Optical Express Limited

Optical Express - Manchester (Deansgate) Clinic

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location stayed the same. 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 care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care and had access to good information.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Refractive eye surgery	Good 	Our rating of this service stayed the same. 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 care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Contents

Summary of this inspection

Background to Optical Express - Manchester (Deansgate) Clinic

We undertook this inspection part of a random selection of services rated Good and Outstanding. Optical Express Deansgate Manchester provides refractive eye surgery for self- referring privately funded patients aged 18 years and over. The eye surgery takes place on limited days every month and is supported by a regional surgery team who also work at other locations across the north west of England and Yorkshire. There are no staff permanently based at the clinic. There is an optometrist on site every day who provides advice to patients about any suitable treatment for their eye condition and can begin the work up for any potential laser eye surgery if appropriate. There is also an optometric service which falls outside the scope of the Care Quality Commission registration.

The main activities and surgery are carried out at the Bridgewater clinic location.

The regulated activities for the service are

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

The service has been open since 2013. There is a registered manager in place. The service was inspected and rated in 2020.

The service carried out 1466 procedures in 2021.

How we carried out this inspection

We carried out an unannounced inspection, however there was no regulated activity taking place at the clinic on the day of the inspection. We revisited the site, on an announced inspection, when there was surgery taking place. We spoke with an ophthalmologist, three ophthalmic technicians, an optometrist, the clinical services manager for the provider and the clinical governance manager for the provider. One of the technicians was the registered manager for the service.

The service was inspected by an inspector and a specialist advisor with experience of this service.

We looked at information about the service before the inspection. During the inspection we looked at the environment of the clinic, we reviewed the policies and procedures of the service and reviewed three patient records. We followed up the inspections by requesting further information from the service.

We followed the patient journey along the surgical pathway for two patients, we observed a consultation between a patient and the ophthalmologist and spoke with a patient before their treatment started.

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:

Summary of this inspection

There had been a significant investment in technology for the service that allowed for better outcomes for patients. There was a piece of equipment that could produce a very detailed contour map of the eye, this scan was used to direct the laser during treatment. This technology was not available at other independent provider services.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Refractive eye surgery

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

Are Refractive eye surgery safe?

Good

Our rating of safe stayed the same. We rated it 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 mandatory training was comprehensive and met the needs of patients and staff. The training included consent, infection prevention and control, health and safety, safeguarding of adults and children, equality and diversity, information governance and human rights. Recently added training from March 2022 was dementia awareness and level three safeguarding for adults and children and young people.

We saw that at the time of the inspection mandatory training compliance was at 100%.

Mandatory training was either delivered face to face or through e-learning when appropriate. Staff completed mandatory training on induction and then every year or three years depending on the training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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 received training specific for their role on how to recognise and report abuse. Staff did level two safeguarding training for adults and children and young people. Safeguarding training at level three had been introduced for appropriate staff in March 2022.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had been no safeguarding incidents in the last year.

Links to the online level two safeguarding training were included in one of the newsletters to staff with the required completion date.

We saw that appropriate staff had disclosure barring service (DBS) checks in place.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

Infection prevention control was part of the audit tool which took place every three months. In August 2021, the audit scored 94% compliance and in December 2021 there was 96% compliance with the audit. There were also handwashing audits.

Staff tested all patients' and visitors temperature and provided them with face masks as they entered the building. There was space between the seats in the waiting room to allow social distancing.

We saw that members of staff kept all areas clean and tidy. Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that PPE was plentiful and that staff used it.

The service offered laser treatment to both eyes on the same day. Once one eye had been treated then all the equipment was replaced, and the theatre team would replace all their PPE to prevent any cross contamination.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

We saw that staff cleaned optometry equipment after patient contact. All equipment used in procedures was disposable.

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 service was in a three- storey building. The ground floor had a patient reception area and a waiting area. There were two rooms containing optometry equipment for diagnostics and a room for the optometrist to speak with patients. On the first floor there was a patient waiting area, an examination room, a discharge room, a laser treatment room/theatre with an adjoining utility room. All areas were well maintained and free from clutter.

The audit schedule which was carried out every three months included equipment maintenance.

The patient experience questionnaire asked patients how satisfied they were with the appearance of the clinic, the score was 9.7 out of a maximum of 10.

Training was provided to staff by the appropriate manufacturer for the laser equipment in the clinic. Following training, staff needed to be accredited by the manufacturer before they could use the equipment, this included the ophthalmologists.

Good

Refractive eye surgery

There was a laser safety policy that was in date with a review date of 2023. The policy outlined the role of the laser protection advisor and the laser protection supervisor role. The clinic had a contract with an external laser protection advisor (LPA). The laser protection advisor was responsible for undertaking risk assessments and providing advice and training on laser safety. They also drafted local rules and investigated laser incidents.

The laser protection supervisor role and these staff supervised all optical radiation protection at the clinic in line with the local rules. The laser technicians were also trained as laser protection supervisors and assumed the role when the supervisor was not available.

We looked at the local rules for the laser equipment. These contained risk assessments and information on the control of laser and gas hazards, and staff roles and responsibilities. We saw that staff had signed the local rules to show they had read and understood all the information.

We saw that the lasers were operated in controlled areas and there were warning lights and signs to show when the laser was in operation and when it was safe to enter the laser area. The laser room had a keypad to control entry.

There were two types of laser used in the clinic and the laser machines had a backup system in the event of a power failure. Patients could be rescheduled to another clinic in the event of a problem with the lasers.

There was a planned maintenance schedule in place that listed when equipment was due for servicing. The servicing and maintenance of equipment, including the laser equipment was arranged with external contractors. We saw evidence of the schedule of maintenance.

The theatre operation register contained the date and details of each procedure, the surgeon, supporting staff and patient. Staff kept labelling information from instruments and medicines prescribed during the procedure for tracking and traceability. Information on batch numbers and expiry dates was also recorded in the patient notes.

Medical gas cylinders were stored securely, and hazard signage was in place where medical gases and other hazardous and flammable items were stored.

There was an automated external defibrillator (AED), a grab bag and an anaphylactic shock kit were available in the theatre area. Other equipment available included chemical spillage packs and eye wash packs. Staff carried out routine checks on emergency equipment on each surgery day and the log sheets we looked at were complete and up to date.

All optometry equipment was checked on the days it was used, and this was recorded by the service.

There had been an investment by the provider in optometry equipment. There was a piece of equipment that could produce a very detailed contour map of the eye, this scan was used to direct the laser during treatment.

Sharps bins were stored and labelled appropriately and there were arrangements with external contractors for the disposal of clinical waste. There were protocols in place for the safe disposal of chemotherapeutic agents and for any spillage of the waste.

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.

Good

Refractive eye surgery

Patients had an initial assessment with an optometrist to determine whether they were eligible to receive treatment at the clinic. This assessment was comprehensive and included information about their medical history, any family history, allergies and any dry eye history. The assessment also included information about the patient's hobbies, their current vision aids and their satisfaction with them and what visual outcome they wanted from laser treatment.

There was a section in the assessment about the mental health of the patient and patients were asked if they had been feeling down depressed or hopeless in the previous two weeks. If they had then the patient's GP was contacted to check if they were appropriate for treatment. If the patient had certain medical conditions such as diabetes, then the GP would be contacted. There were exclusions to treatment including patients with pacemakers or open wounds.

Patients were assessed by the ophthalmologist on the day of treatment to check if there had been any changes to their medical history and that they wanted to proceed with the treatment.

There was a clinical team brief every morning before surgery started when staff discussed the patient surgical list for the day to highlight any issues such as drug allergies, patient's anxieties.

The theatre staff completed the World Health Organisation checklist for ophthalmic procures. We observed that this was completed during the inspection. The service audited this by observation and had achieved a good outcome for the audit.

There was a clinical communications email and telephone service so that clinical staff could obtain a second opinion, clinical guidance and support if necessary. This was promoted in the service newsletter.

We saw that staff training had been completed in basic life support by all staff at the time of the inspection and that appropriate staff (theatre associates) had completed training in immediate life support.

Staff told us that if there was any deterioration in a patient's condition during their time at the hospital then they would contact the emergency services so that the patient could be transferred to an acute hospital.

There were posters in clinical areas about the management of sepsis including the recognition of symptoms, diagnosis and early management of the condition.

There was 24 hour seven days a week helpline for patients following treatment, if they had any problems or concerns.

If a patient contacted the helpline there was a triage process to determine the urgency of any treatment that the patient required. Their symptoms were reviewed, this applied to all patients seen by the service including those on the surgical pathway. There was training for appropriate staff on the triage process.

We observed that staff shared key information to keep patients safe when handing over their care to others. At all stages of the patient journey along the surgical pathway the handover was done face to face with the member of staff taking over the care of the patient.

Staffing

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

Good

Refractive eye surgery

The service had enough staff to keep patients safe.

The clinic did not carry out laser eye surgery procedures every day and staffing levels were based on the number of planned surgical procedures required. There were no clinical staff permanently based at the clinic. Staff members based at the clinic were part of a larger regional team covering clinics across the north west of England and Yorkshire regions.

The regional surgery team included operating department technicians, scrub nurses and health care assistants.

The service did not use agency staff as there were enough staff to cover the rotas as required.

Medical staffing

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

The clinic employed one resident ophthalmologist who carried out most of the laser eye surgery procedures at the clinic. There were other ophthalmologists who were part of the north west team who covered surgical sessions at the location.

The ophthalmologist had been employed by the service for approximately 15 years and had completed the Royal College of Ophthalmologists certificate in laser and refractive surgery. We saw evidence of up to date indemnity insurance in the ophthalmologist's staff file.

We saw evidence of the appraisal of the ophthalmologist including the scope of work and the personal development plan.

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.

Records were electronic and were a complete record of the surgical pathway journey of the patient including the health and well-being assessment, consent and the medicines record. We reviewed three patient records, and all had been fully completed.

Appropriate staff could access the patient records.

A patient records audit was carried out every three months to check for accuracy and completeness of the records. The audit involved a review of at least five randomly selected patient records (paper and electronic). This increased to 10 records if any errors or omissions were found during the audit. In the four audits carried out in the last year each of the four audits had met the service target.

Patient information was not routinely sent to the patients GP but all information and the images of all the scans taken were sent to the patient.

Medicines

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

Good

Refractive eye surgery

Staff followed systems and processes to prescribe and administer medicines safely.

Medicines management was part of the audit schedule that took place every three months.

Medicines were stored securely in locked cupboards and temperature controlled rooms. Fridge temperatures were monitored and audited by the service.

Emergency medicines were available in the theatre area and we saw evidence to show these were routinely checked for correct quantities and expiry dates.

Topical anaesthetic drops were administered to the eye before laser treatment to numb the eye. Following treatment, patients were given eye drops to take home for self-administration. We saw that the expiry dates of the drops were checked by two members of staff before they were given to the patients.

Patients were provided with verbal and written information about their eye drops before they left the service.

The service could use Mitomycin C (MMC) as part of the refractive eye treatment, this is a chemotherapeutic agent used to control scarring following treatment. It was not licensed for use as an eye drop but has been used for many years in specialist eye clinics. We saw that it was stored appropriately in a locked cabinet and there was appropriate stock control. Patients received appropriate information if MMC was used and they gave signed consent to its use.

The optometrists were non- medical prescribers and could prescribe medicines within their area of expertise to patients attending the service.

We saw that allergies were recorded in the patient record which included the prescription chart.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. We saw from the minutes of a staff meeting that incidents were a standing agenda item and that information was shared across the team.

The provider monitored live complications and outcomes so that they could identify any issues that required immediate intervention.

There had been no serious incidents reported by the service in the last year. There were two incidents, one of which was an equipment failure before surgery had been started and the patient was rebooked for surgery. The other incident was a surgical complication. It was a known potential outcome of the surgery and was listed in the consent documentation. The patient was rebooked for treatment when appropriate.

There had been a near miss in 2021 when the patient had been given the wrong eyedrops in their discharge bag. This was picked up by staff in the routine handover when medication was checked by the member of staff who was discharging the patient. The learning from the incident was that the routine discharge process was efficient and had picked up the error. There was a debrief for staff involved.

Good

Refractive eye surgery

We saw that surgical directives were sent out if information needed to be disseminated. Appropriate staff were required to sign the directive to show that they had read and understood the information.

Staff undertook duty of candour training and rates for training were at 100%.

Are Refractive eye surgery effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Care and treatment were delivered to patients in line with the Royal College of Ophthalmologists (RCOphth) Standards for Refractive Surgery and National Institute for Health and Care Excellence (NICE) guidelines in relation to refractive eye surgery.

The providers policies and procedures followed national guidance and were updated by the provider as necessary at a corporate level. All staff could access policies and procedures electronically.

The service audited national guidance and we saw that in April 2021 and there was 100% compliance.

The service carried out the appropriate checks to inform the patient about the type of treatment that would be best for the outcome that the patient desired so that the patient could make an informed decision. Pre- treatment checks were carried out and consent was obtained from the patient.

Any treatment was based on the clinical need of the patient based on national guidelines. Patients were informed if they did not meet the criteria or were unsuitable for certain treatment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Patients were present in the service for a very short time but were offered a hot or cold drink if they wanted one. There was water available in- patient waiting areas.

Pain relief

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

Patients were informed about the procedure and sensations they would experience before the surgery, and they received local anaesthetic eyedrops before the surgery commenced.

We observed that patients could ask for additional eye drops during the procedure if they felt any pain or discomfort.

We spoke to two patients following their procedures and they said that they had been pain free during the procedure and immediately after. They were told that the anaesthetic would wear off about 20 minutes after their procedure and they were advised to take their usual pain relief and to rest or sleep for the rest of the day.

Patients received information in their discharge pack about how to manage any pain symptoms.

Patient outcomes

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

Outcomes and complication audits were collated by surgeons and not by clinical locations. The service collated data for the previous year to support the appraisals of the surgeons. These audits were comprehensive and compared the surgeons to the provider average.

As part of the annual outcome audits, surgeons were given a laser vision correction score based on the patient's pre-operative patient prescription and their refractive target. There was a score for efficacy and safety and a score of 50 was the expected score for the provider. Any score above 50 was above performance expectations. The resident surgeon working at the clinic had scored 57 for both efficacy and safety.

Patients were offered a choice of surgeon for their treatment. They could choose any of the surgeons who worked in the northwest of England. There was an information sheet and surgeon profile for each surgeon which included their qualifications and experience and the number of procedures that they had undertaken. This information was also available on the website for the service.

We saw for one of the surgeons at the clinic that 98.3% of patients achieved 20/20 vision or better and 99.4% of patients were satisfied with the care provided. The surgeon had performed 6185 laser eye treatments to patients. Another surgeon had performed 2674 procedures with 96.6% achieving 20/20 vision or better and for the same surgeon out of 2021 patients, 97.6% were satisfied with the care provided.

There was a surgical event incidence of 0.1% in 2021.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There was a staff training, development and appraisal policy.

There was a clinical education manager for the service and a team of professional education facilitators. The team supported and trained the new professional staff and health care assistants staff through their induction period. They were also responsible for ongoing development and support throughout the individual's career with the service.

The surgery manager for each area was responsible for the induction, training competency assessment programme and appraisal of their team members.

Good

Refractive eye surgery

The surgical support staff had a personalised induction programme with a clear programme with learning objectives and there was a period of supervised practice following the training. Specialist laser training followed staff achieving competencies in other areas. Certificates of competency were issued following the training modules.

Managers gave all new staff a full induction tailored to their role before they started work.

There was a formalised annual appraisal process for all staff and medical staff were subject to an appraisal from the optical express medical appraiser. There was formalised peer review and supervision every year for medical staff and open discussion about the findings of the international medical board.

The optometrists had been funded to complete their independent prescribing qualification. This meant if patients returned to the service with an infection or inflammation there was no delay in treatment.

Optometrists who worked for the service gained continuous professional development points through meetings and training for their registration with the General Optical Council.

Multidisciplinary working

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

There was effective multi-disciplinary work to support patient care. At the beginning of each surgery session there was a team brief so that staff understood their role for the day.

Optometry staff told us that they enjoyed working as part of the multi-disciplinary team with the ophthalmologists. They said that the consultants valued their input into the care and treatment of the patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Minutes of meetings showed that staff from different clinical sites met to review the care and treatment of their patients.

One of the questions in the staff survey related to multidisciplinary working and collaboration with team members, 100% of staff had responded positively to this statement.

Seven-day services

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

The service was available 9am to 5.30pm Monday to Saturday. Laser surgery was arranged to meet the needs of the patients. If patients received one type of laser surgery on a Saturday, they would be seen on the following Sunday for follow up.

Health promotion

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

Patients completed a health and well- being questionnaire before they received treatment and were given advice about smoking if appropriate.

Good

Refractive eye surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Consent was part of the mandatory training schedule and there was 100% compliance with training at the time of the inspection. Dementia training had been added to the mandatory training in March 2022.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients were given written information for all procedures at the initial consultation. The optometrists who undertook the consultation received training and had their competencies signed off for pre and post- operative care for refractive treatment.

Following the consultation, the patient received a copy of the treatment consent form, the terms and conditions documentation and information on the risks and benefits of the treatment. This was sent electronically and he patient electronically signed the record to confirm that they had read all the required information including the consent documents. When this was completed the patient was given a treatment appointment.

There was a “cooling off” period of a minimum of seven days between the initial consultation and the surgery. This was in line with the Royal College of Ophthalmologists guidance.

The final consent for treatment was the responsibility of the operating surgeon on the day of surgery. We observed a consultation between the ophthalmologist and a patient about risks and benefits of the treatment and after care. This was a detailed conversation with the patient encouraged to ask questions.

Costs were fully explained to patients and individually tailored to the complexity of the treatment they needed to achieve their desired outcome. Some of the equipment that was used gave a more detailed picture of the eye and there was an additional cost for this service.

The service did not treat anybody who did not have capacity to consent.

Are Refractive eye surgery caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients were given time at all stages of the surgical pathway to ask questions about their treatment and to voice any concerns they had.

Staff introduced themselves to patients and then went onto explain the next stage of their pathway.

The ophthalmologist asked the patient if they wished to have a commentary during the operation or not.

We observed that staff were polite and courteous to patients who were attending the clinic. We saw that patients were personally handed over to the next member of staff who was delivering their care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We heard a conversation on the telephone between a patient and a member of staff. The patient had attended the clinic and had decided to proceed with laser treatment. They were anxious about the treatment and the member of staff tried to reassure the patient about the procedure and support their decision to have the treatment recommended by the service. They spent time talking through everything that the patient needed to know.

Patients were offered a visit to the theatre treatment area if it was not being used to look at the equipment and environment.

When the patient was in the theatre, we saw that staff reassured the patient and chatted with them to help to relax. The two patients who we spoke with said they were comfortable during the procedure and it was much better than they had expected.

The patients completed a patient satisfaction score following their treatment. The service had completed 357 surveys. The first question was “did the surgery team make you comfortable and at ease?”, the location scored 10 out of a possible 10.

Another question was “how satisfied were you that the surgeon answered all your questions?” the location scored 9.6 out of a possible 10. There was a question about the warmth and friendliness of the surgeon, and this scored 9.9.

The costings given to the patient were for the whole of the treatment. There were no additional added costs.

This clinic generally scored the same or higher than other clinics in the patient survey.

Understanding and involvement of patients and those close to them

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

Patients were given appropriate information about what they should expect from their surgery and realistic expectations about their outcomes in line with the Royal College of Ophthalmologists guidance. Staff supported patients to make informed decisions about their care.

Staff made sure patients and those close to them understood their care and treatment. We spoke to a patient and asked about they had chosen this provider for their surgery. They told us that they had been really impressed with the amount of information that they had been given at their initial consultation with the optometrist. They had explained why they thought that the surgery was their best option for the lifestyle that they wanted and were given all the risks and benefits to consider before they made their decision to proceed.

Good

Refractive eye surgery

The ophthalmologist spent time with the patient on the day of treatment and went through the risks and benefits of their procedure so the patient could make an informed decision about their treatment. They used drawings to show how the treatment worked and provided information about what would happen in the long-term following surgery.

We observed that a patient who had been listed for surgery on the day of the inspection decided to postpone their treatment. This happened during their pre-operative conversation with the ophthalmologist when patients were given advice about activities that they could undertake following treatment. The ophthalmologist explained the risks to the patient, and they asked if they could postpone the treatment to a later date.

Following surgery, patients were taken into a separate room for their discharge. They were given information about when they could resume showering, sporting activities and wearing make-up etc. We saw that the patient's asked questions and were given advice on what they needed to do for the month following treatment.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service through the patient satisfaction surveys. Patient satisfaction was part of the three-monthly audit tool and the service scored nine out of 10 or more in each survey in the last year.

The service produced a newsletter for staff. In the three newsletters we saw there was a patient's video story in each one. The patients explained the reasons for their treatment and their outcomes.

Are Refractive eye surgery responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

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

Facilities and premises were appropriate for the services being delivered. There was a wheelchair accessible lift to the first floor if necessary.

Patients could attend any of the provider's clinics for their initial consultations and their pre and post -operative treatment.

The service carried out laser surgery on limited days every month dependant on the numbers of patients who required surgery. Patients could choose when they wanted to attend surgery, and this included Saturdays.

The service had a camera to look at the back of the eye and patients did not always need to have their pupils dilated. This meant that these patients would be able to drive following this eye examination if necessary.

Good

Refractive eye surgery

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.

Any specific issues, patient requests or needs both physical and cultural which had been discussed in the initial consultation with the optometrist were noted in the patient's electronic record. If a patient needed additional assistance for hearing loss the optometrist would raise this with the surgery manager.

The service employed care co-ordinators to help to meet the needs of the patients

The service had recently introduced a new translator policy with a learning module for staff. There were posters around the clinic informing patients that a translator would be required for informed consent before their surgery.

The provider website had profiles of each ophthalmologist including languages spoken by that ophthalmologist.

Patients with diabetes were flagged to the ophthalmologist and staff tried to put them first onto the theatre list

The service had information leaflets available in languages spoken by the patients and local community.

Access and flow

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

Patients accessed the services by self-referral. When a patient made an initial enquiry about the services offered at the clinic, an initial consultation appointment was made with an optometrist and they were given verbal and written information about the types of treatments offered. Patients could telephone and book an appointment on the same day and at their convenience.

Patient's scans were reviewed by the ophthalmologist responsible for carrying out the procedure before treatment. As part of this consultation, a review of the patient's medical history was carried out to determine whether they were suitable to undergo treatment at the clinic or if there was a need to contact the patient's GP.

Following their attendance at the clinic patients were asked to complete information on-line, including an initial consent document which they signed with an electronic signature.

Patients waited about two weeks for their surgery, this included the weeks cooling off period as recommended by the Royal College of Ophthalmologists. Patients could choose the date and time of their surgery. Appointment times were staggered so patients did not wait very long at the clinic before they had their treatment.

We observed on the day of the inspection that patients moved seamlessly through the different stages of the pathway. On arrival at the clinic they had a diagnostic scan before they went to see the ophthalmologist for their consultation. The ophthalmologist checked any changes to their health and went through the consent for their procedure ensuring that the patient understood what they were consenting for. Following this the patient went to the theatre for their procedure. They were in theatre for about 15 minutes. The surgery took a few seconds but the rest of the time in theatre was taken with administration of anaesthetic, equipment checks, theatre checks and ensuring the the correct patient identification. Following surgery, the ophthalmologist reviewed the results of the surgery before the patient received their eye drops and post -operative advice before being discharged.

Good

Refractive eye surgery

Part of the competency framework for the technicians was flow through the surgical pathway.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas around the clinic. There were posters in all the patient waiting areas in the clinic.

Complaint response times were audited as part of the audit tool that was completed by the service every three months. We saw that the complaints response time was 100% compliant with the timescales in the complaints policy.

Staff understood the policy on complaints and knew how to handle them. We looked at the last four complaints received by the service and saw that the response times had been met.

Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns with an independent complaints adjudicator, the Optical Consumer Complaints Service (OCCS).

Minutes of meetings showed that complaints were discussed during routine staff meetings and clinical governance meetings to raise staff awareness and support future learning

Are Refractive eye surgery well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

The registered manager had overall responsibility for the clinic. The registered manager did not work full time at the clinic, but they attended the clinic a few days every month.

The provider was working with the Institute of Leadership and Management to offer accredited awards. This was offered to all staff so that each team member was given the opportunity for career progression and development. All managers were expected to work to level four management certification.

The service was developing a training course for registered managers. They hoped to achieve accreditation for this. All clinic and surgery managers would be enrolled on the course across the organisation.

There was support for the optometrists to develop their skills with the independent prescribers course that was funded by the service.

Clinical staff worked across several sites in the north west of England and Yorkshire to meet the needs of the service.

Senior staff in the organisation, including the chief executive officer, had a background in ophthalmology services so they knew the challenges and issues of the service. They supported the clinical staff in the operational delivery of the service. They were frequent visitors to the clinic sites. One of the senior leaders described their development through the service into a senior leadership role. Staff knew who the senior leaders were.

Staff told us that they felt well supported by the managers of the service. Staff were aware of their reporting structures and said that local managers were approachable. Clinical staff said that they had support at a clinical and managerial level.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

There was a strategy meeting on the 4 January 2022 with the managing director of the company and the senior managers of the organisation to discuss the objectives for the forthcoming year. There were discussions about the company investment in technology and the green energy programmes. The company had reviewed the reasons that staff had left the company and acted on this information.

The service was working to develop a cataract service in partnership with the NHS due to long waits for cataract surgery in the local health economy.

It was acknowledged that all staff had a role to play in the achievement of the objectives and the need to get all staff on board to make sure that they achieved the objectives.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The values of the organisation were “Exceptional Care, Exceptional Results, Exceptional People, # One Team”. There were posters around the clinic promoting the values and they were included in each newsletter.

Staff completed equality and diversity training as part of mandatory training and were 100% compliant at the time of the inspection.

Staff we spoke with said that they enjoyed working at the clinic. One member of staff we spoke with told us how they liked working with ophthalmologists and being a member of a bigger team. Staff received positive feedback from patients who told them what a difference the surgery had made to their lives.

Theatre staff worked well together and we saw that there was a culture of checking identification of patients along the whole of the surgical pathway. In theatre, laser settings were double checked so that the patients received the right care and treatment. Staff told us that they would challenge any actions or issues if they thought there was something wrong.

There were staff meetings for the Manchester clinics and for the region. Staff concerns was an agenda item on the minutes of meetings. One of the questions on the staff survey was "I understand how my work impacts on the organisation's goals and values."

The service collected information from patient satisfaction surveys to improve their services.

There were opportunities for career development both clinically and managerially. All staff were to complete accredited awards as part of their development. It was hoped that this would encourage staff to stay in the organisation.

We saw that changes were made following patient feedback. A surgical directive had been sent out following feedback from a patient about their experience in theatre. Staff had to read and sign the directive to show that they had understood the content.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

Staff worked across a number of locations in the northwest therefore team meetings were held regionally so that information could be disseminated up and down the organisation. These meetings were held every three months. We saw that agenda items for the meetings included Covid -19, review of incidents across the region, complaints, patient satisfaction audit outcomes, basic life support training and health and safety. Staff were given the opportunity to feedback at these meetings.

The organisation was owned by an individual and so there was not a board or executive directors or shareholders.

There was an international medical advisory board who met every year, they were paid by optical express, and included world renowned ophthalmologists and experts in their own fields. They reviewed technology, protocols, procedures and the techniques that provided the best patient outcomes and they made recommendations to the United Kingdom medical advisory board.

The United Kingdom medical advisory board for the service met twice a year. They reviewed the evidence presented from the international medical advisory board and decided if and how it would be implemented in the United Kingdom.

There were corporate clinical governance meetings every three months. These meetings included the clinical services director, the medical director for the United Kingdom, the surgical services manager and the clinical governance manager. There were sub committees of the clinical governance committee including the medicines management committee.

There were reports from the laser safety committee, the theatre leader committee, the infection control committee and the resuscitation committee at the clinical governance committee. Other agenda items included clinical updates, surgeon's updates, clinical directive updates and freedom to speak up updates.

Practising privileges was an agenda item on the clinical governance meeting agenda, and we saw that there was discussion about new staff who had applied for practising privileges. There was a pack to support the application of new doctors which included disclosure and barring checks.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register process was under review and risk registers were being uploaded to the staff intranet for each location. The new system was being implemented to make it easier to access and therefore more accessible for staff.

The regional clinical governance meetings were used to identify and mitigate risk for each clinic in the region. Agenda items included Covid -19, medicines management and health and safety. The registered manager was able to verbalise the main risk for the clinic and actions that had been put in place.

We saw that risk assessments had been completed and were up to date for the clinic. Risk assessments we looked at were for health and safety issues and Control of Substances Hazardous to Health. These risk assessments were on paper and had been scored with review dates. The risk assessments would be available through the new electronic risk register system later in the year through the intranet and staff would be able to remove and update risk assessments as appropriate.

There was a policy for risk management in the clinic called “Welfare and Safety of Patients and Management of Risk” This was in date with a review date.

At corporate level, there was an audit team who were responsible for the management of corporate risk including financial, insurance and health and safety. The clinic manager and the surgery manager were responsible for the practices within their departments. They were supported by the clinical services director, the clinical compliance manager and the surgical services manager at corporate level. The service had recently audited their central processes and risk management for the insurers of the service.

The corporate clinical services department, led by the clinical services director was responsible for risk management associated with the pre-operative, peri-operative and post-operative patient pathway including consent, monitoring of outcomes, review of incidents and surgical outcomes.

Risk was managed through the clinical governance meetings and through regular and frequent meetings of the corporate team. Whilst these meetings were not always minuted, agreed actions were taken forward by the appropriate team members. If they had not been closed, they were put on the agenda of the clinical governance meetings for further discussion.

Information Management

Good

Refractive eye surgery

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. Data or notifications were consistently submitted to external organisations as required.

The regional meetings were used to discuss the performance of the local clinics. Staff reviewed complaints, incidents and patient satisfaction with information available at a location level. The performance of surgeons was available at an individual level and was monitored by the provider. The biostats team had access to live data about patient outcomes and complication rates.

There was an audit tool that was completed every three months. This provided information to the service on areas including infection prevention control overview, incidents, complaints, patient satisfaction, laser safety, medicines management, personnel management, equipment maintenance and risk management.

Staff completed data confidentiality and information governance training as part of their mandatory training. Records showed 100% of staff at the clinic had completed this training.

Staff could access information such as policies and procedures. The policies we looked at were version-controlled, up to date and had periodic review dates.

The service submitted necessary information to the Care Quality Commission as required.

Engagement

Leaders and staff actively and openly engaged with patients and staff.

The service used feedback from patients to improve services. We saw that changes were made following feedback and that obtaining patient feedback was mandatory for staff.

There was a staff survey every year. We saw in the staff survey for September 2021 that there was a positive response to all the questions.

Staff completed training in equality and diversity as part of the mandatory training schedule and all staff were compliant with the training at the time of the inspection.

There were newsletters for staff containing information about issues such as mandatory training, patient stories, profiles of surgeons and new clinics.

The newsletter included “Perkbox” which was offers and discounts that were available to staff. The newsletter promoted health and well-being for staff, and we saw that there was a walk to work day promotion and in another newsletter about getting in touch with nature to improve well-being. There was a section in one of the newsletters about how staff could support each other with tips about communication skills and how to open a supportive conversation.

The clinic worked with sight charities and gave support through fundraising and collecting used spectacles to be repurposed in third world countries.

Good

Refractive eye surgery

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a culture of learning in the organisation. The international medical advisory board recommendations supported new technology and there was an annual review of protocols, procedures, criteria and new techniques. This was then reviewed twice a year by thy the ophthalmologists who worked for the provider.

The service provided data to support research that was collected by the biostats team to support research carried out by the provider. Information was collected about patient outcomes and complication rates for surgeons.

Staff had been signed up to Turas which is an online e-learning platform provided by NHS Scotland. They were working through their quality improvement modules so that staff at all levels within the surgery team understand what quality improvement meant. The module provided staff with the skills, knowledge and confidence to develop quality management within their teams.

The organisation was working to be “greener” with greener energy programmes and a focus on recycling of contact lenses to reduce plastic waste.

The organisation was working to become more environmentally friendly, and we saw that areas were fitted with sensors so that lights were turned off if nobody was in the room and there was a section in the staff newsletter about saving water.

The organisation was working to highlight the detrimental effects to the environment of putting used contact lenses in the bin or the toilet. There were posters in the clinic describing the effects on the environment of the plastic contact lenses and how many found their way into drains and landfill. There was a recycling bin for used contact lenses in the patient area of the clinic.