspected this service as part of our ongoing independent health inspection programme.

Information about Optimax Laser Eye Clinics - Manchester

The clinic is registered to provide the following regulated activities:

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

During the inspection, we visited all areas within the clinic. We spoke with six staff including patient advisors, medical staff, the registered manager and a senior manager. We spoke with four patients and one relative. We reviewed five sets of patient records and observed care and treatment being delivered.

There were no special reviews or investigations of the service ongoing by the Care Quality Commission at any time during the 12 months prior to this inspection.

- In the reporting period June 2018 to June 2019 there were 334 procedures, all of which required topical anaesthesia.
- 100% of patients were self-funded.

The service had two types of medical staff working at the clinic; ophthalmologists and optometrists. Both

Summary of this inspection

ophthalmologists and optometrists worked at the clinic under practising privileges. The clinic employed one registered manager, one registered nurse and three dual function patient advisors/laser assistants.

Track record on safety:

- No never events
- 11 near miss incidents, none with harm
- No serious injuries
- No incidences of acquired infection such as Methicillin-resistant Staphylococcus Aureus (MRSA), Methicillin-sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile (c.diff) or E-Coli
- 17 complaints

Services provided at the clinic under service level agreement:

- Clinical and non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Laser protection service
- Maintenance of medical equipment

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We had not previously rated this service. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well**.**
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- 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.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- 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.

Are services effective?

Good

We had not previously rated this service. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff assessed and monitored patients to see if they were in pain and gave pain relief in a timely way, when required.
- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

Good

We had not previously rated this service. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs
- Staff provided emotional support to patients and their families, as required. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients and their families; as required, to understand their options in relation to their condition and make decisions about their care and treatment.

Are services responsive?

Good

We had not previously rated this service. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of the patients it served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Are services well-led?

Good

We had not previously rated this service. We rated it as **Good** because:

Summary of this inspection

- Leaders had the experience, 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.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their escorts and staff could raise concerns without fear.
- Leaders operated 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders and staff actively and openly engaged with patients, staff and the public.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Good

Refractive eye surgery

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

Are refractive eye surgery services safe?

Good

We had not previously rated this service. We rated it as **good.**

Mandatory training

- The service provided mandatory training in key skills to all employed staff and made sure everyone completed it.
- Mandatory training included up to 33 modules and these were updated annually or bi-annually. Modules included infection control, first aid, safeguarding, data protection, fire safety and duty of candour.
- Mandatory training was overseen by the clinic manager who held a comprehensive training matrix for all staff who were employed by the service and worked at the clinic. The matrix was colour coded and highlighted when staff were due/overdue training; for example, red for overdue and amber for a date upcoming within the next month.
- At the time of our inspection we saw that mandatory training compliance was at 89%, 96% and 93% for three staff and 100% for the remainder. The clinic manager told us that courses had been booked for those whose training had expired.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- There was a national vulnerable adult protection policy and a child protection policy; both were in date and available to staff electronically.
- The service had no reported safeguarding incidents or concerns within the previous 12 months prior to our inspection.
- All staff undertook safeguarding adults and safeguarding children training, every two years. All staff with the exception of one had up to date training; the non-compliant staff member was booked on to a course within the coming month. We saw that 80% of staff were trained at level 2 in safeguarding adults; which was the minimum requirement and 40% of staff were trained at level 3. The clinic manager was the designated lead for both adult and child safeguarding and was trained to level 3 in both.
- All staff we spoke with during our inspection demonstrated a good understanding of safeguarding principles and their responsibilities, including how to access local urgent support and services.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- There was an infection prevention and control policy which was within review date and available to staff electronically.
- All staff undertook infection prevention and control training, on an annual basis.
- All staff we spoke with during our inspection demonstrated a good understanding of infection

prevention and control principles and hygiene standards. All areas we visited were clean and had appropriate hand wash basins, liquid soap, antibacterial hand gel. The service displayed posters of the World Health Organisation hand hygiene pictorial guides throughout the clinic.

- Personal protective equipment (PPE) was available and we saw that staff used this when delivering care and treatment.
- The clinic's water supplies were tested for Legionella annually and we saw that staff documented the weekly flushing of all taps.
- The provider had a contract in place for microbiological services and advice, support and training could be requested for staff, as required.
- All non-clinical rooms were cleaned daily by a housekeeper and all clinical rooms and areas were cleaned by medical staff, the registered manager or the patient advisors/laser assistants. We saw evidence that rooms were being cleaned regularly; in line with cleaning schedules and that deep cleaning was taking place every six months.
- The laser room complied with the Department of Health Building Notes HBN 00/09 in relation to infection control. Flooring within the room complied with Department of Health Building Notes HBN 00/10 part A in that it could be easily cleaned.
- Hand hygiene audits were undertaken every three months and we saw evidence that compliance was consistently high. The audit for July showed compliance was 100%.
- An infection control nurse employed by the provider carried out annual, unannounced infection control audits to give assurance for standards across clinics and highlight any areas of concern. We saw that the last annual infection control audit showed overall compliance for the clinic of 95.6%.

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.
- All areas observed were tidy and well maintained. Access to all areas was restricted and entry gained through intercom access for main areas and keycode access for consulting rooms, storage areas and the laser room.
- We saw that all areas had warning signs as required; for example, the laser room and hazardous substance/ chemical store room.
- In the reception and waiting areas we saw that there was wipeable seating, hot and cold drink facilities and magazines for patients and their families to read.
- The service had a maintenance log to ensure that equipment was serviced according to a schedule; this included safety testing for electrical equipment and checks of the laser room pre-filters. Both the clinical manager and the central compliance team had access to the maintenance and servicing log.
- Both humidity and room temperature were recorded within the laser room on a daily basis. We saw that there were no missed checks and the recording of both humidity and temperature were monitored on a weekly basis by the clinical manager.
- The laser protection advisor carried out a risk assessment of the laser controlled environment every three years or when equipment was changed. The most recent risk assessment was March 2018. We saw that there were no outstanding actions from this risk assessment and all clinical staff who worked in the service had signed to indicate their understanding.
- Staff were trained every two years in laser safety and we saw that all staff were up to date with their training. Support and advice were available from the laser protection supervisor or the laser protection advisor; as required. All staff we spoke with were able to tell us who they would contact if they had any concerns regarding the laser equipment.
- Lasers were checked daily and calibrated; both checks, and calibration were recorded within separate log books. We saw that checks were made regularly and monitored by the clinic manager who was also the laser protection supervisor. The provider

employed four laser engineers who worked across the provider network. This meant that any issues or problems with the lasers could be investigated swiftly; without the need to contact an external contractor.

- Single-use surgical items and sponges had traceability documentation completed. Item numbers were also documented within the patient notes on the electronic administration system. All equipment records were in line with Medicines and Healthcare Regulatory Agency guidance in relation to laser safety.
- We saw that all stock within storage areas was labelled, in date and stored appropriately; for example, needles and protective eyewear.
- Environmental audits were carried out every six months; the last audit showed that all areas had 'passed 'and there were no defects noted. We saw evidence that environmental audits were regular and completed in the same format each time. Information was collated by the central compliance team and feedback given; as necessary, at monthly compliance meetings.
- The service adhered to standards of the Department of Health Technical Memorandum 07-01 in relation to the safe standards of waste disposal; including clinical and hazardous waste. Waste bins were appropriate to the environment; for example, non-touch pedal operation. Waste was collected by an external company under a contractual agreement and was stored appropriately whilst awaiting collection.
- The use and storage of sharps bins met the requirements of the European Council Directive 2010/32/EU in relation to location and labelling.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- Patients were assessed for their suitability for laser surgery by an optometrist and a doctor; a minimum of seven days before the surgical procedure took place. This met the best practice guidance of the National Institute for Health and Care Excellence; IPG164 and the Interventional Procedures Advisory Committee. A health questionnaire and eye tests; including retinal examination were carried out and any issues highlighted. Optometrists could contact the operating ophthalmologist with any concerns and the final decision for treatment was made by the ophthalmologist. Patients were reassessed by the ophthalmologist on the day, prior to surgery.
- We saw that there was a process for patients who were not medically suitable or had a complex medical history whereby written approval had to be sought and provided from the patient's own general practitioner. In the event of a situation which required immediate intervention; for example, the examination had revealed a detached retina, the optometrist could make an emergency referral to the nearest acute NHS trust for the patient.
- There was a designated laser protection supervisor (clinic manager) who was present on each day that surgical procedures were carried out and we saw that staff had access to the laser protection advisor at all times.
- The surgical team consisted of an ophthalmologist, a registered nurse and a laser assistant. The surgical team used a surgical pause checklist to carry out pre-procedural safety checks. The checklist was based on the World Health Organisation surgical safety checklist and this showed a marked improvement from the last inspection when no checklist was used. We reviewed five checklists during our inspection and saw that all five had been completed correctly within the patient records. The clinic manager completed quarterly audits of the checklist and we saw that compliance for the last quarter was 94%.
- The operating ophthalmologist provided each patient with an emergency contact card for use after their procedure. This provided patients with 24-hour access to clinical advice in case of concerns or adverse symptoms. Patients were given a discharge letter which they could keep for their own records and/or give/show to their own general practitioner.
- All ophthalmologists were required to hold professional indemnity insurance; this was checked by the provider on a monthly basis and we saw evidence that all ophthalmologist at the service had the required cover.
- We were told that patients stayed at the clinic until they felt well enough to go home. We saw that there was a recovery room for patients who felt faint or

needed to rest until they felt well enough to go home. The room was equipped with adjustable lighting, a reclining chair and an emergency call button for patients; which was connected to the reception desk. Staff told us that they routinely checked on patients or stayed with them; based on patient preference, when they were in the recovery room. In the event of serious complications, clinical staff arranged for patients to be transferred to a local NHS emergency department.

- All staff were trained in basic life support skills and we saw that the registered nurse was trained in immediate life support skills. All staff we spoke with could describe what to do in an emergency situation and could demonstrate the appropriate use of equipment. The service had an automated defibrillator and we saw that this was checked regularly and disposable items; such as defibrillator pads, were in date.
- Emergency equipment was available such as oxygen, first aid kits and adrenaline for anaphylactic shock. Emergency equipment was stored correctly, in date and checked regularly. We saw evidence that the service undertook, and recorded resuscitation drills every quarter; this included how long it took for help to be contacted and what equipment staff brought with them when the emergency was declared. Staff performed consistently well and this showed good practice.
- We were told that sepsis training was included within the mandatory first aid training and all staff we spoke with had an awareness of sepsis; though we were told it was unlikely to be seen within the service.
- We saw that there was a designated fire file held at the reception desk, this contained information such as the latest fire and evacuation procedures and the most up to date fire risk assessment; carried out by the clinic manager and another member of staff with fire risk assessment training (every six months). We saw that there was a fire test each week, fire drills happened every six months and were recorded appropriately. We saw that evacuation times were under two minutes which met with standard guidance. We saw that there was a designated fire warden on each shift and the name was clearly displayed on a wipeable board, at reception.

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.
- Two ophthalmologists and three optometrists worked at the service under practising privileges. The granting of practising privileges means a medical practitioner is given permission to carry out services (particular to the medical discipline they are trained in), within an independent hospital or clinic.
- Two full time technicians and three additional clinical staff who had dual functions of patient advisors and laser assistants also worked at the service, on a permanent basis.
- The central human resources team held and maintained an electronic register of checks on medical staff to ensure that they met the requirements of revalidation and maintained the appropriate membership to the professional body their discipline related to. The clinic manager had oversight and was able to access this at any time.
- Staffing was planned in line with the Royal College of Ophthalmology guidance on staffing in ophthalmic theatres and the skill mix was planned in line with the Medicines and Healthcare Regulatory Agency guidance on laser safety. We saw that there was always a registered nurse present for surgical procedures which met with best practice standards.
- A doctor was always on call for the service and provided 24-hour urgent care advice by telephone.
- Patient advisors and laser assistants were a dual role; this meant that they were trained to carry out the duties and responsibilities of both roles. This showed good practice and allowed the clinic manager greater flexibility when planning staffing based on skill mix and experience to deliver safe care and treatment.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service used their own electronic patient administration system. The system contained all

information; for example, patient details, assessments, medical notes and prescriptions. The system was used throughout all the providers clinics. This was important because it meant that if a patient had to be seen at a different clinic; their notes could be accessed straight away. Similarly, compliance staff could access records immediately in the event of an incident or complaint.

- We were told that all traceability documentation from theatre was uploaded; immediately after surgery, onto the electronic system. We reviewed five patient records and saw that this had been done on each occasion, in a timely manner.
- Of the five patient records we reviewed we saw that each had been completed accurately and contemporaneously including; consent, medical notes, pain relief advice and health questionnaires.
- Patient records were audited every quarter and we saw that there was consistently high compliance across all areas audited including clarity of documentation and medical notes. We were told that any concerns from patient note audits were discussed at team meetings.

Medicines

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service had a medicines policy and a policy for prescribing, dispensing and administering medication. Both policies were found to be in date, followed best practice guidance and were available to staff electronically. The introduction of the prescribing, dispensing and administering medication policy had been brought in following concerns found at the previous inspection. Staff we spoke with were aware of the policy and had received additional training in the safe dispensing of medication as part of an updated annual medicines management training course. This showed an improvement from the last inspection.
- Prescribed medication was audited quarterly, and we saw that items checked included; medication batch numbers, patient information leaflets had been given and stock check had been performed before the removal of the medication from the stock cupboard/ fridge. We saw that compliance was consistently high across audits. During our inspection we checked five prescription records and saw that medicines were recorded correctly including the strength, dose and site. Records showed staff checked and documented each patient's allergies and these were reconfirmed before any procedure. However, we saw that there was one occasion when a patient information leaflet had not been annotated as being provided to the patient, with a prescribed medication.
- An overall stock check was carried out once a month by the clinic manager or registered nurse; who were both location leads for the safe management of medicines. Medications were ordered based on the remaining stock levels and the number of surgical and follow-up appointments booked in for the subsequent month. This was monitored centrally by the national team. Advice and support were available from an external pharmacist as and when required.
- Medicines were stored safely and securely; within locked cupboards or fridges, in restricted access rooms, in line with national and manufacturer guidance. We saw that fridge temperatures were monitored and recorded daily. This was important because certain medications had to be kept at; or between, required temperatures in order for them to remain effective for use. All medicines checked were found to be in date with batch numbers recorded.
- Cytotoxic eye drops were disposed of in appropriate hazardous waste bins which complied with the Control of Substances Hazardous to Health Regulations (2002). Cytotoxic medicines are chemicals that are toxic and must be handled using specific safety processes. The service had a safe use of cytotoxic drugs policy which was in date and available to staff electronically. We saw that there was a comprehensive record of the administration, disposal and waste collection of cytotoxic medication which met with local policy and safety regulations.

Incidents

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared

lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- The service reported no never events in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service actively encouraged the reporting of incidents and all incidents were reviewed by both the clinic manager and the national compliance team. This was important because it meant that incidents were reviewed by more than one senior manager; which ensured consistency in the grading of incidents and subsequent level of investigation undertaken. The national compliance team looked for themes and trends within the incident reports over specified periods and we saw evidence that changes in practice were made as a result of this.
- During our inspection staff we spoke with told us they knew how to report incidents and gave examples of the type of things they would report. The reporting system was electronic, and staff described the process as being simple and easy to use. We were told that staff received feedback and learning from incidents at team meetings and we saw evidence of this within the team meeting minutes.
- Staff were able to give examples of when the reporting of an incident had resulted in improved practice; for example, an incident had been reported whereby medical notes had not been completed after a follow-up consultation. As a result of this a checklist had been developed for patient advisors/laser assistants to complete when the patient came out from the consultation room.
- Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff received annual training on duty of candour and could easily verbalise the principles behind the regulation and give examples of when the duty of candour would be applied. The service did not report any incidents where duty of candour had formally been applied within the 12 months prior to our inspection.

Are refractive eye surgery services effective?

Good

We had not previously rated this service. We rated effective as **good.**

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence-based practice.
- We saw that staff used the Royal College of Ophthalmologists Standards for Laser Refractive Eye Surgery, the National Institute for Health and Care Excellence guidance and the General Medical Council guidance when assessing patients' needs and planning their care and treatment for refractive eye surgery.
- We saw that infection control standards, practices and training were standardised against the National Institute of Health and Care Excellence guidance; for example, quality statement 61 in relation to the control of infection.
- A medical advisory board was in place for all clinics within the provider network and set standards for ophthalmologists and optometrists nationally; in line with established guidance. We saw evidence that changes in policies and best practice guidance were discussed and disseminated through multidisciplinary meetings chaired by the chief executive officer with the support of the head optometrist and medical director.
- Policies were readily available to staff along with standard operating procedures and medical staff we spoke with could tell us how they would access them.

Pain relief

- Staff assessed and monitored patients to see if they were in pain and gave pain relief in a timely way, when required.
- Anaesthetic eye drops were provided for patients prior to each refractive eye surgical procedure and we saw that this was recorded correctly, and patients were asked about their pain both before and after procedures.
- Pain relief was provided prior to discharge and this included advice about over the counter pain relief, if required. We saw that the 24-hour clinical helpline which patients had access to included giving advice about pain relief.
- All patients we spoke with told us that they felt staff had explained to them clearly about pain relief, including the most appropriate pain relief to take after their procedure.

Patient outcomes

- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Patient outcomes were monitored centrally, and the provider was able to publish large amounts of data on treatment outcomes and included this information in the patient information booklet. This showed good practice as it enabled patients to gauge results from a large sample size as to how successful treatments were. The service was able to forecast results for new patients based on the previous data which had been collected and we observed this in practice, during a consultation.
- Patients underwent an optometrist consultation, ophthalmologist assessment and a medical review before treatment. Outcomes from each of these stages were used to identify how successful it was likely to be for the intended outcomes to be achieved for each individual patient.
- The service did not contribute data to the National Ophthalmic Database Audit nor did it compare patient outcome data with similar external services. However, the service was able to assess and compare their own services against each other, across clinics and make alterations or improvements as required. The provider monitored patient outcome data via a central national team; for each individual ophthalmologist, to benchmark against expected outcomes on a quarterly basis. Areas of significant concern were investigated and would be discussed at supervision or appraisal meetings. Themes and trends were established, and we were told that areas of concern, issues and good practice overall were discussed at the medical advisory board quarterly meetings.
- We saw that the service monitored unplanned patient returns to theatre, unplanned re-treatment and treatment enhancement. In the 12 months prior to our inspection there had been one unplanned return to theatre and six unplanned re-treatment or treatment enhancements. This represented 2% of the total cases within the 12-month period prior to our inspection. In all seven incidents the service was able to demonstrate that reviews of the assessment, care and treatment had been undertaken by the clinic manager and operating ophthalmologist to establish or identify any opportunities for learning or improving practice, going forwards.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All new starters received a formal induction which included an induction course, mandatory training completion and study of the provider's policies and procedures. All probations were signed off by the director of operations. Staff were then placed on a six-month probationary period which was overseen by the clinic manager and competency checklists were used. We reviewed one completed induction and probation file and saw that it was comprehensive, completed correctly and showed a good standard of training and support.
- There was a robust system for monitoring and managing staff; all permanent clinic staff received monthly 'one to one' meetings with the clinic manager in which they could discuss any issues, concerns and performance. In addition, annual appraisals were also carried out for all staff and we saw that compliance

rate for appraisals was 100%. Part of the appraisal process for medical and nursing staff included ensuring all professional registrations were current and appropriate.

- The clinic manager was the laser protection supervisor and had attended a bespoke training course to carry out the role. The training was revalidated every two years and we saw that there was a competency-based examination which must be passed to receive revalidation.
- All staff who worked within the laser controlled area had completed specific laser safety training and we saw that all the required staff had completed the study day and compliance was 100%. We saw that training included demonstrating the safe operational use of the lasers and a competency assessment.
- All ophthalmologists who provided treatment at the clinic held the Royal College of Ophthalmology certificate in laser refractive surgery and the clinic manager monitored ongoing accreditation for staff.
- The provider's national human resources team maintained personnel records and we saw that minimum amounts of information were held at the clinic location in line with General Data Protection Regulation 2016/679. We were told that the central human resources team held a database which detailed all staff and due dates for checks and revalidations; for example, hepatitis B immunisation dates. The clinic manager was able to request information as required from the national human resources team in relation to required documents and checks; for example, up to date Disclosure Barring Service information. We saw evidence that the manager was able to access this information during our inspection.
- Staff we spoke with during our inspection told us that the induction and probation process had been robust, supportive and well structured. One member of medical staff we spoke with had worked for the provider for 23 years and described the company as "supportive and inclusive".

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 within the clinic to discuss issues, concerns and changes in practice to improve patient experience and patient care. Working relationships within the clinic between non-medical and medical staff were visibly strong. There was a positive ethos and staff from across disciplines provided a supportive environment in which to care for patients.
- Multidisciplinary meetings were a held at organisational level and we saw that various items were discussed to enhance learning and share best practice; both between medical professionals and senior management.
- We saw that if patients experienced complications after a procedure, staff referred them to the most appropriate specialist service or local acute NHS Trust. The clinical team liaised with other healthcare professionals to ensure patients received the most appropriate care.

Consent and Mental Capacity Act

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- The service had a consent policy; which staff were aware of; the policy was in date and available to staff electronically.
- The Royal College of Ophthalmologists recommends that patients should be given a seven day 'cooling off period' in relation to consenting for ophthalmic surgery and we saw that the service met this guidance.
- Patient advisors gave the patient information guide to patients during their initial appointment. This contained the consent form with instructions to read before the patient met with the ophthalmologist. This showed good practice as patients were able to highlight any areas of concern they had or any areas in which they felt they needed clarification.
- Consent was led by the operating ophthalmologist surgeon and we saw that a consent form was completed upon the initial consultation; however,

consent forms were only available in English. Staff told us that this had never been an issue as translation services could be provided. An additional consent check was completed immediately prior to surgery; seven days later and the patient had the opportunity to ask any questions.

- Staff were trained in mental capacity; which included consent, on an annual basis as part of the mandatory training programme. We saw that all staff were up to date with the training and staff we spoke with were able to verbalise the importance of gaining consent and demonstrate an understanding of the Mental Capacity Act (2005).
- We reviewed five consent forms as part of the records reviewed during our inspection. We found that all five were completed accurately, legibly and were in line with the provider policy.

Are refractive eye surgery services caring?

Good

We had not previously rated this service. We rated it as **good.**

Compassionate care

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- We observed staff speaking to patients and their escorts with kindness and compassion, throughout our inspection. We heard patients being welcomed warmly when they came into the clinic and were offered refreshments. Staff were professional at all times and we saw they readily offered reassurance and advice to patients in a variety of circumstances; for example, advice on eye drops and application techniques.
- Privacy and dignity were maintained by staff closing doors during consultations and speaking discreetly and in low voices within the waiting room so that conversations could not be overheard. Patients we spoke with told us that they were treated with dignity and respect by all staff members.
- Patients were asked to complete a satisfaction survey after their treatment. Survey results were collated, and the clinic team used the feedback to make adjustments and improvements wherever necessary. We saw evidence of this being discussed within team meeting minutes.

Emotional support

- Staff provided emotional support to patients and their relatives, as required. They understood patients' personal, cultural and religious needs.
- Patients we spoke with told us that they felt supported and confirmed they were given a named patient advisor as a point of contact and to support them throughout their journey.
- We saw that staff were trained to provide a positive, compassionate and supportive aftercare experience; for example, asking patients about their comfort when they had slept on the first night after the surgery.
- During the initial consultations we saw that staff took the time to ask patients about any specific cultural or social needs they may have had in relation to the treatment.

Understanding and involvement of patients and those close to them

- Staff supported and involved patients and their families; as required, to understand the options in relation to their condition and make decisions about their care and treatment.
- Patients were provided with printed information at all stages throughout their patient journey; including explanations of their planned treatment, likely results and aftercare instructions. All information was discussed verbally during assessments and the printed copy was mainly for reference purposes.
- Patients were directed to the provider website where they could read satisfaction reviews of those who had undergone treatment previously and there was a comment book on the main reception desk for patients and their escorts to read.

Good

Refractive eye surgery

- Patients were supported to understand treatment options; including risks, benefits and potential consequences, as per the Royal College of Ophthalmologists professional standards for refractive eye surgery.
- We saw that during the initial consultation the optometrist gave a detailed explanation of the process of surgery, explained the potential results and was responsive to the patient's questions. We saw that the optometrist used terminology that the patient could understand and confirmed clarity of understanding with the patient. There was a deliberate non-hurried approach and we saw that the patient was appreciative of that.

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

Good

We had not previously rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

- The service planned and provided care in a way that met the needs of the patients it served.
- Services provided were elective and pre-planned procedures only. There was no emergency eye surgery service and no NHS services were provided by the clinic.
- Services were provided for the immediate local population, surrounding areas and patients were also accepted from further afield. Staff informed us that services were planned and delivered for all persons who wished to use the service with the exception of those deemed medically unsuitable, people under the age of 18 years and pregnant women or those who were breastfeeding.
- Patients who required surgery that could not be accommodated at the clinic; for example, lens replacement surgery, were supported to access one of the other provider clinics which performed that specific surgery.
- National and international guidance on refractive eye surgery was reviewed by the medical advisory board to ensure that services and practices were continually adapting to people's needs.

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.
- All staff completed a disability and discrimination awareness course which equipped staff to recognise the requirements of those with disabilities as well as different cultural needs and beliefs.
- Services were tailored to each individual patient's needs; without exception. This included amending and reassessing the patient's needs and expectations at each stage of the pre-assessment process. For example, adjusting the patient forecast if the patient decided they would have monovision (an option which enables patients to see both near and far). Patient result forecasts were completed based on the individual patient's eye profile.
- We saw that patients were required to attend a minimum of four aftercare appointments before they were eligible to be discharged. This was important because it allowed the service to make sure that the treatment had been successful and could be monitored over a specified time period; in line with best practice guidance.
- The service had a hearing loop to assist patients with hearing impairments and we were told that this could be taken into the laser room, as and when required.
- Patients with language restrictions who required translation or interpretation services could have this arranged. These services were provided by external companies and as such could be charged back to the patient. We were told that this would be looked at on an individual case by case basis.
- We saw that the provider was committed to making sure that there was guidance for staff for patients with specific needs or requirements. For example, guidance was in place to allow staff to safely care for those with learning disabilities or complex needs. We saw that this guidance was based on quality standards from the

Royal College of Ophthalmologists. We were also told that the national compliance manager was currently writing guidance for staff for bariatric patients (patients with obesity).

- The service had a range of information leaflets available; for example, aftercare booklets and information on certain conditions such as dry eye syndrome. However, information leaflets were only available in English and did not state that leaflets could be provided in alternative languages or formats. We were told that the patient would be offered spoken translation services in the first instance and that some of the literature could be translated using computer systems.
- The building the clinic occupied was listed and as such adjustments and adaptations could not be made to make it wheelchair accessible. This information was made clear to patients both within the written literature and on the provider's website. We heard staff advising patients on the telephone that the clinic did not have disabled access. Patients who required disabled access where accommodated at the provider's nearest clinic in Liverpool. The service had previously contributed to transport costs for patients who required disabled access to attend alternative clinics.

Access and flow

- People could access the service when they needed it and received the right care in a timely way.
- All patients self-referred to the service and patients were able to access the service by booking an initial appointment by telephone or on the provider's website.
- The provider's national diary team planned treatments up to three months in advance based on the availability of clinical staff and the patient's requirements. This allowed the clinic manager to plan staffing levels ahead to make sure that the right staff where present on the right days.
- As the service used an electronic patient administration system which was shared across the provider network; patient records could be accessed at any branch and patients could therefore move between clinics without the need for records to be requested or retests taken.
- Services at the clinic were available Monday to Saturday from 8am to 6pm. The service provided 24-hour, seven-day access to aftercare for patients. This included an ophthalmologist-led telephone advice line which enabled patients to discuss concerns or issues. Furthermore, patients could return to any of the provider's clinics for advice or review by an optometrist or ophthalmologist after their procedure.
- There were no waiting lists for procedures for the service and the service demonstrated flexibility to meet the patients' needs with regards to appointment times. We observed patient advisors offering patients a variety of appointments and we were told that staff could contact the national diary team and request additional appointments to be put on as required.
- The clinic had cancelled one planned surgical procedure for a non-clinical reason within the 12 months prior to our inspection and staff told us this was an extremely rare occurrence. There were systems in place to monitor cancellations of surgery and this was overseen by the national compliance team. This showed an improvement from the previous inspection whereby there was no monitoring system in place.
- There was a robust system in place to make sure appointments ran as smoothly as possible, led by the clinic manager. Patients were contacted two weeks before their initial consultation to confirm the appointment and make sure the patient was happy with the arrangements and had received the relevant literature. Patients who missed appointments were contacted within 48 hours of the appointment and appointments were rescheduled as required.
- Patients we spoke with told us that they were happy with the appointment system and access to the service and they felt they would be readily accommodated; should they require alternative arrangements or have any concerns.

Learning from complaints and concerns

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- The service had a formal complaints and whistleblowing policy which was in date and available to staff electronically.
- Information for patients in relation to making a complaint was clearly visible in the main waiting area within the clinic and online on the provider website. Complaint forms were readily available at the reception desk.
- All staff were trained to resolve minor issues and complaints as soon as they were raised verbally in the clinic and staff told us they would escalate to the clinic manager if they were unable to resolve them.
- Formal complaints could be submitted to the national head office and would be acknowledged within two working days and responded to, in full within 20 working days. Investigations for formal complaints were actioned jointly by a national complaint's administrator and the clinic manager.
- The service had received 17 complaints in the 12 months prior to our inspection. The main theme from complaints were results of surgery not being as expected. We saw that all complaints which were logged correctly had been acknowledged and responded to within the timescales set out within the complaints policy. However, four complaints did not have either an acknowledgement or response date annotated which meant it was unclear if all complaints were 100% complaint with the provider policy.
- Following our inspection, we reviewed four complaints from a selection provided by the service. We saw that each complaint was investigated thoroughly, apologies were given if appropriate and a resolution was offered.
- The provider did not have membership to the Independent Healthcare Sector Complaints Adjudication Service. This meant that if a complaint could not be resolved by the provider, patients would be referred to the relevant regulatory body to investigate the compliant; for example, the General Medical Council.
- We saw evidence that complaints were discussed, themes identified, and learning was shared; from across the provider's network, at both clinic team meetings and senior management meetings.

Are refractive eye surgery services well-led?

Good

We had not previously rated this service. We rated it as **good.**

Leadership

- Leaders had the experience, 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.
- Optimax Clinics Ltd was established in 1991 and the same individual had been in charge of the operation since that time. All staff we spoke with were aware of the senior leadership team and the team was well respected.
- The service had a clinic manager who was permanently based at the location and ran the service on a day to day basis. When the clinic manager was unavailable, temporary arrangements were put into place to ensure that staff always had access to senior support and advice.
- We saw that the leadership was visible, approachable and well respected by the staff within the service. The clinic manager told us that the service had an 'open door' policy and staff confirmed that this was the case.
- All staff we spoke with were positive about the leadership structure and their relationships with the senior team. Staff knew the senior leadership team by name and could tell us when they last visited the location and confirmed that when they came, they spoke with all staff.

Good

Refractive eye surgery

Vision and strategy

- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- The provider had a corporate level vision in place and this was found on the provider website. We saw that senior management could verbalise how the vision was to be achieved and provided an overview of the overarching corporate strategy that would be used to do this.
- Staff members we spoke with were aware of the vision for the service and told us this was discussed at clinic team meetings. Staff were able to give examples of how the vision would be achieved; for example, expanding of clinics and increasing treatment services available.

Culture

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- All staff spoke highly of the culture and told us there was good team work across the service. Staff spoke positively about the clinic and were proud to work for the organisation. One member of staff told us that they found the provider honest and ethical; both in dealing with staff and in terms of patient care.
- There was a culture of openness and honesty within the clinic and this related to both staff and patients. We saw that staff were happy to speak openly and candidly with leadership and there was evident trust between staff from different disciplines and grades. There was a clear focus on creating a positive environment for team work and a focus on honest, sustainable patient care. For example, treatment outcome data, risk information and simple 'nothing hidden' costings were readily available for patients.

Governance

- Leaders operated 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.
- A national compliance manager, who reported to the director of operations was the designated point of contact for governance and quality issues and led the overall governance and quality control programme for the provider.
- Governance processes were robust and staff we spoke with were aware of governance arrangements for the service. There was evidence of both embedded governance procedures and quality measurement processes and these were overseen nationally by the compliance team.
- All non-clinical policies and procedures were reviewed and amended by the national compliance team. Clinical protocols, policies and procedures were reviewed and amended by the medical advisory board. This meant that there was a clear line of accountability for updates and changes. We saw that there were robust systems in place for oversight of review dates for all policies and procedures and it was evident that the provider was keen to make sure that staff had all the guidance and support they needed. We saw that improvements had been made since the previous inspection and that there was now an adverse event and near miss policy (incidents) and a prescribing, dispensing and administering medication policy.
- Staff told us that clinic team meetings were held every four to six weeks and we saw evidence that this was the case. Team meetings did not follow a set agenda and there was no action log recorded. However, we saw evidence that items which required discussion or updates within subsequent team meetings were followed up and senior management told us that an action log was not required due to the small size of the clinic team. We also saw that items which had originated in higher level meetings; for example, senior compliance meetings had filtered down and were passed onto staff within the clinic team meetings.

- Items discussed at team meetings included; monthly targets, updates in policies/procedures, complaints, incidents and reminders for staff. Minutes were recorded and placed onto the shared drive for staff to access if they were not present.
- The national compliance manager led a monthly compliance call meeting with registered nurses and clinic managers. We saw that these followed a standard agenda and items discussed included; infection prevention and control issues, incidents and near misses including themes identified, policy or procedure updates and complaints. There was no action log recorded; however, we saw evidence that items which required revisiting, further discussion or update were annotated in subsequent meetings. The meetings were minuted and the minutes were available for staff on the shared drive, electronically.
- We were told that the provider scheduled nationwide, face to face management meetings, twice a year. Clinic managers were asked what they would like on the agenda and other items discussed were; potential changes, new practices, themes and trends, sharing best practice and lessons learned.
- We saw evidence of higher-level governance meetings; such as the senior management monthly compliance meeting and the quarterly medical advisory board meeting. There was a clear process for feeding information both up and down the chain of command and this was easily seen from evidence provided by the service.

Managing risks, issues and performance

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- There was a national clinical governance and risk management policy which was found to be in date and available to all staff electronically.
- The service had a local risk register which held risks relevant to the Manchester clinic. This showed an improvement from the last inspection whereby there was no local risk register. Risks contained within the register were found to be within review date, scored appropriately in line with the provider's policy and had relevant actions and action plans to mitigate the risk where appropriate. This was also an improvement from the last inspection. We saw that risks which were scored above a certain level were escalated to the national risk register and discussed by the senior management team.
- We discussed key risks with the clinic manager and national compliance manager and found that they were able to verbalise both local and national risks with ease and these mirrored the risks which were contained within both risk registers. We saw that an annual report was produced which detailed companywide risks.
- We saw evidence that risks were discussed at each level of governance meeting and escalated where necessary and appropriate. We found that staff within the service were able to verbalise key risks to the service both as a location and nationally and tell us what was being done to mitigate the risks. This meant that the systems for escalation, dissemination and mitigation were effective.
- We saw that there was good oversight of incidents, issues, risks and performance by both the national compliance team and the local clinic manager. All information was held electronically however, the clinic manager held a robust and methodical filing system which contained hard copy information on all aspects of the clinic manager's responsibilities; for example, incidents, audits, complaints and action plans. We found the information within each file was contemporaneous and the clinic manager was able to locate any information we requested immediately.
- The national compliance manager carried out a compliance inspection at each clinic location, every six months. The compliance inspection focussed on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with which the provider must be compliant as part of their registration agreement with the Care Quality Commission. We saw that each regulation was listed individually within the inspection document and each had a detailed list of how the provider was meeting the regulation, what evidence they could provide to prove this and gave an overall compliance score. This showed good practice as the process enabled the provider to monitor their

own compliance, compare and benchmark against its other clinics, highlight themes and trends and share best practice. We saw that the latest compliance audit for the service was carried out in February 2019; compliance was consistently high across all areas, there was a small action plan which the local team had completed within 20 days of the inspection.

- Audits were carried out by the clinic manager or the national compliance team; dependent on the type of audit. We saw evidence of a robust, rolling audit schedule which detailed all audits and was held electronically on a shared drive to enable both the clinic manager and the national compliance team access and oversight. We saw that the results of audits were discussed at clinic team meetings and compliance meetings and learning was shared.
- Senior managers monitored performance nationally, for all the provider's clinic sites and we saw evidence that feedback was given to clinic managers and relevant staff on a regular basis. The provider monitored various aspects of performance; for example, conversions from consultation to surgery, treatment results, retreatment rates and unplanned reattendances to surgery. We saw that themes and trends were identified and when required investigation was undertaken.

Managing information

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Staff had access to the provider's intranet system which provided communication facilities and a range of internal and external resource materials to assist staff in their day to day tasks. Staff informed us that they had all the information that was needed for them to undertake their roles effectively. We saw that systems were intuitive and comprehensively linked; for example, the incident reporting system linked to relevant risks and associated risk assessment documents. This was good practice.
- All documentation was electronic with the exception of the consent form and surgical safety checklist which were subsequently scanned onto the computer system when completed. This meant that patient records were available to staff at any clinic; across the provider network. This was important because it meant that patients were able to attend any clinic, nationally and their records and test results could be accessed.
- We saw evidence that the provider had recently undertaken an extensive project to make sure that as a provider they met the General Data Protection Regulation 2016/679. This had involved standardising the data held at each clinic, nationwide, to make sure that only data which was strictly necessary was held on location. All other information was held at the national head office. We saw that there were further plans to improve and streamline data; for example, a system which would allow all clinic managers to access the centrally held information. This was important because it showed the provider was seeking to continuously improve and adapt to new legislation and best practice guidance.
- Important information such as safety alerts from the Medicines and Healthcare Regulatory Agency were cascaded to clinic managers and medical staff by email and adjustments to practice were made as and when appropriate.

Engagement

- Leaders and staff actively and openly engaged with patient, staff and the public.
- The service actively engaged in seeking patient feedback at all stages throughout the patient journey. We saw that there were service and satisfaction questionnaires for patients to complete and these fed into the annual patient guide report which was available for new and existing patients to read, within the clinic. We saw that the service took the results of patient satisfaction surveys seriously and these were discussed at all levels of governance meetings.
- There was a comment book on the reception desk for patients and their escorts to leave comments and we saw that there were many examples of patients who were satisfied with the service and grateful for the 'helpfulness' of staff.

Good

Refractive eye surgery

- We saw that the service had received 39 written compliments on the treatment and care received throughout the 12 months prior to our inspection. Staff confirmed that compliments were shared in clinic team meetings and this often boosted team morale.
- The provider engaged with patients and the public via their website and we saw they were also active on four social media sites. We saw that feedback was unequivocally positive with many recommendations for the services provided.
- Staff told us that they were encouraged to make suggestions and improvements by both the clinic manager and the senior management team. As it was a small team staff felt it was inclusive and there was a strong, positive ethos of engagement.

Learning, continuous improvement and innovation

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Staff gave many examples of changes in practice following issues highlighted through incidents, concerns raised or audits. For example, the incident reporting form had been streamlined to make it easier for staff to complete as it had become apparent that there were difficulties due to the layout of the previous form and lack of clarity.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all complaint acknowledgement dates and response dates are annotated within the complaints log.
- The provider should consider using action logs for all governance meetings to ensure actions are recorded, updated and followed up appropriately.