Edgbaston Eye Consultants Ltd

Edgbaston Eye Consultants

Inspection report

The George Road Clinic
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Date of inspection visit: 26 September 2023 and 13 October 2023
Date of publication: 02/05/2024

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

Ratings

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

Summary of findings

Overall summary

We have not previously inspected this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good, evidence-based care and treatment and managed pain well. The provider monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available flexibly.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided individualised emotional support.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and received coordinated care.
- The provider ran services well using reliable information systems and supported staff to develop their skills. Staff were focused on the needs of patients receiving care and were clear about their roles and accountabilities. The service engaged well with patients and other organisations in the health economy to plan and manage services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated this service as good because it was safe, effective, caring, responsive, and well led. Please see the main summary.

Summary of findings

Contents

Summary of this inspection

Background to Edgbaston Eye Consultants

Edgbaston Eye Consultants is operated by Edgbaston Eye Consultants Ltd. The service provides private ophthalmic care, including cataract, surgical and medical retinal oculoplastics, and glaucoma, to self-paying and insured patients. The service carries out around 400 procedures each year. Oculoplastics is the medical and surgical treatment of conditions affecting the eyes and surrounding areas, including eyelids and tear system.

The clinic is in a dedicated, well-equipped space in a shared building. The service uses its own equipment, medicines, and medical consumables. The building operator is responsible for the maintenance of the premises and grounds and does not form part of our judgement.

All staff except the registered manager, who is the medical director, and clinic general manager, work under practising privileges and are self-employed.

The service operates from a shared-purpose building with its own operating theatre, waiting and recovery rooms, and ultrasound room.

The service registered with CQC in October 2019 to provide the following regulated activities:

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

We have not previously inspected the service.

Several clinical services delivered by other providers take place on site. These do not form part of our inspection or ratings other than consideration of local safety procedures.

How we carried out this inspection

We carried out a short notice announced inspection on 26 September 2023 and an announced inspection on 13 October 2023.

Our inspection team included a CQC lead inspector, a consultant specialist advisor, a nurse specialist advisor, and an off-site CQC operations manager.

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

Outstanding practice

We found the following outstanding practice:

- The provider had a demonstrable focus on the needs of patients by monitoring demand across the regional health landscape. They proactively sought relationships with other providers and implemented service level agreements

that meant patients could be treated for complex conditions without the need for onward referrals that could delay treatment. This approach included the establishment of a shared care optometry scheme with optometrists in the region. The scheme provided a direct referral pathway between optometrists and this service for patients in need of cataract treatment.

- The medical director was active in international ophthalmological research and applied learning from new digital approaches to care to their work with patients with complex needs.
- The service monitored patient outcomes and reported results and benchmarking that were consistently better than national averages.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	☆ Outstanding	Good	Good	Good	Good
Overall	Good	☆ Outstanding	Good	Good	Good	Good

Good

Surgery

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

Is the service safe?

Good

We have not previously inspected or rated this service. We rated safe as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. The provider's mandatory training included 29 modules such as infection prevention and control, health and safety, fire safety and first aid. The provider required all staff working under practising privileges to provide evidence of training completion before delivering care.

Mandatory training was comprehensive and met the needs of patients and staff. The medical director arranged training specific to the local environment as part of the induction process, such as emergency arrangements, cyber security, and whistleblowing.

All staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

At the time of our inspection all staff were fully up to date. The provider managed future training needs by using a comprehensive tracking and planning system.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff maintained training specific for their role on how to recognise and report abuse in line with best practice and local procedures.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. The provider ensured reception staff who worked for the building operator maintained a good standard of training and knew what to do if they suspected someone was at risk, including people accompanying patients.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider kept up to date contact details for the local authority safeguarding team and staff knew how to secure advice and help, including in a crisis.

The medical director was the safeguarding lead and was trained to level 3 adults and children. This was in line with the national intercollegiate document and guidance. They led a safeguarding discussion during each surgical planning meeting and postoperative debrief to ensure staff maintained a proactive awareness of potential risks and patient need.

The provider required all other staff, including those working under practising privileges, to maintain training to at least level 2 adults and children. While the service treated patients who were at least 18 years of age, staff maintained child safeguarding training as good practice in recognition that children and young people may accompany patients and be present elsewhere in the building.

The service reported no safeguarding incidents or referrals in the previous 12 months. The medical director recognised the need to keep up to date knowledge and understanding as safeguarding referrals were rare and maintained a policy and standard operating procedure in line with national guidance.

Staff completed the government's national 'PREVENT' training, which was considered good practice to support staff identify people at risk of radicalisation.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Audits demonstrated the service performed well for cleanliness, including good hand hygiene and decontamination processes.

Staff used records to identify how well the service prevented infections. They documented nurse-led antibacterial cleaning between patients and cleaning by a contractor on non-operational days. The provider had a contract with an external specialist to provide scheduled deep cleaning of the clinical area and on-demand deep cleans following an incident, such as a bodily fluid spillage.

The building operator was responsible for cleaning non-clinical and common areas. The building manager kept good records that demonstrated frequent cleaning and provided access to the medical director as part of ongoing assurance.

Staff followed infection control principles including the use of personal protective equipment (PPE) and the provider kept stocks of this for staff working under practising privileges.

Staff worked effectively to prevent, identify, and treat surgical site infections. Staff checked sterilisation records before surgery took place and the provider maintained end-to-end tracking for surgical instruments sent off site for sterilisation. The service documented tracking details for consumables and reusables and for sterilised instruments in surgical records. This enabled tracing to take place in the event of a suspected infection.

The provider arranged an annual Legionella test of the water system from an external specialist organisation. The building operator supplemented this as part of wider assurance for staff and patients in the building. Staff completed weekly flushes of taps to reduce the risk of bacterial build up as part of a continuous risk management plan.

Good

Surgery

Environment and equipment

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

The provider equipped and designed the environment to follow national guidance and meet the requirements of the building operator, such as with consideration to fire safety.

Staff participated in a monthly health and safety audit that included all services in the building and provided assurance of safety for staff and patients.

The building operator was responsible for the maintenance of the clinical environment and worked with the provider to ensure checks and processes met the needs of the service. The provider was responsible for its own equipment, which they maintained through a planned preventative programme. There had been no clinic cancellations caused by equipment failure and staff had access to an on-call urgent engineering call out service.

The clinical space was adaptable to provide outpatient consultations and diagnostics or surgical procedures with a preoperative room and recovery space.

Carpets were present in many areas of the building, which was not in line with clinical environment design evidence based practice issued by the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09. However, the building operator used a deep cleaning device to mitigate the risk of infections caused by carpeted areas. Treatment rooms had linoleum floors, which reflected evidence-based practice and were compliant with HBN 00/10 flooring in the clinical environment.

Staff carried out safety checks of specialist equipment prior to treatment taking place. We checked a random sample of 10 items of electrical equipment. Each item had evidence of a recent portable appliance testing (PAT) safety test.

The service had enough suitable equipment to help safely care for patients. Hand washing sinks were compliant with DHSC standards, and each sink had a poster displayed to depict best practice handwashing techniques.

Staff disposed of clinical waste safely and used good systems for the management of sharps. The service used service level agreements to manage waste streaming, including the storage and disposal of hazardous waste, in line with national standards. Processes were compliant with DHSC health technical memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste.

Cleaning and disinfection arrangements for the surgical theatre included continuous air filtration using specialist equipment.

Staff used single-use equipment for minor surgery. They documented serial numbers in patient records, which meant items were fully traceable in line with national guidance. The provider had a service level agreement in place for the sterilisation of reusable equipment.

The building operator managed fire safety, including evacuation training and procedures. Each floor of the building had a designated fire marshal, and the clinic general manager was the fire marshal for this service.

Good

Surgery

Medical emergency equipment was located in clinical areas and was appropriate to the care being delivered. This included an anaphylaxis kit, oxygen, an automatic external defibrillator and other resuscitation equipment. Staff carried out pre-clinic checks on equipment to make sure it was ready and safe for use.

The service was compliant with the Control of Substances Hazardous to Health Regulations (COSHH) 2002. For example, staff stored chemicals securely and maintained up to date safety information on their use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health and used a nationally recognised tool to monitor and manage care. The nature of the service meant this was a rare occurrence and staff maintained training and simulated practice to ensure they were prepared. The provider required a surgeon with advanced life support (ALS) training to be present in the building whenever surgery was underway. Where the operating surgeon did not hold ALS, the medical director attended the clinic and provided cover in the event of an emergency.

All other staff were trained in at least basic life support (BLS). Staff were up to date with latest guidance from the Resuscitation Council UK in relation to resuscitation practices following the pandemic.

Staff used the World Health Organisation (WHO) surgical safety checklist to structure procedures and provide assurance of safe standards of practice. We saw consistent standards during our inspection, including clear review and confirmation of the planned surgery and the role of each member of the team. Staff counted and documented checks of key equipment, such as swabs and cannulas, before and after treatment. This was good practice to avoid the risk of a retained foreign object.

Surgeons confirmed the planned procedure with the patient as a final pre-operative check following the team WHO briefing. This was good practice and provided the team with assurance they were proceeding with the correct surgery.

Staff placed a sticker with a unique individual identifier code on each patient's clothing during each procedure. Along with an identifier wristband, the sticker corresponded to the patient's details on the treatment plan and WHO checklist. This was a good safety verification system to avoid the risk of wrong site surgeries or incorrect treatment.

The medical director facilitated a risk-averse environment and empowered surgical teams to stop or postpone treatment where it presented a potential risk to patient safety. The system worked well, and the provider tracked treatment outcomes for patients who were referred onward for urgent care. For example, the team referred a patient to the nearest NHS eye emergency department when they complained of pain before treatment and staff found a retinal tear. In another case a patient presented with symptoms of a transient ischaemic attack (stroke) and arranged for them to be seen urgently at a nearby clinic.

Staff managed postoperative issues in the clinic within the provider's policy. This included complications such as an allergy to eye drops and unexpected soreness.

Consultants ordered blood tests, imaging, microbiology, and pathology tests prior to surgery to ensure the planned procedure was safe where patients had preexisting conditions. They met with patients to discuss results and change planned care if this would improve safety and outcomes.

Good

Surgery

In the previous 12 months, surgeons delayed 3% of planned treatment to investigate the patient's blood pressure and rule out hypertension.

Staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The medical director adjusted staffing levels and skill mix based on planned treatment.

The medical director was the registered manager and a consultant ophthalmologist. Along with the clinic general manager they formed the only permanent members of staff. A team of 10 consultants worked under practising privilege arrangements and were supported by registered nurses and operating department practitioners (ODPs) who worked on bank or agency agreements.

Surgical teams typically included a surgeon, a scrub nurse, and an ODP. ODPs were cross trained as healthcare assistants (HCAs). The provider adjusted teams based on the type and complexity of planned treatment.

Consultants provided specialist care such as complex glaucoma work and ocular plastics. The medical director had good staffing governance systems in place to ensure staff were competent and appropriately skilled.

The provider had an induction process and the medical director adapted this based on whether the individual was joining as a permanent member of the team or as a clinician working under practising privileges or from a bank team or agency. The medical director checked the scope of practice of each consultant to ensure it reflected their NHS work and competencies.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff completed registration details by hand and then added them to a digital cloud-based record. Consultants could access clinic letters, imagery, optometry data, and diagnostics securely and remotely. This meant patients received efficient care and referrals were handled promptly.

Staff securely destroyed all paper records before the clinic closed for the day and the provider's cloud storage system was secured and encrypted.

When patients transferred to a new team, there were no delays in staff accessing their records. Consultants worked collaboratively with specialists in other services to coordinate safe care.

The medical director reviewed the records of all patients treated in the service to ensure information was consistently recorded. They also checked surgeons sent copies of surgical care records and discharge letters to each patient and their referring clinician. In the previous 12 months the provider reported 100% compliance with expected standards.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Consultants carried out double checks before administering cytotoxic medicines and disposed of these in line with national standards.

Good

Surgery

Staff reviewed each patient's medicines at the preoperative stage and provided advice to manage potential contraindications with planned treatment. Most patients required only anaesthetic eye drops and post-operative antibiotic eye drops. Staff administered the first dose to each patient whilst they were in recovery to monitor them for side effects and ensure they could self-administer and tolerate the drops.

Staff completed medicines records accurately and kept them up to date as part of each patient's record.

The provider offered laser and other surgery under sedation. In such cases an anaesthetist was present, and the surgical team provided appropriate post-operative recovery.

The service maintained an audit trail of the cold chain for chilled medicines. The cold chain is a process to ensure refrigerated medicines are kept within the optimal temperature range at all times. The provider had a clear escalation plan in the event of equipment failure or other events where storage temperatures exceeded the manufacturer's safe limits.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. The medical director investigated incidents and shared lessons learned with the whole team and affiliated services. The medical director ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the provider's policy.

The service reported 3 clinical incidents in the previous 12 months. In each case staff worked well together to coordinate care and treatment, including for an emergency referral to the nearest emergency department for a patient experiencing unusual symptoms in the days after a procedure. In each case staff followed up with patients and provided appropriate continuing care to support good outcomes.

Staff understood the duty of candour and completed training in being open. The medical director would take the lead in any situation that required use of the duty.

The medical director investigated incidents thoroughly and involved colleagues and patients in the process.

The medical director monitored national patient safety alerts and field notices issued by equipment manufacturers. They reviewed policies and standard operating procedures to ensure the service was responsive to updates.

Is the service effective?

Outstanding ☆

We have not previously inspected or rated this service. We rated effective as outstanding.

Evidence-based care and treatment

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

Good

Surgery

The provider's ethos was based on delivering a high standard of care, led by advanced specialists, to meet complex needs. This included complications of cataracts, vitreoretinal surgery, and high-risk medical retinal treatment amongst patients living with diabetes. The provider had systems in place to ensure care and treatment followed the most up to date national and international best practice guidelines issued by appropriate professional and industry bodies. These included the Royal College of Ophthalmologists (RCOpth), the World Health Organisation (WHO), and the National Institute for Health and Care Excellence (NICE).

The medical director maintained policies, treatment pathways, and standard operating procedures (SOPs) and ensured these were readily available to staff delivering care. All such documents were available in the clinic in hard copy and the clinic general manager supplied them electronically on request by clinicians.

Staff considered the psychological and emotional needs of patients at preoperative consultations and were trained to recognise the challenges of eye problems amongst older people. This helped them coordinate appropriate individualised care.

Staff used the RCOpth/WHO combined surgical safety checklist for cataract surgery during procedures. This facilitated the safest, most effective standards of evidence-based care within the patient's aims of refractive treatment. For example, the checklist removed the risk of using the incorrect intraocular lens during a surgical procedure.

The service had clear protocols to enable timely surgery to take place in line with RCOpth guidance. Where patients presented with an urgent need and the service did not have surgical capacity, staff used service level agreements to refer patients to other regional providers.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. The provider had developed innovative pain relief techniques and was a sector leader in developing new treatments.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

The provider had developed pain management techniques to provide surgery with minimal discomfort. Surgeons used topical anaesthesia during procedures and encouraged patients to let them know if they felt pain. Staff adjusted the amount of anaesthesia used based on individual patient needs.

Staff provided patients with post-operative pain management advice. This included what to expect and what to do if pain was uncontrolled with simple pain medicine. In such cases the provider arranged an urgent appointment to review the patient for post-operative complications.

The provider asked each patient after surgery if they felt their pain had been controlled. In the previous 12 months, 98% of patients said they had felt no or minimal pain or discomfort. Of those who did experience pain, 96% said staff managed it effectively.

Patients we spoke with during our inspection reported no pain, discomfort, or distress. Staff provided eye shields to help them recover at home with minimal discomfort.

Good

Surgery

Patient outcomes

All staff actively monitored the effectiveness of care and treatment through continual, extensive assessment processes. They used the findings to make improvements and achieved good outcomes for patients that consistently exceeded expectations.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. The provider audited cataract surgery and benchmarked outcomes against the national cataract dataset. This measured complication rates and target achievement rates, including amongst patients with co-pathology. The most recent audit included surgery in 2023 and found results significantly better than all national targets had been met. For example, the national average complication rated was 5% and the provider's rate was less than 1%. The national benchmark for a post-operative visual acuity outcome the same or better than that before surgery was 95%. In this measure the provider achieved 100%.

The service reported no instances of unplanned returns to surgery or emergency department attendances following surgery.

Patients spent time in the recovery room until clinical staff were satisfied it was safe for them to leave and the patient felt comfortable doing so. Staff provided individual post-operative instructions to each patient to make sure they recovered quickly and safely. They spent time with each patient in recovery to answer questions about how to look after themselves at home and what to do if they had unexpected side effects.

Staff carried out comprehensive pre-discharge checks before patients left recovery. This included eye pressures, pain or discomfort, and a review of medicines. They provided each patient with printed guidance on how to manage postoperative concerns, including for complications, during normal working hours and out of hours.

The service met RCOpth requirements that 95% of patients who presented with certain types of retinal detachment were assessed within 24 hours of diagnosis and received treatment in a timeframe appropriate for the condition.

The service monitored outcomes for patients who underwent vitreoretinal surgery (VRS). VRS is a subspecialty that treats diseases of the vitreous and retina. Staff contributed to the VRS national dataset and met the national benchmark for care quality and outcomes.

The provider was equipped to carry out specialist investigations including retinal photography, wide-field imaging, and optical coherence tomography (OCT). OCT is a non-invasive diagnostic technique that provides surgeons with cross-sectional views of the retina. The medical director had developed such types of complex care to meet growing demand in the region and meant patients had access to a broader range of specialists and treatment options.

The medical director reviewed the time between consultations and treatment to ensure they adhered to RCOpth and NICE guidelines. The service consistently met these standards and there had been no reported cases of treatment delays or visual harm in the previous 12 months.

In the previous 12 months 95% of patients reported satisfaction with care and treatment outcomes. During our inspection patients told us they were happy with their clinical outcomes. Written feedback reflected this. For example, a recent patient noted, "[I am] forever grateful to the service for the improvement … to my eye which was nothing short of a miracle."

Good

Surgery

Competent staff

The service made sure staff were competent for their roles. The medical director appraised staff work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The medical director reviewed each consultant's credentials and track record evidence before they were able to provide care and treatment. The provider required consultants to hold up to date General Medical Council registration and the medical director carried out an annual check of their appraisal.

The medical director reviewed each consultant's surgical outcomes, patient feedback, and adverse events record as part of a continuous check of competence and quality. Consultants were typically advanced in their field and research active in academia.

All clinical staff other than the medical director worked substantively elsewhere or worked through a bank or agency arrangement. The provider arranged specialist training and skills development on demand or when they introduced a new care or treatment option.

The clinic general manager was the only permanent member of staff to recently join and had up to date induction records, including 3 monthly 1-to-1 meetings with the medical director and a planned first annual appraisal.

The provider required a permanent member of staff to be present in the clinic whenever surgical activity took place that involved clinicians working under practising privileges. This acted as an ongoing process of care monitoring and meant the medical director and clinic general manager had assurance of consistent standards of care.

The medical director was the nominated lead for cataract surgery and vitreoretinal surgery and had extensive subspecialist training in both.

Multidisciplinary working

The service had developed highly specialised, extensive multidisciplinary care pathways and worked nationally to secure treatment for patients with increasingly complex needs.

Staff held effective multidisciplinary meetings to discuss patients and improve their care. They worked across health care disciplines and with other agencies when required to care for patients. Ophthalmologists reflected a range of different subspecialties and were affiliated with other registered providers, which meant patients had access to multidisciplinary specialists to coordinate complex care.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Where clinicians found an elective treatment presented a mental health risk due to an existing condition, they required an appropriate professional to provide an assessment of the patient before surgery.

Staff referred patients to other services and specialists where they found undiagnosed conditions that would present a risk during surgery. The service had an arrangement with a nearby private GP who could see patients at short notice and staff also referred patients to the NHS on request.

Ophthalmologists provided patients with a referral letter to take with them to other services and contact them in advance by telephone. This helped to provide straightforward access for patients. The provider stayed in touch with patients and monitored the outcome of multidisciplinary referrals to determine if planned treatment remained appropriate.

Good

Surgery

Many patients presented to the service with age-related macular degeneration and staff recognised it was common for patients to be living with other age-related health needs. They worked with other specialists to ensure appropriate treatment including through local hospitals with which the provider held contracts.

The service operated a local rapid referral pathway for GPs and optometrists to use for patients who presented with wet age-related macular degeneration ('wet AMD'). This is a condition where blood vessels start to grow in the back of the eye.

A consultant subspecialist in medical retina (MR) treatment, who was also the nominated lead, ensured high risk diabetic patients were seen and managed on time. The provider had a dedicated MR service that provided care and treatment for patients affected by serious or significant need.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Appointments were pre-booked based on demand and staff availability. The provider arranged out of hours contact and access options for each patient post-operatively. If surgery was in operation on a Saturday, the service opened on Sunday to provide patients with mandatory post-operative checks.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff provided relevant information promoting healthy lifestyles and support to patients on an individual basis where this could improve eye health. Surgical teams provided each patient with postoperative advice to promote a rapid recovery, including in relation to their work, hobbies, and sports.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They completed consent documentation at the preoperative stage and the clinic general manager scanned this into the patient's permanent record. Surgeons checked patient consent on the day of surgery to ensure they still understood the potential risks and benefits and wished to proceed.

The provider audited consent documentation as part of quality assurance. In the previous 12 months 100% of consent processes met the provider's expected standards.

Staff made sure patients consented to treatment based on all the information available. They discussed planned benefits, potential risks and side effects, and recovery times, before surgery commenced.

Good

Surgery

Staff received and kept up to date with training in the Mental Capacity Act 2005 and the consent process included an assessment of competency for each patient. Where staff found a patient could not weight up the information given to them or was unable to provide clear consent, they referred to an appropriate professional.

Is the service caring?

Good

We have not previously inspected or rated this service. We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and went above and beyond expected care to take account of individual needs.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. During our inspection staff demonstrated a good rapport with patients and they tailored communication and care to everyone. For example, some patients preferred a formal relationship and staff demonstrated an intuitive sense of the best way to meet their needs.

Patients said staff treated them well and with kindness. A patient undergoing care during our inspection said, “Everyone has been lovely and helpful. They are all very caring.”

Staff followed policy to keep patient care and treatment confidential. For example, they made sure private discussions could not be overheard and they locked computer screens when left unattended.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with complex needs.

Patient feedback reflected a consistently caring approach from staff. A recent patient noted, “Really caring doctor, made me feel safe and comfortable.” Another individual said, “All the staff, both in reception as well as the nurses, were extremely polite and helpful. I very much appreciate the after-operation care.”

Emotional support

Staff provided emotional support to patients to minimise their distress. They understood patients' personal needs and provided individualised care that reduced worry and anxiety.

Staff gave patients help, emotional support and advice when they needed it. The medical director facilitated care that promoted patient comfort and reassurance. During our inspection surgeons and their teams spent time with patients to reassure them before surgery.

Patient feedback was consistently good. Recent comments included, “I love the [clinical environment] because it’s so calm and everyone is really nice,” and “I was delighted with the care and attention I was given.”

Good

Surgery

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and particularly the concerns of older patients. Where patients were nervous about treatment staff skilfully built an understanding and spoke with them throughout the surgery. This was reflected in patient feedback. A recent patient noted, "Everyone did their utmost to ensure that you felt comfortable throughout the whole process." Another patient said, "Everyone who looked after me was exceedingly kind and considerate. I would like to say a special word of thanks to reception, especially [the clinic manager]. People arrive for eye surgery very apprehensive and nervous. The staff in reception are cheerful, reassuring, helpful and kind. I am very grateful for them. They made the whole thing easier. And this very important – when you arrive for your operation, they are the first people you see and speak to – they do a wonderful job."

Understanding and involvement of patients and those close to them

Staff supported patients to understand their condition and make decisions about their care and treatment. The service sought to maintain a continual understanding of patient need, expectations, and understanding.

Staff made sure patients and those close to them understood their care and treatment. They talked with patients in a way they could understand and adapted communication to the needs and understanding of each patient.

Patients could give feedback on the service and their treatment and staff supported them to do this. The patient survey included 4 questions related to how people had been involved in their care, including whether clinicians had given them opportunities to ask questions and take their views into account. In the previous 12 months, 99% of patients said doctors had listened to their concerns and involved them in making decisions.

Feedback was consistently positive. A recent patient noted, "[The doctor] put me at ease and explained." Another patient said, "[The doctors] were excellent. Both were clear about treatment options, potential risks and expected outcomes. Surgery was stress free and any worries or concerns were cleared prior to surgery."

Is the service responsive?

Good

We have not previously inspected or rated this service. We rated responsive as good.

Service delivery to meet the needs of people

The service planned and provided care in a way that met the needs of people. It worked with others in the wider system and regional organisations to plan care.

The clinic was situated on the first floor of a converted historic mansion with limitations on modifying or adapting the building due to its age and listed status. For example, it was not possible to install a lift and there was no step-free access from the car park to the building. Staff worked within building restrictions to reduce barriers to care as far as possible. They completed risk and support assessments for patients with mobility needs and where care could not be provided safely, staff secured treatment with another provider.

A stairlift was available for emergency use only to aid an evacuation from the first floor.

The building operator provided facilities support, including reception services for arriving patients.

Good

Surgery

The medical director planned and organised services, so they met the needs of the local population. They had increased the range of specialist services available to meet increasing complexities in patient presentations and worked with other services in the region to complement existing care.

The service provided care for self-paying or privately insured patients. However, the medical director was responsive to requests for help from local NHS organisations. For example, they stepped up capacity to provide short-term blocks of care under arrangements with NHS trusts. This was occasional work, and the service accepted such contracts only where they could secure appropriate staffing in advance and with a clear service level agreement from the contracting trust.

The service provided care and treatment to adults over the age of 18. Where parents tried to schedule appointments for a child, the medical director worked with them to identify a suitable paediatric ophthalmologist who could meet their needs.

The service had adapted to carry out complex procedures on demand and where clinical need dictated it. For example, the provider did not routinely offer retinal detachment surgery. However, the medical director was trained and competent to provide this treatment and provided specific lists with trained surgical support teams.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The medical director had established clear safety exclusion criteria for patients who presented with conditions that meant care could not safely and appropriately be delivered. For example, the service did not provide surgical treatment to patients living with dementia. In such cases staff worked with the patient's GP to identify suitable alternatives.

The service required patients to secure an interpreter if they could not understand consent, treatment plans, and aftercare instructions in English. Staff said they would not accept a friend or relative acting as a translator due to the associated risks.

Staff provided each patient with printed information in an accessible format following treatment. This detailed their diagnosis and treatment, explained their medicine, and provided post-operative guidance on managing their condition. The service provided printed information on complex conditions supplied by the Royal College of Ophthalmologists, which meant they had the most up to date and accurate information available.

Staff completed training that helped improve access and ensure patients received equitable, inclusive care. For example, the provider required staff to hold training in autism awareness, dementia awareness, supporting people living with a learning disability, and the impact of visual impairment amongst older people. Such training helped staff to empathise with individual health circumstances and provide care using communication techniques that met specific needs.

The medical director and clinic general manager were trained in the national accessible information standard. This meant they prepared and reviewed printed information to make sure it met national readability and access standards.

The provider had good processes to provide care for patients normally resident overseas. A service level agreement with a pharmacy meant patients could take eye drops home with them to cover the full period of their recovery after they left the UK and before they were followed up by a local professional.

Good

Surgery

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were kept to a minimum.

The service did not have a waiting list and arranged appointments to meet patient demand and clinical team availability.

Cancellations by the provider for non-clinical reasons were rare. In the previous 12 months the service cancelled just 1 appointment on the day due to surgeon absence. Staff rescheduled the procedure, and the patient completed this 1 week later.

Patients accessed the service through a range of options, including self-referral. The service accepted referrals from other private providers who had assessed patients but could not provide care at the level or complexity required.

Surgeons were self-employed and worked in the service under practising privilege arrangements. The clinic general manager had access to each surgeon's diary and worked with their secretary to plan treatment.

The service provided personalised care on a pre-planned basis and staff established clear communication with patients before the day of surgery. Staff reminded patients about appointments using their preferred method of contact, which meant it was rare for a patient to not attend a booked appointment. Where patients had a last-minute illness or emergency that meant they could not attend, the provider worked with them to be as flexible as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service had a policy in place to treat concerns and complaints seriously and investigate them.

The service clearly displayed information about how to raise a concern in patient areas and provided this information on the website.

Staff understood the policy on complaints and knew how to handle them. There had been no formal complaints to the service in the previous 12 months. The medical director maintained an up-to-date complaints management policy, which ensured the service was prepared in the event of a complaint.

The service had been included in a complaint about a referring organisation. Although the complaint did not directly relate to this service, the medical director investigated it as far as possible to identify possible learning associated with the referral process.

Is the service well-led?

Good

We have not previously inspected or rated this service. We rated safe as good.

Good

Surgery

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and worked tirelessly to address them. They were visible and approachable in the service for patients and staff and had a clear track record of effective, evidence-based leadership strategy.

The medical director was the registered manager and had overall responsibility for care, treatment, quality, and governance. A clinical general manager supported the operation of the service and led administration.

Both individuals worked closely with surgeons and bank and agency staff and were well respected by staff we spoke with. They were the 'face' of the organisation and were demonstrably passionate about delivering high standards of care. They maintained continual oversight of the service and recognised the considerable benefits to patients from collaborative, interprofessional working.

Vision and Strategy

The service had created a new vision for what it wanted to achieve and an ambitious strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to regional needs and trends in the health economy. Leaders and staff understood and knew how to apply them and monitored progress through continuous engagement.

The provider recognised the benefits to care and patient outcomes when specialists worked together to provide coordinated streamline care. The medical director had established a policy for consultant ophthalmologists to provide preoperative consultations to patients within the usual scope of the service on site. This expanded capacity and reduced the number of separate locations patients needed to attend for treatment.

The provider had a good understanding of the regional health system, including demands on the private and public sectors for ophthalmological services. As a result, the team was increasing theatre utilisation, expanding relationships with other specialist providers, and developing services that were otherwise difficult to find. For example, the provider had invested in oculoplastic equipment and was developing aesthetic and dry eye medical treatments. In addition, the service provided care for patients who presented with certain conditions at other providers in the region who were not equipped to treat them.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and proactively sought opportunities for joint working and continuous improvement.

We observed a mutually respectful and supportive culture amongst the permanent team, which they extended to colleagues on self-employed, bank, or agency contracts.

The medical director had developed and facilitated a collegiate professional culture in which staff worked with support and mutual respect regardless of their contract or frequency of work. The permanent team held ongoing meetings and postoperative debriefs with the ethos of "let's make it fun" to encourage participation.

The provider supported debriefs by different staff, including nurses and operating department practitioners, as part of a collaborative approach to care.

Good

Surgery

Governance

Leaders operated highly effective governance processes, throughout the service and with partner organisations. Governance was measured quantitatively and qualitatively, and the service had substantial evidence of improvement and assurance as a result. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The board of directors held overall responsibility for governance including medical advisory, information governance, and quality management. The board met monthly, and the registered manager and 2 directors had developed clear governance protocols that reflected the nature of the service. Board meeting minutes demonstrated good standards of consistency in reviewing incidents, patient feedback, changes in regional care demand and provision, and other measures of quality.

The provider was flexible and could safely increase capacity at short notice. For example, they had provided a block of patient treatment to support a local NHS trust experiencing significant waiting times.

The medical director monitored quality assurance through a programme of audits including for patient outcomes and national benchmarking. They included partner organisations in governance policies and standard operating procedures. This meant patients seen by different providers as part of a multidisciplinary treatment plan were assured of consistent quality and safety practices.

Management of risk, issues and performance

Leaders and teams used systems to manage, assess, and improve performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Risk management was holistic, and they had extensive, tested plans to cope with unexpected events.

The medical director maintained a risk register that reflected the nature of the service. The board reviewed existing and new risks each month and kept an ongoing record of mitigation and assurance. For example, a national shortage of vitrectomy cutters (a surgical instrument), caused by supply change issues, meant there was a risk to patients during cataract surgery. To mitigate the risk, the clinical general manager established a minimum stock level of cutters required for surgery to proceed safely.

The provider was seeking alternative suppliers of preservative-free glaucoma eye drops following a national shortage that could impact patient care. Staff ensured enough stock was available in the clinic prior to commencing surgery.

The clinical general manager had joined the service to support the maintenance of policies and procedures and the oversight of service delivery. This resulted from the registered manager's analysis of the service and work to identify opportunities for improvement.

Information Management

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

The provider had an extensive information governance framework, developed alongside the expansion of the service. The framework reflected the complex care offered and included a continuous review of Health and Social Care Information Centre and Information Commissioners Office guidance to protect information and data.

Good

Surgery

The board of directors reviewed policies and procedures according to an annual schedule and updated these where national guidance or learning changed.

The provider had processes in place to manage the risks of cyberattacks or data breaches. Permanent staff completed information governance training. The medical director ensured staff working under practising privileges or other temporary arrangements understood the information governance policy during their induction.

Engagement

Leaders and staff actively and extensively engaged with patients and regional organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. This approach demonstrably led to high quality care.

The service's website ensured patients had access to comprehensive information ahead of consultations, including about common eye conditions and procedures.

The medical director was active in regional, national, and international professional networks and considered service improvements and procedures that reflected the latest understanding of ophthalmological care. They had developed a wide range of relationships with public and private providers that led to care provision for increasingly complex needs.

The provider asked each patient for feedback at least 1 day after their first surgery. This helped staff assess experiences of the whole care pathway. Feedback was consistently positive and in the previous 12 months the provider recorded a 97% satisfaction rate. A recent patient noted, "I would recommend [the service] to anyone, [staff] manner is excellent, and I would trust them 100%." Another patient said, "I was really well looked after and had great confidence in [staff] who was very kind and patient."

Learning, continuous improvement and innovation

The provider was demonstrably committed to continually learning and improving services through inquisitive working, professional development, and research. They had an advanced understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The medical director was embedded in the medical specialty nationally and had set up numerous eye surgery clinics with governance structures compliant with regulatory requirements. Along with an active programme of international research, they drove the service forward with a focus on innovative care to meet the needs of patients with complex conditions.

The provider was exploring the potential for using digital technology as part of care delivery. The medical director had established an ethical research protocol to explore the use of a smartphone-based app for patients to measure their visual acuity. Such exploratory work reflected the provider's ethos of continuous improvement.

The provider was developing a shared care optometry scheme with optometrists in the region. The scheme provided a direct referral pathway between optometrists and this service for patients in need of cataract treatment.

The provider had steadily built capacity in line with its strategy and an analysis of need in the region. Following the successful delivery of a block of care to NHS patients experiencing significant delays at a local trust, the provider was preparing to become an accredited supplier of services. This would enable the team to provide more sustained care to patients in the community.