ACES (Fakenham)

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

ACES Fakenham is operated by Anglia Community Eye Service Ltd (ACES). Facilities include one operating theatre and a patient waiting room. The service has no inpatient beds.

The service provides cataract eye surgery for adults only.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 12 September 2017.

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

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

We rated this service as good overall.

- Although some elements of it require improvement, the overall standard of the service provided outweighs those concerns. We have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

We found good practice in relation to surgical care:

- The provider had established processes for reporting and learning from incidents. All staff could describe what constituted an incident and how to report it. Staff discussed incidents at meetings and shared learning.
- All areas we inspected were visibly clean and tidy.
- Nursing and support staff kept equipment clean and followed infection control processes.
- Staff had a system for recording implants used in theatre. Nursing staff logged lens implant stickers and batch numbers in patients' care records.
- Nursing and medical staff stored medicines securely and completed appropriate documentation of medicines administered.
- Nursing and medical staff kept detailed records of patients' care. We found patient records weresigned, dated, and legible. All records included the patient's details and surgical notes, including clear documentation of the site of surgery and post-operative instructions.
- Nursing and medical staff completed the World Health Organisation (WHO) surgical safety checklist for cataract surgery and five steps to safer surgery for all patients. This is a safety checklist used to reduce the number of complications and deaths from surgery.
- Managers completed annual appraisals for all staff. Allstaff had completed an appraisal in the last year.
- The service managed staffing effectively, ensuring it maintained appropriate levels of staff with the right skills and experience to keep patients safe and to meet their care needs.
- The patient waiting area was comfortable and well maintained.
- Nursing and medical maintained the privacy and dignity of patients.
- Patient feedback provided by the provider and at the time of the inspection about the service was consistently positive.
- Nursing and medical were kind and compassionate in their interactions with patients.
- The service reported no complaints from April 2016 to March 2017. The provider had a process for managing and responding to complaints.
- All Staff we spoke with were positive about leadership of the service and told us leaders were visible and approachable.

Summary of findings

- Senior staff had oversight of risks to the service. The provider had a risk register, which included identified risks, mitigation strategies and actions.
- The provider held governance meetings, board meetings and team meetings wherethe provider discussed incidents, complaints and compliment, information governance and staff competence.
- The provider monitored staff competency though appraisal, professional registration checks and monitoring of clinical outcomes.

However, we also found the following areas of practice that require improvement:

- Mandatory training completion was below acceptable levels, especially in regard to safeguarding children, manual handling and Deprivation of Liberty Safeguards (DoLS).
- Staff did not audit compliance with the WHO checklist. This meant senior staff did not have assurance that these safety checks were always completed. We raised this with senior staff at the time of inspection.
- Safeguarding leads were not trained to the correct level for the safeguarding of children, in line with the Royal College of Paediatrics and Child Health safeguarding Children and Young People: roles and competence for health care staff, Intercollegiate Document.

Following this inspection, we told the provider that it that it should make improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected ACES Fakenham. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Good**	Surgery was the only activity of at the location. We rated this service as good because it was safe, effective, caring, responsive, and well-led. We found: • The provider had established processes for reporting and learning from incidents. All could describe what constituted an incident and how to reportit.. Staff discussed incidents at meetings and shared learning. • All areas we inspected were visibly clean and tidy. • Nursing and support staff kept equipment clean and followed infection control processes. • Nursing and medical staff stored medicines securely and completed appropriate documentation of medicines administered. • Nursing and medical staff kept detailed records of patients' care. • Nursing and medical staff completed the World Health Organisation (WHO) surgical safety checklist for cataract surgery and five steps to safer surgery for all patients. • Managers completed annual appraisals for all staff. • The provider managed staffing effectively and the service always had enough staff with the appropriate skills, experience and to keep patients safe and to meet their care needs. • Staff maintained the privacy and dignity of patients. • Staff were kind and compassionate in their interactions with patients and patient feedback was consistently positive. • The service reported no complaints from April 2016 to March 2017. • All staff we spoke with were positive about leadership of the service and told us leaders were visible and approachable. • Senior staff had oversight of risks to the service. The provider had a risk register, which included identified risks, mitigation strategies and actions.

Summary of findings

- The provider held governance meetings, board meetings and team meetings where the provider discussed incidents, complaints and compliment, information governance and staff competence.

We found the following areas the service should improve:

- Mandatory training completion was below acceptable levels, especially in regard to safeguarding children, manual handling and Deprivation of Liberty Safeguards (DoLS).
- Staff did not audit compliance with the WHO checklist. This meant senior staff did not have assurance that these safety checks were always completed. We raised this with senior staff at the time of inspection.
- Staff had not received the correct level of training in the safeguarding of children.

Summary of findings

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Services we looked at

Surgery

Summary of this inspection

Background to ACES (Fakenham)

ACES Fakenham is operated by Anglia Community Eye Service Ltd (ACES). The service was founded in 2007. It is a private eye surgery service based in a local medical centre in Fakenham, Norfolk providing a community acute day surgery service for eye conditions. The service primarily serves the communities of the North Norfolk area. It also accepts patient referrals from outside this area.

Care is funded via the local NHS clinical commissioning groups (CCGs) and provided to NHS patients over the age of 18 years old.

The current registered manager has held the position since January 2012 and the regulated activities are:

• Treatment of disease, disorder or injury

• Surgical procedures

• Diagnostic and screening procedures

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector. Fiona Allison, Head of Hospital Inspection, oversaw the inspection team.

Information about ACES (Fakenham)

- The main service is eye surgery including but not limited to; cataract surgery, glaucoma surgery, minor eye surgery, and oculo-plastic surgery performed in an operating theatre at a medical centre. The provider had plans to move all activity including surgical procedures to another location early in 2018.This will give the patients and staff more space and ensure patient continuity as at present they have their initial consultation at another location and their surgery at Fakenham Medical practice.
- During the inspection, we visited the operating theatre, patient waiting room and staff areas. We spoke with seven staff including; a registered nurse, two health care assistants, medical staff, and senior managers.
- We spoke with four patients. We also received eight 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed five sets of patient records.
- There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. CQC have inspected twice previously in February 2013 and January 2014, during which we found that the service was meeting all standards of quality and safety it was inspected against.
- From April 2016 to March 2017, 948 cataract surgeries were performed, 1,038 patients were treated, all NHS funded by West Norfolk CCG, South Norfolk CCG and North Norfolk CCG.
- Three surgeons worked at the hospital under practising privileges. ACES employed registered nurses, and care assistants.
- During the reporting period April 2016 to March 2017, there were no never events, two no harm clinical incidents and one non-clinical incident.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal.
- Maintenance of medical equipment other than those specified in the report.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The provider had established processes for reporting and learning from incidents. All could describe what constituted an incident and how to report it. Staff discussed incidents at meetings and shared learning.
- Staff understood their responsibilities in relation to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- All areas we inspected were visibly clean and tidy. Staff followed 'bare below the elbows' guidance and used personal protective equipment in line with provider policy.
- Nursing and support staff kept equipment clean and followed infection control processes. We found that equipment was visibly clean.
- The provider had processes for the maintenance of equipment. Equipment was serviced in line with manufacturers' requirements.
- Staff completed the World Health Organisation (WHO) surgical safety checklist for cataract surgery and five steps to safer surgery for all patients. This is a safety checklist used to reduce the number of complications and deaths from surgery.

However, we also found the following issues that the service provider needs to improve:

- Mandatory training completion was below acceptable levels, especially in regard to safeguarding children (73%), manual handling (36%) and Deprivation of Liberty Safeguards (DoLS) (55%).
- Staff had not received the correct level of training in the safeguarding of children.

Are services effective?

Good

We rated effective as good because:

- All staff had access to policies and guidance and there was a process for updating policies. Policies were version controlled, dated and included references to national standards, guidance and law.

Summary of this inspection

- Theatre staff took steps to manage patients' pain during surgery.
- The service reported no unplanned returns to theatre from April 2016 to March 2017.
- Managers completed annual appraisals for all staff. All staff had completed an appraisal in the last year.
- The registered manager completed disclosure and barring service (DBS) checks for all new staff and reviewed these every three years.
- Patient care records contained clear documentation of consent.

However, we also found the following issues that the service provider needs to improve:

- Staff did not audit compliance with the WHO checklist. This meant senior staff did not have assurance that these safety checks were always completed.

Are services caring?

Good

Are services caring?

We rated caring as good because:

- Staff showed kindness and compassion in their interactions with patients.
- Patients we spoke to and completed comment cards were consistently positive about the service.
- Staff talked to patients and encouraged them to talk to each other before their procedure to reduce any anxieties.

Are services responsive?

Good

Are services responsive?

We rated responsive as good because:

- The number of referrals received determined the number of theatre slots booked and could be flexed to meet fluctuations in demand.
- Designated disabled parking was available. Parking at the location was free of charge. There was level access to the location and a wheelchair accessible toilet.
- The service reported no complaints from April 2016 to March 2017. There was a process in place for managing and responding to complaints.
- Discussion of compliments and complaints was a standard item on the team meeting agendas.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Staff were consistently positive about leadership of the service and told us that leaders were visible and approachable.
- Senior staff had oversight of risks to the service. The provider held a risk register, which included identified risks, mitigation strategies, and actions..
- The service did not have documented vision and strategy. However, the registered manager stated that the strategy for the service was to put patient safety first, and continuously improve the service they deliver in line with NHS Guidelines.
- Staff understood the vision of the service was to put patient's safety first. Staff understood the vision of the service is to maintain and improve the care for patients and the clinical results of patient's surgery.
- The provider monitored the competency of consultants.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as **good.**

Incidents

- No never events were reported for the period April 2016 to March 2017. Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- There was a system and process for the reporting of incidents. The incident reporting policy was adopted on 30 May 2017 and was due for review on 30 May 2020. We asked four staff about incident reporting and all could describe what constituted an incident and how to report an incident. The incident reporting form was accessible for all staff to fill in by hand.
- The service reported two clinical incidents and one non-clinical incident (all graded no harm) from April 2016 to March 2017. We asked two members of staff about learning from incidents and both could describe incidents that had occurred and where learning and discussions had taken place from these incidents. For example, an HCA told us about a change in process for checking patients' biometry at pre-assessment and on the date of their surgery.
- A consultant was responsible for investigating all incidents. Any incident that was deemed significant was discussed at clinical governance meetings, and any further training was organised and feedback provided to staff at team meetings.
- Feedback and learning from incidents was provided at team meetings and team huddles at the start of shifts. Senior staff kept an incident log, which recorded details of incidents, actions taken and the date each incident was discussed at the clinical governance meeting
- From November 2014, all providers were required to comply with the duty of candour regulation 20 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person.
- We spoke to four members of staff regarding their understanding of duty of candour. Staff understood their responsibilities with regard to the duty of candour legislation. Staff we spoke with could describe the principles of being open and honest with patients. One member of staff gave an example of when the duty of candour had been used when a procedure had not gone as planned; they apologised to the patient, explained what had gone wrong and informed them of the options for rectifying the mistake.
- We reviewed the postoperative de-briefing checklist, which included a prompt for staff to consider any errors or near misses during surgery and to report any incidents.

Clinical Quality Dashboard or equivalent

- The provider used a quality dashboard to maintain oversight of a number of metrics including, but not limited to; patient experience, infection prevention and control, quality improvement medicines management, safeguarding and incidents.
- We reviewed the dashboard for the reporting period, April 2016 to March 2017and saw that all metrics had clear review dates and were red, amber, green (RAG) rated to indicate if results fell within an acceptable range. This meant the service had oversight of the quality of the services provided to enable them to make changes should this be required.
- We reviewed the dashboard, which showed all areas were 'green', with the exception of mandatory training rates, which were rated as 'amber'. This was due the overall mandatory training completion rates falling between 75% and 89%. Training records did not include a target for mandatory training.
- The service monitored post-operative infections. The service reported no post-operative infections from April 2016 to March 2017.

Cleanliness, infection control and hygiene

- The service had cleaning services provided via the medical practice under a service level agreement (SLA).
- The clinic was visibly clean and uncluttered. The operating theatre and equipment were visibly clean.
- The entrance to the clinic and all side rooms had antibacterial gel dispensers at entrances and in the operating theatre. Appropriate signage regarding hand washing was visible at the entrance to the ward in line with World Health Organisation (WHO) guidance.
- Rooms had appropriate facilities for the disposal of clinical waste and sharps. Staff signed a label on bins used for the disposal of sharp objects (sharps bins) which indicated the date they were constructed. This was in line with regulation 5 of the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013..
- Waste was appropriately segregated with separate colour coded arrangements for general waste, clinical waste and sharps (needles). There was a separate dirty utility room available in the clinic for the disposal of clinical waste. The room was visibly clean and the floor was free from clutter. Clinical waste was correctly disposed of through agreed protocols with the medical practice.
- Clinical and non-clinical waste was clearly segregated and stored securely in appropriate coloured bags to indicate clinical waste for incineration. Removal of waste was provided under a service level agreement with the medical practice where the service was located.
- The provider had an infection control policy dated 30 June 2017. The policy was version controlled, ratified and in date for review.
- Personal protective equipment (PPE), including gloves and aprons, was available for all staff in the theatre and waiting room.
- Decontamination of surgical instruments was provided under service level agreement with a nearby NHS trust.
- All clinical areas had laminate flooring, which enabled easy cleaning. This was in line with the Department of Health (DH) Health Building Note 00-09: Infection control in the building environment.
- Surgical instruments were provided under service level agreement with a local NHS trust. Surgical instruments were delivered in sterile packaging. All packs had an identifiable barcode and serial number to allow for the tracking of instruments. Therefore, there were processes to monitor the use of, and the location of surgical instruments.
- The service did not carry out screening for Methicillin Resistant Staphylococcus Aureus (MRSA) prior to treatment. We discussed our findings with a senior consultant in the service who explained that all patients were treated using aseptic non-touch technique to prevent the spread of infection. This meant that the service were taking steps to control and prevent the spread of infection with the use of this technique.
- The service had a separate hand hygiene policy for staff to follow. The policy provided guidance on hand hygiene techniques including the World Health Organisation's (WHO)'five moments for hand hygiene'. We also saw this information displayed throughout the service as guidance for both staff and visitors. The five moments for hand hygiene focuses on five moment when hand hygiene practices should take place. This is before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings.

Environment and equipment

Good

Surgery

- The medical practice was responsible for the provision, servicing and maintenance of equipment for ACES under the existing SLA. The SLA detailed a concise list of equipment that was available for use by ACES.
- Equipment maintenance was provided under a service level agreement with an external company. We reviewed maintenance records for the phaco machine (a machine used in cataract surgery) and the microscope used in theatre. Both pieces of equipment had been serviced in line with the manufacturers' requirements.
- Theatre equipment was correctly stored, sterilised and within expiry date. However, two cartridges for use in transferring lenses were past their expiry date of 9 September 2017. Staff disposed of both cartridges at the time of the inspection.
- Nursing staff had a system for recording implants used in theatre. Nursing staff logged lens implant stickers and batch numbers in patients care records and kept a theatre record book, which contained records of each operation performed and the lens implant used. We reviewed five patient care records and found all five contained information on the lens used and its batch number. This meant that lens implants could be traced effectively if any safety issues were identified.
- The service did not have its own resuscitation trolley. Staff had access to the medical practice resuscitation trolley if required but did not have oversight of safety checks for resuscitation equipment at the time of our visit.

Medicines

- All medicines in use in the theatre were correctly stored and were within their expiry date.
- The medication fridge was locked and staff monitored the temperature on each day ACES was present at the location. This was to ensure the integrity of medicines that needed to be kept within a certain temperature range. Record checks revealed that checks had taken place on a daily basis without gaps. The temperature was automatically monitored by the medical practice on days that ACES staff were not at the location. ACES staff were alerted by the medical practice staff if the fridge temperature had gone outside its acceptable range.
- The main medicines store was at the provider's main site. When staff attended ACES Fakenham, medicines were transported in a cooled, secure container, which was kept with a doctor or nurse at all times and then transferred to the medicine fridge.
- We reviewed five patient care records and found that medicines were appropriately documented and signed for by medical and nursing staff. Staff clearly documented patient allergies in all records.
- No controlled drugs were stored or administered at the location. The service did not use any cytotoxic medicines at this location
- The provider held a medicines policy dated 30 May 2017, which was version controlled and in date for review. The policy referenced relevant national legislation and guidance.

Records

- Records are not stored at ACES Fakenham but are transported from another ACES location on the day of surgery. Records are transported in a locked case to and from the other ACES location, which approximately two miles away and are kept in sight of staff at all times. We observed that patient records were kept with a member of staff at all times.
- We reviewed five sets of medical records. The service used a paper based records system. The records we looked at were accurate, complete, legible, and up to date. Records included a pre-operative assessment, patient consent, and details of procedure undertaken.
- Staff told us records were transferred back to the provider's main site by a member of staff in a locked case and all notes were checked back in after transportation. Staff members did not take records home.
- The service conducted monthly audits of patient notes to ensure the correct patient information was recorded in case of emergencies. The service provided the results for the last six months audits (January to June 2017) of patient notes, which showed 100% compliance.
- There was a records management policy, dated 30 May 2017, which was in date for review.

Safeguarding

- The registered manager and one of the consultants were the leads for safeguarding. Staff we spoke with knew who the safeguarding leads were and how to contact them in the event of a safeguarding concern. Staff told us they would contact the local authority for specialist safeguarding advice if required.
- The service did not treat patients who were under the age of 18. However, children were permitted to visit the service. Whilst staff, including the safeguarding lead had

received level one training in safeguarding children and young people. This did not meet intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two, whilst safeguarding leads should be trained to level three.

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- There were no safeguarding concerns reported for the period April 2016 to March 2017.
- At the time of our inspection, 100% of staff had received level one safeguarding adult training. However, safeguarding children level one was below acceptable levels at 73%.
- We spoke with four members of staff who were all clear on the process of how to report a safeguarding concern.
- An information folder was available on the wards containing contacts for escalating a safeguarding concern. Staff we spoke with in all areas could explain the escalation process for a safeguarding concern and could provide examples of when they would raise concerns or seek advice from the trust safeguarding lead.
- The registered manager completed disclosure and barring service (DBS) checks for all new staff and reviewed these every three years. We reviewed records showing all staff working in the service had completed a DBS check.
- The provider adopted the most recent Protecting Vulnerable Adults from Abuse Policy on 30 June 2017, which was due for review on 30 June 2020. The most recent Child Protection Policy was adopted on 30 May 2017 and was due for review on 30 May 2020.

Mandatory training

- Mandatory training included; safeguarding adults, safeguarding children, information governance, infection control, fire training, equality and diversity, challenging behaviour / conflict resolution, moving and handling: theory / level 1, moving and handling: assessment / level 2, manual handling, health and safety, deprivation of liberty safeguards (DoLS), mental capacity, basic life support/cardiopulmonary resuscitation (CPR).
- Completion rates in mandatory training were variable with the lowest completion rate being manual handling at 36% and DoLS at 55%, which are below acceptable levels. However, training records did not include a target for mandatory training. The highest completion rates were safeguarding adults at 100% and fire training and infection control both at 91%. The provider had scheduled relevant update training for all staff so that they will have completed their mandatory training by November 2017.

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

- The provider was compliant with requirements for the World Health Organisation (WHO) Surgical Safety Checklist for Cataract Surgery, which is designed to reduce the risks of mistakes in surgery. During our observations in theatres, we found good compliance against steps of the checklist. Staff completed the checklist with the full surgical team present.
- We reviewed five sets of patient notes all of which contained signed and fully completed checklists.
- Pre-operative assessments took place approximately two weeks before the scheduled operation at another of the providers' locations. Pre-operative assessments included an assessment of the patients' general health prior to surgery, informing the patient of the details of the procedure, gaining consent and advice on how to access to further information.
- The service had an acceptance and exclusion criteria in place to ensure that only clinically safe patients were able to access the service. The document clearly outlined patients who were unsuitable for treatment at the service due to certain exclusion criteria such as those requiring general anaesthetic, specific pre-existing medical conditions or patients under 18 years of age.
- In the event of a deteriorating patient staff described the process for alerting the nurse and consultant. Staff had access to an emergency alarm to alert staff in the medical practice to attend. In the case of an emergency staff knew to call 999 .
- There were regular observations of patients taken prior to and during surgery, however, these were not part of an early warning scoring system to identify deterioration in a patient's general health.
- All patients were provided with 24-hour post-operative telephone number for the on call consultant in case their condition deteriorated after discharge. If a patient

should need to contact someone in an emergency and the situation could not be dealt with by the provider then patients would be advised to attend the local emergency eye hospital department as an NHS patient
- There was no service level agreement with the local NHS trust to transfer a patient whose condition had deteriorated. Patients were told to contact their GP or attend the local hospital if required.

Nursing and medical staffing

- The provider planned and reviewed staffing levels and staff skill mix so that people received safe care and treatment at all times. The registered manager was responsible for scheduling and staffing the location. However, a staffing tool was not used.
- On the day of our inspection, there were three nursing and support staff working. This was adequate to meet patients' needs.
- The provider did not employ bank or agency nurses. Staffing levels were arranged approximately two weeks in advance when a full theatre list was known. Staff sickness and annual leave was covered by staff from other locations run by the provider if required.
- There was 24-hour dedicated mobile telephone access direct to a consultant for the immediate postoperative period in case the patient deteriorated or they had questions or concerns regarding their surgery.
- Three eye specialists delivered all the care and treatment to patients at the location under practicing privileges. All three eye specialists were on General Medical Council (GMC) specialist register in ophthalmology.
- The directors of ACES were responsible for ensuring revalidation of clinical staff.

Major incident awareness and training

- The provider had a Business Continuity Plan that was next due for review in September 2017.
- The medical practice had a back-up generator on site in case of loss of power to ensure that if there was a power cut during a procedure patient safety would not be compromised.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- Practice guidelines, for example National Institute of Health and Care Excellence (NICE) guidance on management of cataracts in adults were available to staff at the location to ensure practice remained in line with national guidance. Guidance and information for patients was based on Royal College of Ophthalmologists (RCOphth) guidelines.
- We reviewed a selection of the provider's policies and procedures and found that they were version controlled, dated and included references to national standards, guidance and law, for example the medicines policy contained applicable reference to the Medicines Act 1968 and the Misuse of Drugs Act 1971.
- The provider had a process in place for reviewing and updating policies. Senior staff reviewed and approved policies and procedures at clinical governance meetings, which took place every two months.
- All staff we spoke with could identify how to locate policies when required. Staff confirmed that policies were regularly updated and that they were notified of updates.
- The provider conducted a variety of local audits, including hand hygiene and patient waiting times.
- Staff did not audit compliance with the World Health Organisation (WHO) surgical safety checklist for cataract surgery and five steps to safer surgery. This meant senior staff did not have assurance that these safety checks were always completed.

Pain relief

- Nursing staff gave patients a local anaesthetic injection to prevent pain during their procedure
- We observed the theatre nurse checking on a patient's comfort and asking the patient whether they had any pain.
- Patients could contact the service directly during normal operational hours if they had any issues, and speak to a nurse or their consultant if they were

experiencing any pain after a procedure. If the clinic was not open, patients could contact their general practitioner (GP) or attend the local hospital in the case of an emergency.
- Staff advised patients to obtain any over the counter medication for pain from the onsite medical practice pharmacy.
- All four patients we spoke with during our inspection had not required supplementary pain relief during their appointments.

Nutrition and hydration

- All patients are offered a glass of water on arrival and a hot drink and a biscuit post-surgery.
- All four patients we spoke with felt the level of nutrition and hydration provided was appropriate and sufficient.

Patient outcomes

- The service started submitting data to the Royal College of Ophthalmologists (RCOpth) national audit in September 2017. No results from this audit were available at the time of our inspection.
- The provider takes part in the capsule rupture audit for consultants, which can benchmark the capsular rupture rate against the RCOpth published rates. The provider provided the details of the most recent audit for all three of their surgeons, which gave an average capsular rupture rate of 0.49% over the period April 2016 to March 2017 which was much better than the 2%.benchmark set by the College of Ophthalmologists .
- The service reported no unplanned patient returns to theatre from April 2016 to March 2017.
- Senior staff monitored complications following cataract surgery. The service reported no post-operative complications from April 2016 to March 2017. Audit results dated September 2016, January 2017 and May 2017 confirmed this.
- Staff monitored visual improvements following cataract surgery and consultants told us they compared results against the RCOpth national dataset as part of their appraisal process. Records dated September 2016, January 2017 and May 2017 confirmed these visual outcomes were monitored.

Competent staff

- The provider had an induction programme for new members of staff, which included safeguarding adults and children, fire, health and safety and confidentiality. We reviewed an example of a checklist for one member of staff, which was completed appropriately.
- As of September 2017, all staff had received an annual appraisal. All staff we spoke with said appraisals were a positive experience with follow up from managers. Staff told us that they felt well supported and senior staff gave support and supervision.
- Staff appraisals included records of role-specific competencies, which staff completed annually. These included topics such as visual fields, biometry, and administering medication.
- Nursing staff we spoke with told us they felt supported to develop new skills, train and progress within the provider. One member of nursing staff was being supported to train as an advanced nurse prescriber.
- A consultant provided clinical training to health care assistants once a month so they could be prepared to answer questions and queries from patients and relatives about their procedure.
- We reviewed records showing that senior staff monitored registration and revalidation with the Nursing and Midwifery Council and General Medical Council (GMC) for all professionally qualified staff.
- Staff attended team meetings every two months. Meeting minutes dated February 2017 and April 2017 showed discussion of significant events, complaints, and changes to systems and processes.

Multidisciplinary working

- We observed medical, nursing and support staff working together effectively in theatre and waiting areas. Staff we spoke to were positive about their working relationships and support form senior staff.
- All five patient records we looked at included a referral from a GP and a follow up report back to the patients GP and optometrist with findings and any recommendations.
- Staff reported a positive working relationship with reception staff at the medical practice who often had to signpost patients to the service.

Seven-day services

- The location did not provide access to seven-day services. The service operates on Tuesdays 8.30am to

12.30pm and Fridays 8.30am to 12.30pm and 1.30pm to 4.30pm. Clinics were arranged depending on patient demand. This was sufficient to see the patients accessing the clinic.

- The consultants who have operated on patients are on call for 24 hours after surgery or all weekend/bank holiday if the surgery takes place on a Friday to ensure patients' have a point of contact outside normal GP opening hours. Consultants could access the building out of hours if patients required or they have the option of attending an alternative ACES location if that was more convenient for the patient.

Access to information

- Patients were referred to the service by optometrists or their GP, through e-referral. Patient appointments were managed centrally at another location run by the provider.
- Medical records for surgical patients contained discharge information, which was shared with the referring optometrist and the patient's GP.
- Patient care records were kept in paper format and were accessible to staff. Records were kept in a locked case, which was in sight of staff at all times.
- Staff could access policies and guidance online or in paper format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a policy for consent to treatment or examination, which included guidance on the Mental Capacity Act (MCA) 2005. We reviewed the document, which provided clear guidance for staff. The policy also referred to the Deprivation of Liberty Safeguards (DoLs) and clearly referenced the responsibilities of staff. This policy was within its review date. Staff had access to this policy at the location.
- Staff we spoke with understood the principles of the MCA and DoLs.
- We reviewed five sets of patient notes, all of which had documented that patient consent was gained prior to treatment at their pre-operative clinic. The provider ensures informed consent is given by explaining and providing written information about all risks, benefits, and realistic outcomes of the surgery.
- We observed staff re-confirming patients' consent to procedures at the time of surgery.
- The service demonstrated that patients were given a 'period of reflection' between the pre-operative assessment and surgery being performed to give them time to change their mind.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- We observed staff to be polite and friendly towards patients and relatives.
- We spoke with four patients who were unanimously complimentary of staff and the service. They all stated they were treated with kindness and compassion.
- We observed staff interacting with patents in a professional and compassionate manner in theatre and in the waiting area.
- Staff told us they talked to patients and encouraged them to talk to each other before their procedure to reduce any anxieties.
- Patients told us staff were kind, respectful and always introduced themselves; this was also observed during the inspection.
- We observed the health care assistants being kind, courteous and helpful when talking to patients on arrival.
- Patients told us that their privacy and dignity was always maintained. Staff told us that patients were always offered a private room for the pre-operating discussions. Patient privacy was maintained whilst in side rooms by the use of an inner curtain.
- During our inspection, all four patients we spoke with said they would recommend the clinic.
- One patient described staff at the service as "Caring and helpful." Another patient stated, "I can't fault any aspect – it's the second time I've been and it couldn't me more pleasant."
- The service conducted an annual patient satisfaction survey in annually each September. The most recent survey was conducted in September 2016. Nineteen patients responded to the question on quality of care from theatre staff, with 15 rating it as excellent and four

as good. Nineteen patients responded to the question on quality of care from the health care assistant (HCA) after surgery with thirteen rating it as excellent and five rating it as good**.**

Understanding and involvement of patients and those close to them

- Patients we spoke with told us that their treatment was discussed and explained to them in detail and in a manner they were able to understand.
- Consultants provided advice and information in relation to treatment and the next steps after their pre-operation consultation and operation.
- Patients were given the opportunity to be accompanied by a friend or relative during consultations and during the procedure.
- During our observation of a patient journey, the patient was fully briefed beforehand and their relative was informed about the likely duration and directed to waiting areas.

Emotional support

- Patients were given the option of a having their pre-operation discussion in private which meant people could discuss their emotional needs in confidence.
- All four patients we spoke with said that they were part of the decision making process regarding their treatment plan. All four patients gave specific praise for the emotional support they had received from staff prior to and post-surgery.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- Local clinical commissioning groups (CCGs) commissioned the service and provided NHS funded services for patients in a local health centre without the need for patients to attend a hospital.
- The provider offered surgery services all year round and surgery was scheduled at least three weeks in advance dependent on patient need to ensure patients could plan their journey to and from the location and ensure sufficient personal support.
- The number of referrals received determined the number of theatre slots booked. Senior staff told us if demand increased, there was the option of booking additional theatre slots. If there was a rise in demand at the point of pre-assessment then they would increase the number of theatre slots booked to match this.
- Designated disabled parking was available. Parking at the location was free of charge. There was level access to the location and a wheelchair accessible toilet.
- There were clear processes for planning ongoing care in the community for surgery patients post discharge from the service, for example arranging referral to the patients' optician or GP as appropriate.
- Patients told us they were offered a choice of appointments to suit them.
- Access to the clinic was provided via the main entrance of the medical practice. Patients were sign posted to the ACES waiting area where a member of ACES staff met them. The entrance to the clinic was clean, clear of clutter and well lit. There was adequate seating in patient waiting areas.

Access and flow

- The patients' general practitioner (GP) or optometrist referred them to the service. Information from the provider showed the average waiting time for surgery at ACES Fakenham was six weeks.
- The service had not cancelled any procedures in the reporting period April 2016 to March 2017.
- The service monitored patient waiting times by ensuring there was enough capacity upon the receipt of the referral to the date of pre-assessment and surgery. If there is a rise in demand at the point of pre-assessment, the service matched the capacity for the surgical demand by scheduling further appointments or more staff.
- The service monitored referral to treatment times (RTT) for surgical appointments. For the months of October 2016 to December 2016, patients waited on average six to seven weeks for surgery. For the months of January 2017 to March 2017, patients waited on average nine weeks for surgery.

Good

Surgery

- Information from the provider showed the average waiting time from arrival at the location before going into surgery was five to 10 minutes.
- Patients were discharged home on the day of surgery and received a follow up appointment one to two weeks after surgery at another ACES location.

Meeting people's individual needs

- Staff knew of the availability of interpretationservices for people who did not speak English as a first language. Thesecould be provided by telephone or face-to-face.
- The service had access to a sign language interpreter for patients who werehearing impaired.
- Senior staff were aware of the accessible information standard and told us they were compliant with the requirements of this standard. The accessible information standard tells organisations how they should make sure that patients and service users, and their carers and parents, can access and understand the information they are given.
- Staff did not receive specific training on dementia or learning difficulties. However, staff described a good working knowledge of dealing with patients with additional needs.

Learning from complaints and concerns

- The service had received no complaints during the reporting period April 2016 to March 2017.
- The provider complaints policy was adopted on 20 May 2017 and was next due for review on 30 May 2020. The provider policy stated that complaints were discussed at clinical governance meetings and at team meetings. It was the responsibility of the ACES Board to review the handling of complaints and compliments.
- The registered manager initially dealt with complaints and discussed these with the nominated individual. The policy set out processes timescales which stated provider contacted patients by their preferred communication method and all details confirmed in writing. All complainants should receive a written acknowledgement within two working days of receipt of their complaint (unless a full reply can be sent within five working days) and a full response within 10 working days of receipt of the complaint.
- We reviewed team meeting minutes dated February 2017 and April 2017, which showed that discussion of compliments and complaints was a permanent item on the agenda.
- The registered manager stated that any learning from complaints would be shared with all relevant staff.

Are surgery services well-led?

Good

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

Leadership / culture of service related to this core service

- The service is led by the nominated individual, the responsible officer and the registered manager supported by a multidisciplinary team. Staff had access to senior registered nurses for support.
- All staff we spoke with were clear in the line of reporting to senior management and told us they felt valued, supported and respected in their roles.
- Staff told us that they felt confident to approach their immediate manager with any concerns. Staff informed us they received feedback and guidance from their line managers.
- All staff we spoke with thought highly of the management team. Staff told us that managers were supportive and created a positive culture for the service.

Vision and strategy for this core service

- The service did not have documented vision and strategy. The registered manager stated that the strategy for the service was to maintain patient safety and continuously improve the service they deliver in line with NHS guidelines.
- The leadership team had a clear strategy going forward with an oversight of the aims of the provider and a shared commitment from all senior leaders. This was in line with the Royal College of Ophthalmologists clinical guidelines.
- Staff told us they understood the strategy of the service was to put patient's safety first. Staff understood the vision of the service to always look to improve the care for patients and the clinical results of patient's surgery.
- The strategy for the future of the service is to move out of the medical centre and provide all services at an alternative ACES location. This would avoid the patients

having to travel to two separate locations for pre-operative assessment, surgery, and post-operative care. It would also give the service more control and flexibility over how they deliver the service.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The location risk register was reviewed as part of clinical governance and risks were appropriately mitigated as far as possible. All risks identified by the inspection team were on the existing risk register and staff we spoke with was aware of the risks. Current risks included staff training, infection control and medicines. The risk register including mitigation strategies and outstanding actions, for example the service had instigated further monitoring of medicines storage and planned further audits to mitigate the risk. However, the register did not include a date that the risks were first identified or a target completion date.
- Governance meetings took place every two months at the provider's main site. Senior medical and administrative staff attended governance meetings from all sites run by the provider. We reviewed four sets of meeting minutes dated from 27 October 2016 to 4 May 2017, which showed meetings included discussion of incidents, complaints and compliments and information governance.
- The provider had a process in for monitoring the competency of consultants. Senior leaders had oversight of consultants' revalidation status and yearly appraisals, which included monitoring of surgical outcomes for each consultant. The registered manager kept a log of the consultants General Medical Council (GMC) registration, indemnity insurance, and copies of appraisals from any other employers.
- We reviewed four sets of board meeting minutes dated from 10 October 2016 to 11 May 2017, which confirmed that senior leaders monitored staff competency, including appraisals and revalidation.

Public and staff engagement

- The service conducted an annual patient satisfaction survey in annually each September. The most recent survey in September 2016 found that all 28 respondents gave the service an "Excellent" rating.
- Information was shared with staff at team meetings, which took place every two months. We reviewed meeting minutes dated February 2017 and April 2017, which showed meetings, included discussion of incidents, complaints and compliments and updates on systems and processes. Staff we spoke with told us they attended regular team meetings with their managers and received information about changes to the service face-to-face and by email.

Innovation, improvement, and sustainability (local and service level if this is the main core service)

- At the time of our inspection, a bespoke information technology system was under development to provide all data and performance outcomes for the service.
- Senior staff told us that they intended to move the service to one location in the long term so that patients only had to visit one location for their pre-operative clinic, surgery and post-operative care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the level of safeguarding training staff receive is in line with the Royal College of Paediatrics and Child Health safeguarding Children and Young People: roles and competence for health care staff, Intercollegiate Document.

Action the provider SHOULD take to improve

- The provider should ensure there is assurance regarding staff compliance with the World Health Organisation (WHO) surgical safety checklist for cataract surgery and five steps to safer surgery.
- The provider should ensure that nursing and medical staff complete all necessary safeguarding and mandatory training including basic life support.
- The location risk register should include a date that risks were first identified and a target completion date.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to prevent abuse of service users** **How this regulation was not being met:** • Staff were not trained to the correct level for the safeguarding of children, in line with the Royal College of Paediatrics and Child Health safeguarding Children and Young People: roles and competence for health care staff, Intercollegiate Document. **Regulation 13(2)**