Midland Eye

Quality Report

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

Ratings

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

Overall summary

Midland Eye is operated by Aspen Healthcare. Aspen Healthcare is a group healthcare provider that provides independent services across the UK. The Midland Eye clinic is an ambulatory day surgery clinic with no inpatient beds or wards. Facilities include an operating theatre, an anaesthetic room, a small recovery area, a pre-assessment room, a diagnostic room, three consultation rooms and two patient waiting areas.

The service provides surgery, and outpatients and diagnostic imaging. We inspected both of these core services. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 26 and 27 September 2017, along with an unannounced visit to the hospital on 11 October 2017.

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

Summary of findings

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 was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

Services we rate

We rated Midland Eye as good overall.

We found good practice in relation to surgery and outpatients:

- Patients were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong.
- The safety systems in place kept patients safe from avoidable harm, which was reflected in an excellent track record in safety.
- Staffing levels were appropriate to keep people safe at all times.
- The clinic invested in staff training, skills and competence. Competence of staff was integral to achieving the service's aim of providing first class healthcare.
- There was a comprehensive suite of policies and procedures that supported staff in providing high quality, safe and effective care. The policies and procedures were reviewed regularly and were in line with current best practice guidelines and legislation.
- Patients had good outcomes because they received effective care and treatment that met their needs. Outcomes were routinely monitored and reviewed alongside patient experience to assess quality of care.
- Staff treated patients with compassion, kindness, dignity and respect. Patients were respected and valued as individuals and were empowered as partners in their care.
- The clinic provided patient centredcare and treatment. Services were organised and tailored to meet the needs of the individual patients. The clinic delivered services in a way that ensured flexibility, choice and continuity of care.
- The leadership, management and governance of the clinic assured the delivery of a high-quality person-centred care, supported learning and innovation, and promoted an open and fair culture.
- Governance and performance management arrangements were proactively reviewed and reflected current best practice.
- Risks were clearly identified and monitored effectively. Performance issues were escalated to the relevant committees and the board through clear structures and processes.
- Patients and staff were highly respected and valued. A full and diverse range of patients' views and concerns were encouraged, heard and acted on.
- Information on patient experience was reported and integrated with performance data to give a clear and accurate all round picture of quality and safety.

We found areas of practice that require improvement in relation to surgery and outpatients:

- We found that patient identifiable information was not always present on all pages within the paper notes and the authorised signature sheet at the front of the notes were not always completed. Correspondence letters to other health professionals did not always have a penned signature present. On our return visit, the clinic had put things in place to ensure that these issues were rectified
- The clinic did not have a designated area for recovery and patients had to recover in the shared waiting area. Although no patients raised this as an issue, staff recognised that the shared waiting and recovery area was not ideal for patients privacy.
- The clinic was not currently submitting data to the Private Healthcare Information Network (PHIN).

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

Summary of findings

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity at the clinic. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. All management and governance systems, along with staffing were managed jointly with outpatients' services. We rated this service as good as it was safe, effective, caring and responsive. Well-led was outstanding.
Outpatients and diagnostic imaging	Good 	The outpatients' service was small and compact and the management team, governance systems and staffing were the same across the surgery and outpatients service. We do not repeat information throughout the report but cross-reference to the relevant section of the surgery section. We rated this service as good because it was safe, caring and responsive. Well-led was outstanding. There is currently not enough evidence nationally to give a rating for effectiveness of outpatient services.

Summary of findings

Contents

Good

Midland Eye

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Midland Eye

Midland Eye is operated by Aspen Healthcare. The service was established in 2003 and owned by four consultant ophthalmic surgeons. Aspen Healthcare acquired part of the business in 2012 and it remains jointly owned at present. Midland Eye is an ambulatory day surgery clinic and is located in Solihull, West Midlands. The clinic offers specialist consultation rooms, on-site diagnostic testing and operating facilities for ophthalmic eye conditions, which includes refractive eye surgery. The clinic provided NHS and private procedures of which a large proportion was NHS. The clinic primarily serves the communities of the Solihull and also accepts patient referrals from outside this area. The clinic did not treat patients under the age of 18.

The clinic had a registered manager in post since August 2011. A new manager had recently been appointed and was registered with the CQC in February 2017.

The clinic had been inspected in December 2012 and December 2013 using a previous inspection methodology. This inspection was the clinic's first inspection under our current methodology. In the 2012 inspection, the service was found to be compliant in the five outcomes that were inspected. In the 2013 inspection, the service was found to be compliant in four of the five outcomes that were inspected. They were found not compliant in outcome 14, suitability of staffing, support for workers. The provider had since implemented a staff training and competency database.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. There was access to a specialist advisor with expertise in ophthalmology via the telephone. The inspection team was overseen by Tim Cooper, Head of Hospital Inspection.

Information about Midland Eye

The clinic provides ambulatory day surgical procedures and diagnostic testing. There are no inpatient wards or beds. The main service the clinic provides is surgery. The consultants working under practising privileges provide both surgery and outpatient services.

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 of the clinic, including the theatre, consultation rooms and diagnostic rooms. We spoke with 12 staff including; registered nurses, health care assistants, administrative staff, medical staff, ophthalmic technicians, laser protection advisor and senior managers. We spoke with six patients and their relatives. We reviewed ten sets of patient records and we observed three surgical procedures, one of which used a laser.

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

Activity (September 2016 to August 2017)

- In the reporting period July 2016 to August 2017, there were 21,055 patient episodes of care recorded at the clinic; of these 81% were NHS-funded and 19% other funded.
- In the same reporting period, there were 2,639 procedures performed at the clinic. Of these, the top four most common procedures were:
  - Cataract removal (2,056)

Summary of this inspection

- Intravitreal injection (198)
- Clear lens extraction (89)
- LASEK refractive eye surgery (70)

Eight ophthalmologist surgeons, seven anaesthetists and six optometrists worked at the clinic under practising privileges. The service is supported by a Medical Advisory Committee (MAC). The MAC chair reviews documentation and advises the registered manager to ensure all the correct checks and documentation is in place before practising privileges are granted. The MAC chairvisits the service once a week. The service is supported by an external Laser Protection Advisor who visits the clinic regularly and can be called upon for advice at any time. There were two employed registered nurses, one health care assistant, two ophthalmic technicians, three receptionists and 12 administration staff. The two ophthalmic technicians and the health care assistant were also the Laser Protection Supervisors. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- There had been no never events since 2014
- There had been 93 reported incidents categorised as no harm between September 2016 and August 2017
- There had been no serious incidents since 2014

There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).

There were no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).

There were no incidences of hospital acquired Clostridium difficile (C.diff).

There were no incidences of hospital acquired Escherichia coli (E-coli).

The service had received two formal complaints in the reporting period of July 2016 to August 2017 and 22 compliments.

Services accredited by a national body:

- AfPP Accreditation- The clinic had secured accreditation with the Association of Perioperative Practices (AfPP) in 2015 and was successful in being reaccredited in 2017.
- WorldHost® Accreditation – nationally recognised badge of excellence for customer service, with Aspen Healthcare being a first in healthcare.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Decontamination of multi-use equipment
- Drugs dispensing service
- Interpreting services
- Grounds maintenance
- Laser protection advice service
- Maintenance of medical equipment
- Pathology and histology

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 rated safe as good because:

- Patients were protected by strong and comprehensive safety systems. There was a clear culture of openness, transparency and learning when things went wrong.
- All staff were fully committed to reporting incidents and near misses, and safety concerns raised by staff were highly valued as integral to learning and improvement.
- There was a detailed investigation of incidents. There was ongoing, consistent progress towards safety goals reflected in an excellent track record of safety.
- All staff were encouraged to participate in learning to improve safety as much as possible, including participating in local and national safety programmes.
- The comprehensive safety systems took account of current best practice and the whole team were engaged in reviewing and improving safety and safeguarding systems.
- Innovation was encouraged to achieve sustained improvements in safety and an excellent track record in harm free care.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. Staff shortages were responded to quickly and adequately.
- There were effective handovers to ensure staff could manage risks to patients. Staff were up to date with training in all safety systems.

However:

- We found that patient identifiable information was not always present on all pages within paper records, authorised signature sheets were not always completed and correspondence letters to other health professionals did not always have a penned signature present.
- The clinic did not have a designated area for recovery and patients had to recover in the shared waiting area. However, we saw risk assessments and controls in place to mitigate limitations within the clinic setting.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Care and treatment was evidence based. New evidence based techniques and technologies were used to support the delivery of high quality care.
- All staff were actively engaged in monitoring and improving quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation were proactively pursued. High performance was recognised by credible external bodies.
- Staff were proactively supported and funded to acquire new skills and share best practice. Development of staff skills, competence and knowledge were recognised as essential in providing high standards of quality care and treatment.
- Discharge of patients was proactive and planned at the earliest possible stage and were reflective of individual circumstances and preferences. Staff members had specialist vocational qualifications in discharge.
- Multi-disciplinary team work was effective. All staff were committed to working collaboratively.
- Staff had appropriate access to information. Information systems to manage and share information were fully integrated and provided real-time information across teams and services.
- Consent practices and records were actively monitored and reviewed to improve how patients are involved in making decisions about their care and treatment. Consent processes were appropriately followed.
- The clinic worked with external specialist organisations and patients to inform the development of tools and support to aid informed consent.

However:

- The provider was not submitting data to PHIN at the time of our inspection.

Are services caring?

Good

We rated caring as good because:

- Feedback from patients was consistently positive about the way staff treated them.
- There was a strong, visible patient-centred culture.
- Staff were highly motivated and inspired to offer care that was kind, promoted dignity and maintained a supportive and strong relationship.
- Staff recognised and respected patients' needs as a whole and always took their personal, cultural, social and religious needs into account.
- Staff were fully committed to working in partnership with patients and empowered patients to have their own voice.

Summary of this inspection

- Staff spoke with patients in a manner they could understand.
- Patients' individual preferences and needs were always reflected in how care was delivered.
- Staff understood the effects of treatment on the patient. Patients' emotional and social needs were valued by staff and were embedded in their care and treatment.
- Costs of procedures were provided at the first possible opportunity in a sensitive and appropriate manner.

However:

- The clinic did not have a designated area for recovery and patients had to recover in the shared waiting area. Although no patients raised this as an issue, staff recognised that the shared waiting and recovery area was not ideal for patients privacy.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered to meet the needs of local people.
- There was timely access to initial appointment, diagnosis and treatment.
- The service was flexible and allowed patients to access services at a time that suited them.
- There were innovative approaches to providing integrated patient-centred pathways of care that involved other service providers, particularly for patients with multiple and complex needs.
- The service took into account the needs of different people. Staff took a proactive approach to understanding the needs of different patient groups.
- Complaints and concerns were managed appropriately. Feedback from patients was highly valued and was recognised as integral for improving the way in which the service was delivered.

Are services well-led?

Outstanding

We rated well-led as outstanding because:

- The leadership, management and governance of the Midland Eye assured the delivery of a high-quality patient-centred care, that supported learning and innovation, and promoted an open and fair culture.
- There was a clear statement of vision and values that were driven by quality and safety. A comprehensive, clear and achievable strategy with well-defined objectives was in place and was proactively reviewed.

Summary of this inspection

- Strategic objectives were supported by an effective and comprehensive quality framework that provided measurable outcomes that were cascaded throughout the service.
- The clinic was proactively working with organisations to improve care outcomes and to tackle health inequalities.
- Governance, risk and performance management arrangements were comprehensive, proactively reviewed and reflected current best practice.
- Risks were clearly identified and monitored effectively. Performance issues were escalated to the relevant committees and the board through clear structures and processes.
- The comprehensive audit programme and processes included within, worked well and had a positive impact on quality governance with clear evidence of action to resolve concerns.
- There were high levels of staff satisfaction across all equality groups. Staff were extremely proud of working for the clinic and spoke highly of the open, transparent and no-blame culture.
- All staff members were highly respected and valued. A full and diverse range of patients' views and concerns were encouraged, heard and acted on.
- Information on patient experience was reported and integrated with performance data to give a clear and accurate all round picture of quality and safety.
- There was strong collaboration and support across all functions locally and with staff at other Aspen sites. There was a clear common focus on improving quality of care and patient experience.
- The leadership was strong and drove continuous improvement; staff were accountable for delivering change.
- Safe innovation was encouraged and celebrated. There was a clear and proactive approach to seeking out and embedding new models of care.
- Consultant ophthalmologists were innovators in their field.

However;

- The provider was behind on implementing provisions for submission of data to PHIN. The deadline set by the CMA was September 2016.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	☆ Outstanding	Good
Overall	Good	Good	Good	Good	☆ Outstanding	Good

Notes

*Nationally there is not enough evidence to rate outpatient services' effectiveness.

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as **good.**

Incidents

- Performance showed an excellent track record of safety. When something went wrong, there was a comprehensive and thorough investigation that involved relevant staff and patients.
- There was a proactive approach to keeping patients safe and all staff were encouraged to improve systems and reduce avoidable harms.
- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were no reported never events in the previous 12 months. The last never event reported happened in April 2014.
- The registered manager and a technician had external training in investigating root cause analysis (RCAs) of incidents and were trained to Level 3 Investigators. However, the registered manager recognised that as they did not complete RCAs often, they would bring in a member of staff from Aspen who were more familiar with conducting RCAs.
- There were no reported incidents in the previous 12 months that had met the threshold for the duty of candour regulation.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The Aspen group had their own duty of candour training and had leaflets for patients on duty of candour. All staff we spoke with clearly understood what duty of candour was and were clear on their role and responsibility.
- There were no reported incidents that met the threshold of the Serious Incident Framework (2015) and no mortality incidents in the previous 12 months.
- The clinic had a patient safety programme in place, which Aspen developed to engage all members of staff with patient safety and improving systems to reduce avoidable harm. The programme was called, “STEP-up to Safety”, which stood for Spot, Talk, Examine and Prevent.
- All members of staff had completed STEP-up to safety training and there were two STEP-up to safety champions based at the clinic. For example, staff had raised biometry as a potential safety issue using the STEP-up to safety prompts. Biometry is a test to measure the size and shape of the eye. Biometry parameters are crucial to ensure that correct lenses are ordered for patients.

- Staff used visual aids to highlight and escalate unexpected measurements for consultants to review. The visual aids including using pink paper for unexpected measurements and yellow paper for measurements within the normal parameters.
- Patients and those close to them were encouraged to actively engage with managing their own risks whilst at the clinic. We saw patient information leaflets that included safety steps for patients to follow during their visit.
- All staff had access to the clinic's electronic incident reporting system, which fed into the Aspen group governance dashboard. Staff understood the importance of reporting incidents so learning and themes could be identified.
- The clinic provided data for incidents that staff reported during the period of September 2016 to August 2017. There were 93 incidents reported, including evidence of reported near misses. All incidents were categorised as no harm. There was evidence that staff gave patients an explanation and an apology within the incident reports.
- The staff held "safety huddle" meetings daily in the morning. We observed a safety huddle, which involved all relevant staff. Discussions involved potential safety risks for the clinic and theatre lists that day.
- Patient safety and incidents was a standardised agenda on monthly team meetings and learning was disseminated at these meetings as well as in quarterly patient safety newsletters. Urgent safety issues and learning was disseminated via email.
- Staff were positive about information received on safety issues and were able to give examples of where practise had changed as a result of an incident.
- Staff gave an example where a patient was operated on the wrong eye. The staff had implemented visual aids to prevent reoccurrence. Those visual aids included colour coded clipboards for pre-operative assessment, and identity wrist bands being placed on the same side as the procedure. The visual aids were used in addition to the consultant marking the correct site of surgery.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Aspen had a group governance dashboard that had 70 key performance indicators (KPIs), which Midland Eye utilised. The clinic reviewed their performance against the measures and produced an exception report that was presented at appropriate governance forums both locally and within the group.
- The clinic benchmarked the WHO Surgical Safety Checklist audit with other Aspen locations. Audit results for September to November 2017 showed 100% compliance for Midland Eye, compared to a range of between 90 to 100% across Aspen.
- The Medical Advisory Committee (MAC) carried out clinical review for trends for each consultant using the dashboard. They routinely monitored and audited unplanned return to theatre and number of cancelled operations for non-clinical reasons. For September to November 2017, both measures were zero.

Cleanliness, infection control and hygiene

- The clinic was proactive in reducing the risk of surgical site infections. There were many processes in place to support a clean and hygienic environment. All areas we saw were visibly clean.
- We observed good compliance with provider key infection prevention and control policies. For example, all staff were arms bare below the elbow in clinical settings and there were hand washbasins in the anaesthetic room and scrubbing facilities in the clean utility room of the theatre.
- We saw hand gel provided at the entrance of reception and in all diagnostic and consultation rooms and we observed staff and patients using these.
- The clinic had no incidents of surgical site infections in the previous 12 months. They reported on the number of MRSA, MSSA, C.diff, E-coli, as well as other blood-borne infections, to the Aspen group quarterly governance meetings. A blood-borne infection is a bacterium or virus that is carried by the blood.
- The Aspen group undertook annual reviews on infection prevention and control. We reviewed the 2016 annual report and found that Midland Eye were fully compliant in all aspects of the criteria.
- The clinic had been undertaking the National Saving Lives High Impact Intervention Audits since 2012, which

covered hand hygiene. Aspen had a requirement that these audits were carried out quarterly; however, Midland Eye undertook the audits monthly. The clinic were fully compliant with all objectives of the infection, prevention and control programme.

- We reviewed hand hygiene audits for August 2017. The clinic scored above the Aspen target of 80% with 96% compliance. The clinic consistently scored above the target of 80% for the previous 12-month period.
- Monthly infection control audits and clinical practice audits included waste management, sharps, environment and equipment. Throughout 2016, the clinic had a compliance rate between 97% and 99% each month, which was above the target of 80%.
- Water quality was tested by an external organisation on a monthly basis and a quality test for Legionella was carried out every two years. The latest Legionella test in January 2016 met the required standards.
- The clinic had a service level agreement (SLA) with a local hospital for the decontamination of reusable medical devices (there was only one device which was reused). Clinical waste was collected daily. The local hospital used for decontamination services had been assessed and registered by a UK notified body for medical devices. The hospital had conformed to the requirements of EN ISO 134585:2012 quality management system.
- There were good systems in place to ensure that dirty equipment was taken a different route out of the clinic from sterilised equipment to reduce contamination.
- All ophthalmic packs for individual patient procedures, including theatre bed covers and blankets were disposable. There were good processes in place to ensure a clear audit trail, which included bagging individual patients' procedural equipment in one clear waste bag and adding the barcode stickers from the ophthalmic packs into patient notes.
- The clinic had an infection control lead who was responsible for ensuring staff maintained standards and for carrying out infection control audits. The clinic used a "glow box" to train staff and to audit good hand washing techniques. Glow boxes use ultra-violet light to detect areas on hands that people have missed washing.
- We observed staff preparing for surgery in line with good practice, policies and procedures. We observed staff clearing away dirty items after a patient had finished their procedure, and cleaning theatre beds and medical machines with alcohol wipes after every use.
- Clinical staff were responsible for cleaning clinical and medical equipment. All other areas of the theatre and clinic were cleaned daily by an external cleaning company. We saw evidence of completion of daily and weekly tasks from June to September 2017 in the form of cleaning rotas and checklists.
- There were a number of infection control policies that had clearly defined roles and responsibilities, were version controlled, reviewed regularly and had reference to relevant and current guidelines and legislation.
- There was a good system in place to ensure the clinic conformed to the Human Tissues Act (2004) when taking tissue biopsies. The clinic had an SLA for biopsies to be taken to a local hospital and there were processes in place to ensure the biopsies were secured and tamper proof.

Environment and equipment

- The equipment and environment was maintained to a high standard. There were good systems and processes in place to ensure patients and staff were kept safe and free from harm.
- The clinic had an SLA with an external Laser Protection Advisor (LPA) who was a health and safety specialist in laser safety risk assessments. We saw the agreement between the clinic and LPA and spoke with the LPA during our inspection.
- Under the agreement, the LPA undertook risk assessments, including reports on their findings, drafted the clinic's local laser safety rules, and provided an advisory letter to the registered manager. Risk assessments, local rules and training content were based on optical radiation safety guidance. They were on hand throughout the year for advice, visited the clinic once a year and attended annual Aspen group laser safety meetings.
- The clinic had a standard operating procedure for the use of the laser equipment and an authorised user's register. Seven members of staff at the clinic had

undergone specific laser safety training and had signed the user's register. We saw that staff were adhering to optical radiation safety guidance including the use of a laser warning light when lasers were in use.

- There was one resuscitation trolley in the admission area of the theatre. This was not locked but was kept in a staff only access area of the clinic. It was easily accessible to staff should they need to use it for patients in admission, recovery, and the waiting room down stairs or the theatre.
- Staff had access to the Association of Anaesthetics for Great Britain and Ireland (AAGBI) safety guidelines at the front of the resuscitation trolley folder. We reviewed six months' of checks from April to September 2017, staff checked the trolley daily for content and expiry dates. The electrocardiogram (ECG) machine was tested daily and the print out was stuck to a page in the folder and signed by the staff member who performed the test.
- All equipment and most of the environment was visibly clean. However, we pulled the freezer away from the wall in the anaesthetic room, and found dust and rubbish behind it. When escalated to staff, they agreed it was unacceptable and cleaned it straight away. The rest of the environment was very clean and tidy.
- All medical supplies were stored in a tidy and organised manner. All cupboards were clearly labelled and all supplies we checked were in date.
- We saw that the humidity and temperature of the theatre room was checked daily on opening and closing of the theatre. The theatre had laminar flow, which helped to maintain the humidity and temperature as well as reducing the risk of surgical site infections.
- It is important that the temperature and humidity of theatres where laser surgery is performed is maintained to a high standard, as a small change in humidity or temperature can affect the sensitive lasers.
- We saw that an external company came to do annual checks on the humidity and temperature with the most recent annual check undertaken in September 2017. There were no actions identified.
- The clinic had an asset register for all equipment in the theatre, consultation rooms and diagnostic rooms. Each piece of equipment had an asset number for ease of identification. All staff using the equipment were trained in how to use it safely.
- All electrical equipment in the theatre, admission area and anaesthetic room had received an annual service and safety test. The maintenance of the equipment was carried out by an external company. The lasers and microscopes had an annual manufacturer's service, which included a safety test.
- We saw green labels on most items to show that the equipment was up to date with servicing and safety testing. These labels included the date the test was carried out and the date of the next test was due. The equipment that had manufactures services had a servicing sticker from the manufacturer.
- However, there were three items (a freezer and two electrical leads) that had out of date service stickers. We bought this to the registered manager's attention who was able to evidence that the items were up to date with safety testing and servicing from the asset register.
- On our return unannounced visit, the issue with the safety testing stickers had been rectified and a system had been put in place to ensure this did not reoccur.
- The environment had little storage for big equipment, however the staff ensured the equipment was stored in a safe manner and was covered by dust protectors when not in use.
- Although the clinic areas were fit for purpose, there was no designated separate recovery area. Staff carried out appropriate risk assessments and controls were in place within the limitations of the physical environment. Patients were well informed prior to their admission and this was not an issue for patients. Staff we spoke with said they would like more space to accommodate a separate designated recovery area.

Medicines

- There were comprehensive systems in place to ensure the safe storage and management of medicines and medical gases. Staff within theatres were actively engaged in the medicine management process, which was monitored and improved when required.

Good

Surgery

- The clinic had an Aspen group controlled drugs policy, an antibiotic stewardship and prescribing policy, and a patient group directions policy. All policies contained clear and concise definitions, roles and responsibilities were clearly defined and referenced up to date guidance and legislation. The policies were version controlled and reviewed on a regular basis.
- The clinic used standardised Aspen drug charts for all procedures apart from refractive eye procedures. This was because the refractive eye surgeon had a preference for an alternative drug chart. The nurses told us that they sought advice from the Aspen group pharmacist and policy team before agreeing to use the alternative drug chart. All consultants had to review and sign the drug chart before any medicine was administered.
- The clinic did not dispense any medicines at the location. There was a local independent pharmacy that provided dispensed medicines and take home medicines (TTO) for patients. Prescriptions were for topical antibiotic eye drops or topical pain relief eye drops if needed.
- There was no formal SLA agreement with the pharmacy; however, the registered manager was in talks with a local franchise pharmacy nearby to set up an SLA with them. This franchise pharmacy was used as a backup in case the independent pharmacy was unable to supply medicines for the clinic.
- Midazolam was the only controlled drug stored at the clinic. Controlled drugs (CDs) were stored securely inside the controlled access anaesthetic room. The registered manager was the responsible officer for CDs.
- Registered nurses checked CDs twice daily for doses, quantity of medicines and expiry dates. We observed these checks taking place and saw that two nurse signatures, doses and stock balances were recorded consistently on a daily basis. We observed no alterations, unaccounted quantities or any days where checks were not carried out.
- The clinic held a Certificate of Conformation for mitomycin, a cytotoxic drug and an antimetabolite used for refractive eye surgical procedures. Mitomycin was not stored at the clinic. Staff ordered mitomycin on a patient by patient basis a week before the procedure was due to take place. It was stored securely in a locked fridge whilst on-site.
- We saw a folder that contained all order and delivery notes for mitomycin, which was signed and initialled by staff and patients.
- The clinic routinely used local and topical anaesthetic for surgical procedures. There were facilities and procedures in place for safe sedation of patients or use of intravenous anaesthetics if needed. Staff told us that patients who required sedation were identified at first consultation and arrangements were put in place in advance. The clinic had not carried out sedation or used intravenous anaesthetics for surgical procedures in the previous 12 months.
- Fridge temperatures, room temperatures and humidity checks were carried out daily when the theatre was open. We observed documented checks from May to August 2017 and all daily checks were signed and documented with no gaps.
- Medical gases were stored securely in a medical gas compound. Empty and full cylinders were clearly labelled and kept separately within the store. All oxygen cylinders were in date and staff checked these daily. They did not use piped gas at the clinic, as medical gases were not used routinely. The clinic had a designated nurse with specialist medical gas training provided by an external training company.
- In addition to standard practice checks of medicines during procedures, the staff had implemented an additional visual aid for easily identifying the correct medicines once drawn up at the beginning of the procedure. This was done using different colour syringes.
- The admission nurse administered dilating and anaesthetic eye drops to patients in the admission area to allow time for the eye drops to take effect. The nurse said they had a strict policy where they would not administer any medicine until the consultant had reviewed and signed the drug chart. We saw staff adhering to this whilst observing procedures.

- We observed surgical procedures taking place and saw that the scrub nurse withdrew medicines witnessed by another nurse. They both checked the vial of medicine; the dose needed on the form before drawing, and then checked the drawn amount was the correct quantity.
- Staff encouraged patients to help them maintain their safety by ensuring patients bought all current medicines and a list of why they were taking them to the nurse on admission. They encouraged patients to speak up about any medicine allergies and explained that they should wear a red wrist band should allergies be declared.

Records

- Patient records were documented and stored in a way that kept patients safe and ensured a complete audit trail for all aspects of a patient's procedure.
- Surgical records were contemporaneous, accurate, complete, legible and up to date. The majority of records were stored electronically. There were two electronic patient record systems, one for private patients and one for NHS patients.
- The only paper records kept were for private patients undergoing refractive eye procedures. This was due to diagnostic tests being coloured and the risk of different computer monitors depicting colours differently.
- We observed that pre-operative assessments were carried out by admission nurses and saw that staff recorded relevant observational checks in records. We observed this information handed over to the surgical team both verbally and physically when the patients arrived in theatre.
- We saw that surgical staff recorded instrumentation and equipment checks in patient notes and on a white board during surgical procedures. All barcodes from instruments used and from lens implants were added into patient notes.
- Paper surgical records were scanned onto individual patient's electronic patient record at the end of theatre lists. Staff disposed the paper copies in confidential waste.
- Patients were seen and operated on by the same surgeon seen at consultation. During consultation the records were input directly onto the electronic patient record. No patient records were taken off-site.
- Only one surgeon used paper patient records and this was specifically for refractive eye procedures. Those records were kept securely in the administration office at the clinic. Patient records that had not been needed for more than 12-months were archived and stored at a separate location.
- We reviewed three surgical notes and found them to be legible, complete and included relevant information about the procedure and information about equipment and implants used. All documents had patient name, date of birth, patient number and address present. We saw medicine allergies documented on drug charts where applicable and where there were no allergies present, we saw no known drug allergies recorded.
- However, some of the clinic staff that we spoke with said it could be confusing at times working on two electronic systems that operated differently. The clinic were in discussion with Aspen head office to move all patient records on the one system.

Safeguarding

- There were clearly defined and embedded systems, processes and procedures in place to keep patients safe and safeguarded from abuse. All staff played an active role in ensuring patients were safeguarded.
- The Aspen standard for safeguarding training compliance for both adult safeguarding and children safeguarding was 90%. Midland Eye achieved this target as at 31 July 2017.
- All staff working at the clinic were required to complete adult safeguarding level 1 and children safeguarding level 1. As at 31 July 2017, the clinic had a compliance rate of 100% for both adult's level 1 and children's level 1 training.
- The two registered nurses employed at the clinic were required to complete adult safeguarding level 2 and children safeguarding level 2, both of which had 100% compliance as at 31 July 2017. There was at least one registered nurse on duty each day surgery was taking place.
- The two members of staff required to complete children safeguarding level 3 were 100% compliant. The clinic did not treat patients under the age of 18, which meant that not all staff were required to take children safeguarding level 3.

- The clinic's policies for safeguarding adults and children were reliable and reflected national, professional guidance and current legislation. They were version controlled and reviewed regularly to minimise potential for error.
- All staff we spoke with clearly understood their role for safeguarding and knew how to raise any concerns. They all knew whom the safeguarding lead for the clinic was and where to find the safeguarding policy.
- There was a safeguarding flow chart on the staff room wall, which clearly identified the safeguarding lead for the clinic and the contact numbers for the multi-agency safeguarding hub (MASH) and social services. The clinic had domestic abuse leaflets for patients and staff in patient waiting areas.
- There had been no safeguarding concerns raised in the previous 12 months.

Mandatory training

- Staff were supported and engaged with the clinic's mandatory training plan. Staff told us their training was effective and ensured that they were competent in keeping patients safe and free from avoidable harm.
- The clinic had a comprehensive training programme that included mandatory training and statutory training. The programme consisted of 28 training modules. Training was required annually, every two years or every three years depending on the module. The e-learning training modules were provided by the NHS National Skills Academy.
- As at 31 July 2017, the clinic had an overall average compliance of 96% against a target of 80%.
- The duty of care module was the only module that did not reach the clinic's target. Clinical staff were required to complete duty of care. The clinic had a compliance rate of 67% for this module.
- Twenty of the 28 training modules had a compliance rate of 100% for all staff groups. Of the 25 modules that clinical staff were required to complete, 22 had a compliance rate of 100%.
- The clinic had three laser protection supervisors (LPS) in post all of which attended LPS specific training on 18 July 2016 provided by the external laser protection advisor (LPA). This meant the LPS staff were 100% compliant with their laser protection training.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Staff were attentive and supported for assessing and responding to patient risk. There were processes and tools in place to ensure patients were risk assessed, monitored and escalated appropriately should they deteriorate.
- The clinic had an exclusion criteria that took account of psychological and physiological checks. They did not carry out surgery that required general anaesthetic or on children (less than 18 years of age). The exclusion criteria was appropriate, in line with best practice guidance and was based on risk to the patient.
- Staff monitored and recorded patients' vital signs appropriately during procedures. There was a surgical checklist champion whose role was to ensure that the information the theatre team had, was up to date and accurate, including potential risks and complications.
- Each member of the theatre team had a role when procedures were taking place and this was clearly displayed on the theatre safety notice board in the anaesthetic room.
- The clinic used an Aspen surgical safety checklist, which was based on the WHO surgical safety checklist for general ophthalmic surgical procedures. There was a separate cataract surgical safety checklist.
- We observed the surgical safety checklist being undertaken and all staff were fully engaged and attentive throughout the checklist and procedure. The clinic audited the surgical safety checklist and benchmarked with other Aspen locations. For September to November 2017, the clinic scored 100% in this audit. Other Aspen locations scored between 90 and 100%.
- We observed surgeons discussing the procedure with their patients before taking them to theatre. All

complications and risks were discussed and the patient confirmed they were still happy to go ahead with the procedure. The surgeon then checked the type of lens and biometry results.

- All staff had basic life support training and all consultants, as well as the registered manager and theatre lead, had immediate life support.
- We saw a standard operating procedure that set out clear instructions for staff if a patient deteriorated and needed transferring to a local NHS hospital, which included staff ringing 999. All clinical staff have attended training to recognise the signs of a deteriorating patient, and senior staff and consultants were trained in immediate life support (ILS).
- There was an Aspen group sepsis policy for staff to use as guidance and this included the sepsis six pathway. All clinical staff had attended training on sepsis and staff were confident in identifying patients displaying symptoms of sepsis.
- The clinic had a 24-hour emergency call arrangement in place for patients following discharge. Staff provided patients with post-operative packs that included discharge advice, information and emergency telephone numbers. For NHS patients, the emergency cover was provided by a local NHS specialised eye centre. For private patients, the number diverted to the on-call consultant.

Nursing and support staffing

- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times using the AfPP "Staffing for Patients in the Perioperative Setting" guidance. Any staff shortages were responded to quickly and adequately. There were effective handovers to ensure staff could manage risks to people who used services.
- Staffing was reviewed annually to ensure that staffing requirements were safe, with the last review taking place in June 2017. The staffing review looked at theatre sessions, theatre teams, and number of consultants. There was a policy in place that set out the agreed number of staff needed to ensure the theatre was staffed appropriately and safely.
- There was one registered nurse in admission, one registered nurse in ambulatory recovery and two registered nurses in theatre. The clinic could use five nurses for complex lists and more if needed. We saw that the clinic was appropriately staffed at all times.
- The clinic employed two whole-time equivalent (WTE) registered nurses and fulfilled the other nurse roles with Aspen bank nursing staff. The clinic provided data that showed in the previous three months, they had used nursing bank staff for 35 shifts.
- The clinic employed 0.9 WTE healthcare assistants. Data provided in the previous three months showed that the clinic used HCA bank staff for 30 shifts.
- They had an SLA with a specialist nursing agency but used agency very rarely and staff told us the last time they needed to use agency was in April 2017.
- Agency staff had to undertake a thorough competency test, signed off by the theatre lead before they could work on shift. The registered manager would see all evidence of mandatory training and competency checks from the agency before accepting an agency nurse.
- The clinic had no vacancies and the average staff sickness rates for the previous three months were very low, 1.0% for nurses and 0% for HCAs.
- Nursing staff carried out comprehensive, structured and detailed handovers in team briefs at the start of theatre lists and when patients were in theatre. We observed a team brief and handovers during theatre, which included all members of the theatre team
- The handovers were very comprehensive, structured and detailed any concerns, potential risks, anticipated prescriptions and medicines that the patients currently took. They used the SBAR approach to assess risk, which stood for Situation, Background, Assessment and Recommendation.

Medical staffing

- There was sufficient medical staffing cover to keep patients safe at all times. As the clinic was an ambulatory day surgery clinic, there were no out of hours or weekend lists or clinics.

Good

Surgery

- The clinic did not directly employ any ophthalmologists but had six ophthalmic consultants working under practising privileges, four of which established the clinic in 2003 and sit on the board.
- There was always a consultant present at the clinic when patients were receiving treatment, as the clinic was consultant lead.
- The consultants were available on-call outside of the clinic hours. We saw there was an on-call rota for both consultants and anaesthetists that contained contact details for all consultants and anaesthetists.
- The clinic was supported by a Medical Advisory Committee (MAC) and the chair visited the clinic weekly to offer support. The chair of the MAC was responsible for overseeing the practising privileges and important documentation needed from the consultants practising at the clinic.
- Evidence of yearly appraisals, revalidation, qualifications and indemnity insurance was needed and reviewed by the MAC before practising privileges were provided. We reviewed three staff profiles and saw evidence of all relevant documentation.
- The registered manager told us that if the consultants were slow at getting their appraisal documentation to the MAC when it was due, the chair of the MAC would write to the consultants explaining that they would be suspended from practising until the documentation was received.

Emergency awareness and training

- The clinic had major incident plans and all staff knew who to contact in the event of a major incident and where to access the plans they had to follow.
- The major incident plan was purposely generic to ensure that every incident was covered. It incorporated the gold, silver and bronze leadership and responsibility model. The clinic undertook a test scenario for a chemical gas leak, which was a table top exercise and was led by the Aspen health and safety lead.
- All staff that worked at the clinic had undertaken a theory based fire safety training course and a practical fire safety training course. The clinic was 100% compliant for the theory and 92% compliant for the practical.
- All staff had major incident walk through tests during their health and safety training and fire evacuation tests in their fire safety practical course.
- There were four fire wardens in post at the clinic all of which had recently done their annual fire warden refresher training.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The National Institute for Health and Care Excellence (NICE) guidelines were assessed monthly and reviewed for its application and a baseline assessment was undertaken when required.
- The clinic had extensive and comprehensive policies based on the NICE and relevant Royal College guidelines. All policies were clear, contained definitions, implementation, roles and responsibilities of each staff group, and made reference to up to date guidelines and legislation. All policies were version controlled, reviewed and updated on a regular basis.
- All policies were held on an electronic system that all staff were able to access. The policies were time stamp controlled for assurance that staff had read and signed to say they understood the policies. The clinic undertook a quarterly review of the time stamps.
- All staff we spoke with were aware of all policies in place and knew where to access them. We observed staff adhering to local policies and procedures.
- One of the consultants at the clinic was a member of national ophthalmic committees and was involved with improving evidence-based care and good practice guidelines. This innovative practice was utilised at the clinic.
- The clinic understood the need to monitor their performance and benchmark against other providers. They did this by auditing and monitoring clinical effectiveness.

Pain relief

- Admission nurses prepared patients for procedures, which included anaesthetic eye drops prior to surgery. During the procedure, the consultants used topical anaesthetic to keep the patient comfortable.
- During procedures, the consultant and runner (HCA) ensured patients were not experiencing discomfort or pain. All patients we saw during surgery confirmed they were not in pain and were comfortable.
- Nurses discussed pain relief with patients in pre-operative assessments and there was pain relief information in patient discharge packs for post-operative pain relief. The clinic did not prescribe pain relief take home medicines routinely.

  If a patient was experiencing pain after their procedure, the consultant would prescribe pain relief eye drops and in very rare cases stronger pain medicines not available over the counter (co-codamol).

Nutrition and hydration

- After the procedures had taken place, patients were provided with hot drinks and biscuits whilst they were in recovery, where they would stay for a minimum of 15 minutes.

Patient outcomes

- The clinic took a holistic approach to monitor and improve quality and outcomes, and all staff were fully engaged in the processes. They were proactive in identifying opportunities for participating in benchmarking, peer review, accreditation and research.
- The clinic undertook a comprehensive local audit programme, which was fed into yearly Aspen group audits. Audits included infection control, medicines management, consent, patient records, surgical safety (for theatre departments), surgical observational checklist, pain, practising privileges, safeguarding, information governance, privacy and dignity and antibiotic stewardship.
- The clinic received feedback on their local audit results from the Aspen audit lead who provided the clinic with a yearly report. Aspen directors also carried out unannounced “deep dive” visits at the clinic.
- Unplanned returns to theatre numbers were routinely monitored and audited. An exception report used indicators and audit results to analyse and identify any trends. These were reviewed at the local quality governance meeting and the MAC.
- Performance from any national audits and registries, surgical complications and consultant compliance with NICE guidelines were used to support the assessment of clinical effectiveness. These were reviewed at quality governance meetings and by the MAC. If there were any deviations and outliers, the quality governance meetings and by the MAC.
- Midland Eye were peer reviewed by the West Midlands Quality Incentive Scheme in May 2016. The review findings were positive and found no areas of immediate concern at the clinic.
- Consultants at the clinic carried out their own peer review when assessing patients post-operatively. The patient journey consisted of a pre-operative consultation with the consultant performing the procedure; the procedure and a post-operative follow up appointment with a different consultant.
- This was so the consultants could peer review the notes and techniques carried out by the operating consultant. If patients requested to see their operating consultant post-operatively, the clinic accommodated the patients’ preference.
- The clinic recorded all refractive patients’ pre and post-operative refraction data in patient medical records. The consultant reviewed these results to assess effectiveness; however, the clinic did not currently have the tools to review this data.
- They were in the process of implementing software that would allow them to review this data and submit data to relevant national audits.
- The clinic asked patients that had cataract surgery to complete a Patient Reported Outcome Measures (PROMs) form. In the year 2016 -2017, Midland Eye report 48 cases of PROMs data in their Quality Accounts, all of which were private patients. The percentage of patients who had reported an improvement in their vision was 58%.
- Midland Eye did not currently participate in submitting data to the National Ophthalmology database. They had

purchased hardware that will allow them to submit data to the database and at the time of our inspection, they were in the process of testing between the new hardware and the electronic patient records system to ensure data is collated effectively.

- During July 2016 to August 2017, the clinic had no unplanned returns of patients to theatre, unplanned re-treatment or treatment enhancement following refractive eye surgery in the previous 12 months.
- For the same period, there were 66 planned returns to theatre for other procedures provided at the clinic, 43 were for entropion and ectropion procedures, and 23 were for Ptosis procedures.
- There was only one patient that had experienced complications following refractive eye surgery in the previous 12 months.
- The Competition Markets Authority (CMA) set September 2016 as the deadline for all private healthcare providers to submit data to the Private Healthcare Information Network (PHIN).
- Midland Eye was not currently submitting data to the PHIN in accordance with legal requirements. This was due to system data compatibility issues and work was underway to address this. The clinic was hoping to have this rectifiedto allow them to submit a sub-set of unidentifiable data to the PHIN by January 2018.

Competent staff

- Continual development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality of care. Staff were proactively supported to acquire new skills and share best practice.
- All staff we spoke with had received an appraisal and we saw evidence of this on an electronic staff database and within staff profiles. Staff told us that appraisals were structured and were objective based.
- Staff also received regular one to one meetings with the registered manager. Staff told us and we saw that the one to one meetings were detailed and comprehensive. Further training that staff wished to anticipate in was a standing agenda.
- There were processes in place to ensure that staff were competent to fulfil their role to a high standard. This included permanent, new and temporary staff. Permanent staff had formal competency checks carried out on employment and if there was a need to put a member of staff on performance management, competencies were rechecked.
- The clinic did not use agency staff often. When agency staff were needed, they were recruited through a specialist nursing healthcare agency that had to provide evidence of mandatory training and competency to the registered manager before the agency nurse was appointed. The clinic then carried out their own induction and competency check of the agency staff before their shift commenced.
- The clinic required new nursing staff to undergo an induction process that included working through an induction pack and observing practice for two to three days. Competencies were signed off during the induction process.
- Many staff at the clinic had taken specialist training that the clinic had funded. This included Scottish Vocational Qualification (SVQ) Level 3 training in Admission and Discharge, SVQ Level 3 in Health (Perioperative Care – Surgical Support) and a Masters in “Investigative Ophthalmology and Vision Science” at a UK university.
- The clinic’s infection, prevention and control lead had a two day specialist training course with the Aspen Consultant Nurse of infection control.
- All Midland Eye staff had undertaken specialist training in customer care.
- The clinic required all consultants and anaesthetists practicing under practising privileges, to provide a reference from their responsible officer and one other reference. The MAC regularly reviewed documentation needed to secure practising privileges for example, indemnity insurance, General Medical Council (GMC) checks, and revalidation. We saw these documents were all up to date in staff profiles.
- The clinic also asked consultants to provide their personal development programme (PDP) and appraisal summaries regularly to ensure they understand the scope and limitations of the consultants’ practice. PDP’s pull through any issues identified with a consultant’s practice, which the appraisal summary would not always document.

- All surgeons who currently performed refractive eye surgery at Midland Eye held the Royal College of Ophthalmology Certificate in Laser Refractive Surgery.
- There were three Laser Protection Supervisors (LPS) in post at the clinic. All LPS' had annual laser safety management for medical applications training, including a competency assessment that the Laser Protection Advisor (LPA) had delivered and assessed. A copy of the certificates were filed in staff profiles and we saw these present in the files.
- All members of staff on the register of authorised users for the laser equipment had undergone the LPA's laser safety management for medical applications training. There were seven members of staff on the register.
- The clinic had a complications book that they kept for surgery. This included all surgeons practising at the clinic and patients' outcomes. The complications were regularly reviewed at the MAC and discussed between the consultants.

Multidisciplinary working

- We saw excellent examples of internal multi-disciplinary working, which enabled the staff to provide comprehensive joined up care to patients. All staff were involved with all aspects of patient care and supported each other to ensure the care and treatment provided was of a high quality and standards.
- We observed a daily safety huddle meeting where members of the theatre clinical team, receptionists, diagnostic ophthalmic practitioners and administrative coordinators engaged with each other to discuss any potential safety risks throughout the day. Discharge arrangements and staffing was discussed as well as ways in which other staff members were able to offer support when needed.
- Discharge of patients was proactive and planned at the earliest possible stage. We saw evidence of discharge discussed during pre-operative consultation in patient notes and evidence of discussion between all members of the team in patient safety huddles. Discharge arrangements reflected individual circumstances and preference of service users. A number of staff members had specialist training in discharging patients effectively.
- The clinic had a high level of multi-disciplinary working within the Aspen group. The theatre lead told us they participated in quarterly meetings with theatre leads across the Aspen group where they discussed challenges, supported each other and shared best practice. The clinic's IPC lead also attended quarterly infection control meetings with all the IPC leads within Aspen.
- The clinic worked very well with a number of external organisations. They had service level agreements (SLAs) with a local hospital, cleaning organisations, maintenance organisations, training providers and a Laser Protection Advisor (LPA).
- We saw evidence of clear and regular communication between patients' GPs and optometrists as well as with external organisations the clinic had SLAs with. There was evidence in the incident reporting system that showed when incidents arose from fault of an external organisation, the external organisation was involved in the review and learning was disseminated to them.

Access to information

- The systems to manage and share information that was needed to deliver effective care was fully integrated and provided real–time information across teams and services.
- The clinic had two electronic systems they used for patient records, one system for private patients and another for NHS patients. Staff told us they were in discussion of streamlining patient records so both private and NHS patients were on the same system.
- The system allowed staff to print directly from it, which meant that theatre lists were collated and printed directly from the source of the information. This ensured that theatre list details were current, live and up to date.
- All clinical and administrative staff were able to access the electronic patient record system and there were no concerns or issues with access to patient records.
- One consultant at the clinic who carried out refractive eye surgery, preferred paper patient records. This was due to some of the diagnostic tests involved relying on colour pigmentation.
- There were occasions where patients were referred from local NHS hospital trusts. On these occasions, the clinic would ensure that the records were available for staff at least a week prior to the procedure.

Good

Surgery

- Staff told us there used to be issues with accessing patient records historically when patients were referred from other hospitals, and we saw incidents reported where trust paperwork was incomplete. The clinic reviewed its processes to ensure the risk of not having all relevant information was eliminated, which would reduce cancellation of procedures.
- If a patient was having their aftercare managed by an external optometrist, the consultant who treated the patient ensured all relevant information was given to the optometrist co-managing the patient prior to their follow up appointment.
- The co-managing optometrist sent operating consultants a copy of post-operative outcome sheets for their review and signature, which would then be filed within patients' medical records. The co-managing optometrist would also have seen the patient pre-operatively.
- If patients who were followed up by an external optometrist experienced complications, the optometrist informed the operating consultant and the Midland Eye clinical team. The consultant arranged to see the patient on the same day if required and dependent on the complication.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent practices and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment. Staff were competent and knowledgeable about the mental capacity act and how to assess patients for capacity.
- All staff we spoke with had a good understanding of the mental capacity act and the importance of gaining informed consent.
- All clinical staff had to undertake consent training every three years, which included the mental capacity act training. Midland Eye had a compliance rate of 83% for staff completion of consent training, which was above the Aspen group target of 80%. There was one member of staff who had not completed this training.
- Midland Eye had a Dementia Local Champion from the local Solihull Alzheimer's Society who helped to develop tools and support for staff at the clinic. There were sufficient tools in place to support staff with assessing patients' capacity that included cards with the five principles for aid memoire, clear flowcharts and prompt charts for assessments.
- The clinic had a comprehensive policy that was based on the Department of Health's Reference Guide to Consent for Examination or Treatment (second edition 2009) that included updates on legislation relating to obtaining valid consent. This incorporated the mental health act 2005, which was referenced on numerous occasions throughout the policy.
- The clinic used a two stage consent process. The first stage consisted of providing patients with information of the procedure, along with alternative treatment, recommendations for decisions and risks involved. Patients were given this information orally in their initial consultation with the consultant and were provided with a paper copy of the consent form to take away with them.
- We reviewed five patient records and saw that the first stage consent form was present in all of these records. Patients were required to initial after each bullet point of information to indicate that they had read the information. They then had to sign and date the form and bring it with them for their procedure.
- Patients undergoing procedures had their initial consultation at least ten days before they were booked in for treatment, to allow them a cooling off period. When patients came in for their procedure they were given the opportunity to ask the surgeon any questions before the surgeon gained the second part of the consent process.
- We observed one incident in the incident reporting log, where the patient had a lot of questions to ask about the procedure on the day. The consultant made the decision that, as the patient was showing signs of doubt, that they needed time to absorb the new information before going ahead with the procedure. It was cancelled and rebooked for a later date.
- Consent was audited quarterly and reports were discussed in quarterly local quality governance meetings.

Are surgery services caring?

Good

Surgery

Good

We rated caring as **good.**

Compassionate care

- There was a strong, visible person-centred culture. All staff were focused on giving patients first class care in a comfortable and welcoming environment.
- Feedback received from people who used services and those close to them was consistently positive. People said that staff always provided care that exceeded their expectations.
- The clinic carried out quarterly patient satisfaction surveys that were managed by an external survey provider and included the Friends and Family Test. The tests allowed patients to provide comments and a report on issues, and themes were provided on a quarterly basis.
- The clinic had agreed "red flags" with the survey provider, which meant if a patient rated the clinic as very poor on key measures; it was immediately escalated to the clinic manager so they could address the concerns promptly.
- The results for the August 2017 patient satisfaction survey showed that 100% of patients would recommend the clinic to their friends and family. All patients surveyed felt they were treated with dignity and respect.
- Patients said, "I was impressed by the warmth and friendliness of all the staff I met," "staff are incredible," and "everyone was friendly and helpful."
- We observed interactions between staff and people who used services. Staff from all staff groups were kind and caring towards patients and those close to them. Staff took the time to interact with patients in a respectful and considerate manner.
- It was clear that staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff recognised that patients having to recover in the shared waiting area was not ideal for ensuring patients' privacy and dignity. Although regular "Sit and SeeTM" observational audits were undertaken to ensure staff were upholding the clinic's high standards of care and that patients' dignity was always maintained.
- The theatre team consisted of a "runner" who supported patients to be independent after their procedure. We observed the runner talking to patients in a calm and respectful manner, checking they felt well enough to stand up and walk out of theatre. They gave patients the option to walk unaided, holding their arm for support or in a wheelchair.

Understanding and involvement of patients and those close to them

- All staff we spoke with talked to patients in a manner that they could understand. All aspects of the patient journey were explained to patients so they understood why things were being done, staff said this relieved anxiety that patients had.
- All patients we spoke with said they understood the treatment they were having done and were active partners in their care and treatment.
- We observed the surgeon talking each patient through each stage of their procedure in order to reduce anxiety, which included an explanation and assurance when injecting anaesthetic, dilation medicines or saline. This ensured compliance with the Royal College of Anaesthetists Guidance for Provision of Ophthalmic Anaesthetic Services (2015).
- Staff recognised when people using services and those close to them needed additional support to help them understand and be involved in their care and treatment. This included language, special advice and advocates.
- People who used services were given information verbally and in writing that they were able to take home. They were given a cooling off period to give them time to read and understand the information they were provided.
- The clinic encouraged patients to have a voice. They proactively gained feedback on improvements they could make to any aspect of the patient journey, by encouraging patients to attend patient forum meetings, provide feedback via a general email, patient satisfaction survey and involving patients in Patient Led Assessments of the Environment (PLACE) audits.

Good

Surgery

- When patients enquired or were referred to the service, the staff provided patients with detailed information about the different services that were available and the cost of these. The patient had the choice to receive this information by email or in the post. Once the patient made a decision about their treatment, they would book an appointment, where the consultant would discuss the costs of the procedure again during an initial consultation.

Emotional support

- Staff at the clinic recognised the impact of a person's care, treatment or condition had on their wellbeing both emotionally and socially. People who used services were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- The service allowed carers and family members to stay with patients in the admission and the recovery areas. Whilst in theatre, the team included a designated staff member to provide emotional support to the patient throughout the procedure, which they called the "hand holder." Their role was to offer reassurance and support to the patient to keep them calm.
- All staff we spoke with were aware of counselling services that they could refer patients for cosmetic procedures. Staff told us they rarely encountered a situation where they would needed to refer patients.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The service was planned and delivered in a way that reflected the needs of the population served and ensured flexibility, choice and continuity of care.
- The clinic heavily invested in the facilities and premises during 2014, to ensure they were appropriate for the services that were planned and delivered. However, most staff we spoke with expressed the wish for a separate designated recovery area. The premises was not big enough to currently provide this and the recovery area was situated in one-half of the waiting room.
- The business strategy included timely access to care and treatment, and responding promptly to referrals. The services were planned and delivered to meet patients' needs whilst ensuring care was patient-centred, designed around the individual and includes their involvement at every stage.
- The clinic had a positive relationship with the clinical commissioning group, which included being a pilot site for a quality review for which the clinic received excellent feedback and recommendations to further improve the service. We saw an action plan as a result of the quality review with actions fulfilled and others working towards completion.
- When demand was high, the clinic would implement an additional surgical or clinical list, dependent on agreement and availability of the consultant. The clinic also had the ability to introduce new service lines if required.
- Prior to implementing additional or new service lines, the clinic completed a quality impact assessment to ensure that they understood the potential impact on service quality of any service change or development. This was to ensure the staff were able to continue to maintain service standards to meet their patients' needs safely and effectively.

Access and flow

- Patients had timely access to initial assessment, diagnosis and treatment. The clinic had no waiting list for refractive eye surgery and the clinic was meeting the national referral to treatment times (18 weeks) for cataract surgery. The current waiting time for cataract patients was 14 weeks with an average over the previous 12 months of 14 weeks.
- Patients were able to access care and treatment at a time to suit them and staff gave us examples of where they had altered clinic operating times to enable access to the service for some patients.
- The clinics ran on time and staff informed patients when there were disruptions to the service. All patients we

spoke with said there was minimal waiting time when visiting the clinic. The maximum they had to wait was for 10 minutes and they were always informed of a delay with an apology.

- In order to ensure patients were seen in a timely manner, they were prescribed dilating eye drops during their initial consultation and provided with information on how and when to administer them. This ensured that the patient was prepped and ready for surgery minutes before their procedure took place and minimised the amount of time spent at the clinic.
- Staff told us that they prioritised care and treatment for patients with the most urgent needs. This was for patients with serious eye complications as well as patients with other conditions, such as diabetes or patients with complex needs.
- The clinic used an electronic referral system for private patients that were referred through the NHS. The majority of NHS patients were referred from GPs or opticians; in these cases, they used electronic fax or direct booking.
- Patients were given the flexibility to choose when to have their appointments with the clinic. The administration staff would offer private patients the days and times each consultant had available and the patient could book any slot that suited them.
- For NHS patients, there was not a choice of consultant but they were also given all available days and times so they could chose the most suitable time for them. This ensured the clinic had a very small do not attend rate.
- Consultants assessed ease of access for patients referred by optometrists before deciding what would be best for the patient.
- Consultants asked local optometrists to co-manage patients follow up for those travelling a long distance. There were processes in place that ensured relevant information was shared adequately between the health professionals involved in patients' care and treatment.
- There had been no refractive eye surgical procedures that the clinic had cancelled for non-clinical reasons in the previous 12 months.
- There was one list that had to be cancelled within the previous 12 months for non-refractive laser procedures. This was an error on the consultant's part, who had cancelled their morning clinic list but had forgotten to cancel their afternoon theatre list.
- The two patients that came to the clinic had their procedures accommodated by another surgeon and the other patients were cancelled and rebooked at their convenience.

Meeting people's individual needs

- The service took account of the needs of different patients for example, on the grounds of age, disability, gender and religion.
- Staff completed an assessment of individual needs during the initial consultation and an individualised patient pathway was agreed between staff and patients. We saw evidence of patient pathway decisions and agreement with patients in their medical records.
- Patients were assessed for suitability for procedures at the clinic based on psychological and physiological checks, outlined in the clinic's exclusion criteria and based on best practice guidance.
- The patient was also given the opportunity to look at the facilities before assessment to ensure whether the clinic was suitable for them. The exclusion criteria did not discriminate on grounds of age, gender or religion.
- We observed surgeons talking each patient through each stage of their procedure in order to reduce anxiety, which included an explanation and assurance when injecting anaesthetic, dilation medicines or saline. This ensured compliance with the Royal College of Anaesthetists Guidance for Provision of Ophthalmic Anaesthetic Services (2015).
- Patients were able to stay in their own clothes during the procedure and patients of religious and culture background were allowed to wear their religious and culture attire. Headscarves were covered with hair nets and clothes were covered with protective, disposable blankets.
- The clinic was engaged with the local Alzheimer's Society and had a member of the society as their

dementia champion. All staff had specialist online dementia training and were confident in and proactively referring patients to services that could help meet their everyday needs.

- Staff at the clinic implemented reasonable adjustments for patients with complex needs and disabilities. We were given an example where staff accommodated a patient with learning disabilities outside of normal clinic operating hours, to accommodate the patient's need for quiet and non-crowded spaces.
- Staff gave us examples of when they organised clinic and theatre lists dependent on the patients that were attending that day. They told us that they try and ensure that patients with diabetes were scheduled at the beginning of the list to avoid patients waiting around meal times.
- The building was an old Victorian house converted into a clinic. Midland Eye had heavily invested in the premises to ensure it was fit for purpose. This included the installation of a self-operated lift to enable wheelchair users' access to all areas of the clinic.
- There was a free carpark close to the entrance of the building, ramp access and automatic doors to allow ease of access for patients with limited mobility and wheelchair users.
- Staff told us they had access to language line for NHS patients and were able to book interpreters for assessments, procedures and follow up appointments. Interpreters were not able to attend theatre during a procedure.
- Consultants at the clinic had learned how to say basic commands, such as "stay still" and "this will feel slightly uncomfortable" in languages such as Urdu for example, so they could communicate with patients during procedures. There were also prompt cards available in theatre with the most common languages encountered in the area.
- Most of the consultants at the clinic were able to speak a number of languages. All of the information about the consultants including the languages they were able to speak were advertised on the clinic's website.
- Interpretation services were provided free of charge to patients paying privately for their procedures. If a patient required patient information leaflets in other languages and in braille, the clinic were able to provide this for them. The clinic had access to British Sign Language interpreters if required.
- The service was an ambulatory day case service within an old Victorian building. The management team came to the decision that a hoist would not be appropriate within the setting.
- The team explained to patients on first contact about the facilities available, which included that there were no hoists in theatre. Patients were invited in to the clinic for a look around before choosing the service to assess whether they felt the clinic was suitable for them.

Learning from complaints and concerns

- There was a comprehensive and easy to access complaints procedure at the clinic. We saw clear and informative complaints leaflets that outlined how patients could raise concerns, both informally and formally. In addition to the leaflets, patients were able to access information on how to raise concerns through the clinic's website.
- Staff encouraged patients to complete a patient satisfaction survey, which included a section asking if the clinic could contact them should any concerns be raised.
- There was a comprehensive process in addressing, reviewing and responding to complaints. Midland Eye used the Aspen Healthcare complaints policy that followed the Independent Sector Complaints Adjudication Service (ISCAS) code and guidance.
- The process involved three stages, with each stage having a set timeframe for a response. This included local review and resolution, review by Aspen head office (stage 2) and access to independent, external adjudication by ISCAS (stage 3).
- NHS patients, who remained dissatisfied with their treatment after stage 2, were given details of how to escalate their concerns by writing to the Parliamentary and Health Service Ombudsman (PHSO).
- An annual report of complaints was collated each year, which pulled out themes and actions taken to improve patient experience as a result of responding to complaints.

Good

Surgery

- We reviewed the annual complaints report for 2016, which showed the clinic had a consistently very low number of complaints. In the previous 12 months, the clinic received two complaints, both of which were formal and upheld. This was the same number of formal complaints that were received in 2015.
- The percentage of formal complaints per number of patient contacts was 0.01%. There were no stage 2 complaints that were referred to Aspen Head office for resolution and there were no complaints referred to external review to the ISCAS or PHSO.
- The number of complaints responded to within the policy timeframe requirement of 20 days was 100%.
- The clinic managers reviewed and analysed complaints. We saw evidence of discussion around results at the MAC meeting in September 2016 and the local governance meeting in October 2016. We saw learning was shared and discussed at team meetings and was detailed on the monthly quality key performance indicator sheets.
- We saw examples of concerns raised and improvements the clinic had implemented as a result. All staff we spoke with were aware of the complaints that had been raised in the previous 12 months and were able to describe how practices had changed as a result of complaint outcomes.

Are surgery services well-led?

Outstanding ☆

We rated well-led as **outstanding.**

Leadership / culture of service related to this core service

- The leadership at the clinic was strong and leaders had a shared purpose to deliver and motivate staff to succeed. There were comprehensive leadership strategies in place to ensure delivery and develop the desired culture.
- The clinic was jointly led and the management worked well together. The clinic manager had overall responsibility for governance and the management of the clinic, whilst the clinic remained very much a consultant led service.
- The clinic manager had overall responsibility for the clinic and was supported by a team of senior staff. There was a business manager in charge of the business side of the clinic finances.
- The team consisted of an NHS administration team lead, a private administrative team lead and a theatre lead. All leads knew who and what they were accountable for and felt extremely well supported by both the local leadership and the group leadership model.
- There were high levels of staff satisfaction across all equality groups. Staff were extremely proud to work for the clinic and spoke highly of the leadership and the culture.
- Numerous times, we were told that the clinic staff were like a family, everyone looked out for each other and everyone supported each other. Every member of staff felt like a valued contributor within the team.
- When asked what they were most proud of, most staff members said the feedback they get from their patients, the quality of care and treatment they were able to provide, and the fact they were able to provide a truly holistic and patient-centred service.
- There were high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.
- The local leadership was passionate about patients and staff. They very much felt their role was there to support staff to achieve their potential and help them when they faced challenges.
- There was an open, transparent, no-blame culture. The clinic manager was approachable and visible at the clinic on a regular basis.
- Every staff member we spoke with only had positive things to say about the management. It was clear that staff highly respected the clinic manager and the consultants at the clinic, which was mutual and reciprocated.

- We saw evidence in staff profiles that showed the clinic manager valued their staff. There were letters to nursing staff that said, "I wanted to take the opportunity to write and say thank you for the valuable contribution you make to the clinical team at Midland Eye and for your hard work and commitment."

Vision and strategy for this core service

- There was a clear vision and set of values, which were patient-centred with quality and safety as the top priority. The clinic's vision was "to provide first-class private healthcare in the local community in a safe, comfortable and welcoming environment; one which we would be happy to treat our own families."
- There were five values that were developed at Aspen level with staff from across all Aspen sites. The values were "beyond compliance, personalised attention, partnership and teamwork, investing in excellence, and always with integrity."
- The service had a comprehensive and realistic strategy, which was divided between business objectives and quality priorities, both of which had a strong patient-centred focus.
- Business objectives for 2017 consisted of three objectives. These were:
  - Literature - including producing a consultant directory to distribute to external bodies, support awareness days and awareness weeks promoting healthy eyes to people in the community, and frequently asked question sheets.
  - GP, optometry and community liaison - including GP lunch and learn sessions, basic life support sessions, newsletters, optometrist workshops, visits to GP surgeries and opticians in the local area, community group educational talks, and shopping stands to offer advice to the public on eye health.
  - Website and social media – including continuing to evaluate and update the website and social media pages, and increase followers on the three main social media streams.
- Quality priorities for 2017-2018 consisted of three objectives. These were:
  - Patient safety – including continuing progress with the STEP-up to safety programme, patient safety champions and using patients' experience to improve safety.
  - Clinical effectiveness – including the development of an annual practical training programme, introduction of software to allow outcome data to be submitted to the National Ophthalmology database, and improving the outcome of any assessment, treatment and care patients receive to optimise patients' health and wellbeing.
  - Patient experience – including implementation of a dementia awareness strategy with the local dementia champion, develop ways to improve meaningful patient involvement and continuing with the patient forum.
- It was clear during our inspection that the clinic's values were fully embedded with all staff members displaying the values in every aspect of their role. There was a values champion at the clinic who was also the customer services training champion.
- All staff we spoke with knew what the values and vision of the service was. They were all fully committed to working towards the business and operational strategic objectives. Staff were passionate about patient safety and ensuring patients received an excellent standard of care.

Governance, risk management and quality measurement

- There was an effective governance framework that supported the delivery of the strategy and a high standard of quality care. Objectives were supported by measurable outcomes that were shared throughout the organisation. All staff members understood their role and were clear about what they were accountable for.
- There was a systematic approach to working with other organisations to improve care outcomes. The clinic provided educational opportunities for local GPs and optometrists, to raise awareness of what Midland Eye did and to give them the knowledge needed for appropriate referrals to the service for people in the community.

- The clinic manager was the lead for governance and quality monitoring. There was a risk management framework and policy in place that was aligned to current best practice guidance and the risk assessments and risk register were central to the framework.
- The risk register aligned to the corporate objectives and an Aspen risk register module was used to record and monitor control of risks. The risk register was proactively reviewed at the local quality and MAC meetings, including a review and assessment of the identified controls and mitigating actions. All risks that were identified as above 15 were escalated to Aspen's chief executive officer and were routinely reviewed at each quarterly group quality governance committee and the quality board.
- We reviewed minutes from the quarterly MAC meetings and the quarterly local quality meetings. These minutes were detailed and evidenced discussion and review around the risk register, risk management and audit results.
- We reviewed the risk register and found it to be comprehensive and clear. There were actions in place to mitigate the risk, with responsible leads and review dates. Staff at all levels clearly understood and were able to identify risks. Current and future risks were present on the risk register, were proactively monitored and reviewed, and were addressed.
- There were strong relationships between the clinic senior management team, the MAC and the Aspen group. The MAC Chair met weekly with the theatre team and clinic manager and had quarterly formal meetings at the clinic. The quarterly local quality meetings were chaired by the clinic manager with attendance of Aspen leads to support the local team.
- The senior management team meetings were held quarterly and were chaired by the director of clinics from the Aspen group. The senior management team had an overview of all risks and performance against local and corporate objectives. These meetings fed through to the Midland Eye board meetings chaired by the Aspen group director of clinics, which then fed into the Aspen group quality governance committee and the Aspen quality board.
- All staff were included in governance. There was a daily patient safety communication meeting held in the morning before the clinics and theatre lists started. We observed this meeting on our inspection and found it to be detailed but concise and included all relevant staff. Staff identified and took a proactive approach to mitigating potential risks that could occur throughout the day.
- There were robust assurance systems in place to ensure that all staff working under practising privileges had up to date and appropriate indemnity insurance. All of the current staff working under practising privileges at the clinic had an appropriate level of indemnity insurance in place and we saw evidence of this in staff profile records. Staff working under practising privileges were not allowed to invite external staff to work with them or on their own.
- There were yearly local laser safety protection meetings involving all laser protection supervisors at the clinic. We reviewed the meeting minutes from July 2016, which showed detailed discussion around laser safety and an action plan with completed actions. The Aspen group also held annual radiation protection meetings that included laser protection.
- Service level agreements with third parties were managed by the clinic manager and were reviewed annually. If a third party were not providing a service that was in line with the agreement and clinic standards, the clinic would give a months' notice of termination of contract.
- The provider was behind with implementing software that would allow them to submit data to PHIN. This was a legal requirement set by the CMA, which stated that all private providers had to submit data to PHIN by September 2016.

Public and staff engagement

- The clinic used innovative approaches to gain feedback and to engage with the public, including people from different cultural groups. Feedback and involvement of patients was constantly sought and was supported using the Aspen patient involvement toolkit.
- We saw a "You said, We did" board in the reception area that detailed comments of improvements and actions the clinic had taken in response. Examples included reviewing the clinic times to minimise any overlap that may lead to limited seating.

Good

Surgery

- The clinic held patient forum groups to discuss and review the patient pathway, and seek views on how the clinic may further improve their patient experience. This involved including patients in PLACE audits and Sit and SeeTM observational audits. Patients were all encouraged to complete patient satisfaction surveys, which analysed on a quarterly basis.
- The community was a big focus for the clinic, which held awareness weeks and information evenings for members of the public to attend. There were different topics for each of the awareness weeks. For example, raising awareness during National Eye Week 2017 during 18 to the 24 September.
- Regular staff forums and meetings were held where staff were continuously involved in engaging with and achieving the business and quality objectives.
- Staff of all levels spoke to each other on a regular basis in addition to quarterly one to one meetings, monthly team meetings and annual appraisals.
- The leadership team carried out walkabouts and all staff we spoke with knew who the leadership of the clinic was.
- The Aspen executive team held an annual roadshow, which had a primary purpose of engaging with staff and to inform staff of group-wide initiatives. The clinic staff were able to access the Aspen staff benefits scheme that included discounts, health and wellbeing and investing in you [staff].

Innovation, improvement and sustainability

- The leadership at the clinic saw continuous improvement as integral and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear and proactive approach to seeking out and embedding new and more sustainable models of care.
- The founding consultants of the clinic were all pioneers within their field. They were involved in research and developing new and innovative ways to providing the best quality care.
- Midland Eye was the second European Centre to install state of the art laser technology for eye surgical procedures. This meant they were able to offer treatment for more abnormalities in the eye.
- The clinic was able to offer complicated treatment such as macular rotation and were able to provide dedicated eye plastic surgery using a carbon dioxide laser, which meant there was no blood, less bruising and swelling.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Outstanding

Are outpatients and diagnostic imaging services safe?

Good

The main service provided by this clinic was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as **good.**

Incidents

- For detailed findings on incidents, please see the safe section of the surgery service report

Cleanliness, infection control and hygiene

- The clinic employed an external cleaning company that cleaned all areas of the clinic apart from the medical equipment. We saw evidence of cleaning schedules signed by the cleaning staff on the back of toilet doors and consultation room doors.
- For more detailed findings on cleanliness, infection control and hygiene, please see the safe section of the surgery service report.

Environment and equipment

- The outpatient clinic was located on the second floor of the premise. All patients entered the premise through the main reception and were accompanied to the relevant waiting area.
- There was a separate waiting area on the second floor for patients that were visiting the clinic for initial consultations and for follow up appointments.
- The clinic had three consultation rooms and a diagnostic room, which was used for the treatment of minor conditions that were easily treatable. This included the latest treatment for dry eye called Intense Pulsed Light (IPL) Therapy.

Medicines

- For our detailed findings on medicines, please see the safe section in the surgery service report.

Records

- All patient records were kept electronically on two separate electronic patient record systems, with the exception of the refractive eye records that were kept in paper format. One system was used for private patients and one was used for NHS patients.
- We reviewed five patient records and found they were organised, clear and legible. There was evidence of discussion with patients, correspondence with external healthcare professionals and discussion of costs involved. In all patient records we reviewed there were consent forms present.
- We saw consultants were writing, "[dictated but not signed]" in correspondence letters to GPs and other health professionals, present in the five records we reviewed on the electronic patient record system. We also saw that patient identifiable information was on every page of the electronic records.

Good

Outpatients and diagnostic imaging

- However, in all of the five paper records we reviewed we found that the authorised signature sheet at the front of the records was not complete. We saw signatures within the records that had not been added to the authorised signature sheet.
- We saw there was no patient identifiable information on all pages of the paper records, notably on diagnostic test results, which was a potential for results to go missing or be put into the wrong patient record.
- We found that four out of the five paper records had no written signature on correspondence letters from consultants to GPs and optometrists. There was an electronic signature present that detailed the consultants name, qualifications and the information of the clinic. It would have been best practise to type "dictated but not signed" where the written signature was missing in line with what we saw on the electronic patient records.
- On our return visit, the clinic had put things in place to ensure that these issues were rectified.
- For more detailed information on records, please see the safe section in the surgery service report.

Safeguarding

- For detailed information on safeguarding, please see the safe section in the surgery service report.

Mandatory training

- For detailed information on mandatory training, please see the safe section in the surgery service report.

Nursing staffing

- There were no nursing staff that worked in the outpatient department. Optometrists and consultants ran the outpatient clinics supported by administration teams.
- The clinic employed three permanent optometrists and had additional optometrists working under practising privileges.
- For more detailed information on nursing staffing, please see the safe section of the surgical service report.

Medical staffing

- The consultants that ran the outpatients service were the same as the consultants who performed surgical procedures.
- All staff were working at the clinic under practising privileges and none were permanent employees of the clinic.
- For detailed information on medical staffing, please see the safe section in the surgery service report.

Emergency awareness and training

- For detailed information on emergency awareness and training, please see the safe section in the surgery service report.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Nationally there is not enough evidence to rate outpatient services' effectiveness**.**

Evidence-based care and treatment

- For detailed information on evidence-based care and treatment, please see the effective section in the surgery service report.

Pain relief

- For detailed information on pain relief, please see the effective section in the surgery service report.

Nutrition and hydration

- Nutrition and hydration was not appropriate for this setting as patients were not at the clinic for long periods of time. There were hot and cold drinks facilities available for patients in the waiting room.

Patient outcomes

- For detailed information on patient outcomes, please see the effective section in the surgery service report.

Competent staff

Good

Outpatients and diagnostic imaging

- Optometrists that worked for the clinic under practising privileges had their training and competency checked by the MAC and reviewed by the clinic manager before being allowed to practise at the clinic.
- We spoke with two optometrists that practised at the clinic under practising privileges. They told us that the clinic proactively encouraged them to attend additional specialist training that they would not otherwise have access to. They were able to claim costs back if the training course was a requirement of Midland Eye and the Aspen group.
- For detailed information on competent staff, please see the effective section in the surgery service report.

Multidisciplinary working

- For detailed information on multidisciplinary working, please see the effective section in the surgery service report.

Access to information

- Patient records were predominately electronically stored. There were two different systems, one for NHS patients and one for private patients. We were told that the clinic was in the process of making a decision to transfer all patients onto the one system.
- We were told by staff and saw whilst on inspection, that the private and NHS electronic patient record systems worked differently, which could cause confusion when working on both systems.
- We saw that records were stored in a way that made it easy for staff to find relevant information. Documents were clearly recorded and theatre and consultation documents were stored separately. There was a function that allowed all of the notes for one patient to be viewed in one place.
- For more detailed information on access to information, please see the effective section in the surgery service report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- For detailed information on consent, mental capacity act and deprivation of liberty safeguards, please see the effective section in the surgery service report.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- For detailed information on compassionate care, please see the caring section in the surgery service report.

Understanding and involvement of patients and those close to them

- For detailed information on understanding and involvement of patients and those close to them, please see the caring section in the surgery service report.

Emotional support

- For detailed information on emotional support, please see the caring section in the surgery service report.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- For detailed information on service planning and delivery to meet the needs of local people, please see the responsive section in the surgery service report.

Access and flow

- For detailed information on access and flow, please see the responsive section in the surgery service report.

Meeting people's individual needs

- For detailed information on meeting people's individual needs, please see the responsive section in the surgery service report.

Learning from complaints and concerns

Good

Outpatients and diagnostic imaging

- For detailed information on learning from complaints and concerns, please see the responsive section in the surgery service report.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated well-led as **outstanding.**

Leadership and culture of the service

- For detailed information on leadership and culture of the service, please see the well-led section in the surgery service report.

Vision and strategy for this core service

- The service was hoping to implement more outreach clinics in the community to improve access for people and to provide more information clinics on how the community can maintain healthy eyes.
- For more detailed information on leadership and culture of the service, please see the well-led section in the surgery service report.

Governance, risk management and quality measurement

- For detailed governance, risk management and quality measurement, please see the well-led section in the surgery service report.

Public engagement and staff engagement

- For detailed information on public engagement and staff engagement, please see the well-led section in the surgery service report.

Innovation, improvement and sustainability

- For detailed information on innovation, improvement and sustainability please see the well-led section in the surgery service report.

Outstanding practice and areas for improvement

Outstanding practice

- The clinic had a comprehensive patient safety programme in place to engage all members of staff with patient safety and improving systems to reduce avoidable harm. The programme was called, "STEP-up to Safety", which stood for Spot, Talk, Examine and Prevent
- The registered manager and one other member of staff had external training in investigating root cause analysis (RCAs) of incidents.
- Staff had implemented visual aids, in addition to following best practice guidance, to prevent serious incidents and never events. Those visual aids included different colour syringes during surgery, a colour coding process for patients to mitigate the risk of the wrong eye being treated, and a colour coded process for diagnostic test results.
- Consultants were innovative and at the forefront of their specialisms.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all sheets within the paper patient records contain patient identifiable information to mitigate the risk of diagnostic test results going missing and results being put in the wrong records.
- The provider should continue to try and implement a separate designated recovery area within the premises to maintain patient privacy.
- The provider should consider ensuring that either consultants provide a written signature or the caption "dictated but not signed" is present in line with what we saw in electronic patient records.
- The provider should submit data to PHIN in line with legal requirements.