ACES (Cromwell Road)

Quality Report

32 Cromwell Road,
Wisbech,
Cambridgeshire.
PE14 0SN
Tel: 01945 466222
Website:www.aceseyeclinic.co.uk

Date of inspection visit: 5th and 6th September 2017
Date of publication: 12/12/2017

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?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Overall summary

ACES (Cromwell Road) is operated by Anglia Community Eye Services. The service, which was founded in 2007, is an independent provider of NHS Eye Services, where patients are able to receive eye care in the community from Consultant Ophthalmic Surgeons. The location at Cromwell Road is one of four locations in the ACES group.

Facilities at ACES Cromwell Road include two operating theatres, one laser treatment room, four consultation rooms and six diagnostic rooms.

The main service provided is non-laser cataract surgery. Other surgery provided at the service includes eyelid and lacrimal (eyelid) surgery and outpatient clinics. The service provides all surgery under local anaesthetic only. All patients attending the service for consultation or treatment are at least 18 years of age.

ACES Cromwell Road has had a registered manager in post since May 2015.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 September 2017 along with a further announced visit to the service on 6 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.

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

Services we rate

We rated this hospital good overall.

We found the following areas of good practice in relation to surgery:

- 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.
- There were robust incident reporting processes. All staff we spoke with knew how to report and escalate incidents. Staff were clear about their responsibilities in relation to the duty of candour.
- There were effective infection prevention and control measures.. All areas within the surgical department were visibly clean.
- Medical records were complete, legible and up to date.
- Staffing within the surgery department was planned in advance and sufficient to meet the needs of the patients.
- There were systems to record all implants used during surgical procedures.
- Senior nursing and managerial staff monitored staff competencies for both nursing and medical staff.
- The service had received consistently positive feedback from patients. All patients we spoke with reported staff were kind and caring whilst maintaining their dignity and privacy.
- Senior staff ensured the service was planned and delivered to meet the needs of patients. Access to the service was seamless and in a timely manner.
- The service had an effective governance framework. Clinical governance meetings demonstrated a good attendance by a broad range of staff.
- Staff reported a positive culture within the service. Staff described senior managers as "supportive and approachable".

However, we also found areas for improvement:

- We found cytotoxic medicines that had not been risk assessed, managed or stored safely. We highlighted our concerns to the registered manager who took prompt action in the suspension of this medicine prior to implementation of appropriate risk assessments, policy amendments and provision of guidance for staff.
- We found an out of date medicine in an emergency resuscitation trolley. Staff had not checked this equipment on a regular basis. However, when we raised our concerns, the registered manager took immediate action to replace the out of date medicine and implement new checking procedures.
- The risk register did not contain all risks relevant to the service; the use of cytotoxic medicines was not on the service's risk register. However, when we raised our concerns, the registered manager took immediate action to address our concerns.

We found the following areas of good practice in relation to outpatient care:

- All staff we spoke with knew how to report and escalate incidents and safeguarding concerns. We saw evidence that learning as a result of incidents was shared with staff.
- All outpatient areas, both clinical and non-clinical were visibly clean, well-organised and free from clutter.
- Equipment was well maintained and serviced within recommended periods. Personal protective equipment (PPE) was available for staff where required.

Summary of findings

- The service had an acceptance and exclusion criteria in place, which clearly outlined patients who were clinically safe to access the service.
- Staffing within the outpatient department was sufficient to meet the demand of patients.
- The service had received consistently positive feedback from patients. During our inspection we saw that staff treated patents in a kind and friendly manner, treating them with respect.
- Staff working within the outpatient department told us they were well supported and encouraged to develop in their role.

However, we also found areas for improvement:

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected Anglia Community Eye Services Cromwell Road 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 main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated surgery as good because the service was safe, effective, caring responsive and well-led. We found: Incident reporting processes were robust. Staff understood their responsibilities in relation to the identification, reporting and escalation of incidents and safeguarding concerns. The service had effective infection prevention and control processes. All areas were visibly clean. The surgery service had adequate nursing and medical staffing in place to meet the need of patients. Medical records were complete, legible and up-to-date. Policies were evidence based and referenced national guidance. All policies were in date and easily accessible to staff. The surgery department demonstrated effective multidisciplinary working as part of a cohesive team. Patient feedback was consistently positive. Patients told us they felt cared for and respected. We saw staff treating patients with courtesy and respect during our inspection. Patients were able to access the service in a timely manner. The service was meeting the demands of the local community. The service had an effective governance framework. Staff reported a positive culture and told us they felt respected and supported by senior management. **However, we found the following areas the service should improve**: Risk assessments for cytotoxic medicines were not in place. We could not gain assurances that these medicines were being overseen, managed and stored safely.

Summary of findings

The risk register did not contain all risks relevant to the service; the use of cytotoxic medicines was not on the service's risk register. However, when we raised our concerns, the registered manager took immediate action to address our concerns.
We found an out of date medicine in an emergency resuscitation trolley. We reviewed check sheets, which demonstrated staff had not checked this equipment on a regular basis.
Staff had not received the correct level of training in the safeguarding of children.

Outpatients and diagnostic imaging

Good

We rated outpatients as good. This was because the service was safe, effective, caring responsive and well-led.
We found:
Incident reporting processes were robust. Staff understood their responsibilities in relation to the identification, reporting and escalation of incidents and safeguarding concerns.
The service had effective infection prevention and control processes. All areas within the outpatient areas were visibly clean.
The outpatient service had adequate nursing and medical staffing in place to meet the patients' needs. Medical records were complete, legible and up-to-date.
The outpatient service demonstrated effective multidisciplinary working as part of a team. During our inspection we saw effective communication taking place between staff in the outpatient department.
Patient feedback was consistently positive. Patients felt cared for, supported and respected.
Patients were able to access the outpatient service in a timely manner. The service was meeting the demands of the local community.

Summary of findings

Contents

Good

ACES (Cromwell Road)

Services we looked at

Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to ACES (Cromwell Road)

ACES (Cromwell Road) is operated by Anglia Community Eye Services (ACES). The service opened in 2015. It is a private hospital in Wisbech, Cambridgeshire. The hospital primarily serves the communities of Wisbech and the local area of North Cambridgeshire and West Norfolk. The hospital also accepts patient referrals from outside of this area.

Care and treatment is funded by a number of local NHS clinical commissioning groups (CCG's) and the service is offered to NHS patients over the age of 18 years old. The service does not offer care to privately funded patients.

The service has had a registered manager in post since May 2015.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one CQC inspector.

The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Why we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 September 2017 along with a further announced visit to the service on 6 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.

How we carried out this inspection

During the inspection, we visited all clinical and non-clinical areas in the surgery and outpatient departments. We spoke with 16 staff including; registered nurses, health care assistants, reception staff, medical staff and senior managers. We spoke with eight patients and one relative. We also received 133 'tell us about your care' comment cards which patients had completed prior to our inspection. During the course of our inspection, we reviewed 12 sets of patient medical records.

There were no special reviews of investigation of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with the CQC on 30 April 2015.

Information about ACES (Cromwell Road)

ACES Cromwell Road has two operating theatres, four consultation rooms, six diagnostic rooms and a laser treatment room. The service is registered to provide the following regulated activates:

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

Summary of this inspection

During the reporting period of April 2016 to March 2017, the service carried out 2,123 phacoemulsification cataract surgery procedures and 604 lid and lacrimal procedures. In addition to surgery, the service carried out 7,488 outpatient clinic appointments for glaucoma, diabetic outpatients and general ophthalmic outpatients during the same period.

At the time of our inspection, there were 10 consultants, one optometrist, three specialist ophthalmic nurses (registered nurses), three registered nurses and 19 healthcare assistants (HCA's) in post. The service did not have a controlled drugs accountable officer (CDAO) in post, as there were no controlled drugs held on site.

During the reporting period of April 2016 to March 2017 in relation to both the surgery and outpatient department:

- There were seven clinical incidents in the outpatient department and no reported incidents in the surgery department. All incidents within the outpatient department had been classified as no harm.
- There were 27 non-clinical incidents during the same reporting period.
- There were no never events.
- There were no episodes of methicillin resistant staphylococcus aureus (MRSA) and no reported incidences of hospital acquired methicillin-sensitive staphylococcus aureus (MSSA).
- The service had received three complaints in the reporting period, one of which one had been referred to the Parliamentary Health Service Ombudsman (PHSO). This complaint was not upheld by the PHSO and related to the outpatient department.

- Services accredited by a national body:

- A national body does not accredit the service.
  - Services provided at the service under service level agreement (SLA):

- Sterilisation of instruments
- Laundering of theatre scrubs
- Clinical waste removal
- Confidential Waste Removal
- Recycling and general waste removal
- Pathology services
- Radiation Protection Adviser support
- Maintenance of medical equipment
- Water risk assessment
- Air Handling unit maintenance
- Theatre battery back-ups/controls/trolleys maintenance
- Theatre phacoemulsification machines maintenance
- Theatre microscope maintenance
- Laser equipment maintenance
- Information technology hardware and backup maintenance
- Hoist maintenance
- Outpatient clinic equipment maintenance
- Air conditioning maintenance
- Building management system maintenance
- Plant room boiler servicing
- Lighting maintenance
- Fire extinguisher maintenance
- Cleaning services
- Human resources support
- Health and Safety Support

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:

- Staff knew how to report incidents. There were processes to report and share learning as a result of incidents. Staff were aware of their responsibilities in relation to the duty of candour.
- There were effective infection, prevention and control measures. All equipment, clinical and non-clinical areas were visibly clean, free from clutter and well maintained.
- Medical records were complete, legible and up-to-date.
- All staff we spoke with knew what constituted a safeguarding concern and how to report them.
- The service had a clear acceptance and exclusion criteria. This meant that the service only accepted patients that were clinically safe for treatment at the service.
- The service had adequate nursing and medical staffing to ensure patients' needs were met.

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

- We found cytotoxic medicines that had not been risk assessed, managed or stored safely. The service did not have a Control of Substances Hazardous to Health (COSHH) risk assessment or any other procedure to ensure the safe use of cytotoxic medicines. However, when we raised our concerns, the registered manager took immediate action to address them.
- We found an out of date medicine in an emergency resuscitation trolley. Staff had not checked this equipment on a regular basis. However, the registered manager took immediate action to replace the medicine and implemented new checking procedures to prevent this happening again.
- Staff had not received the correct level of training in the safeguarding of children.

Are services effective?

Good

We rated effective as good because:

- Policies in use were evidence based and reflected current evidence based practice. Policies were in date, version controlled and accessible to all staff either electronically or in paper format.
- Staff ensured that adequate pain relief was provided during surgery. Staff provided patients with further guidance and information on discharge in relation to pain relief.

Summary of this inspection

- The service was meeting the nutritional and hydration needs of patients.
- The service carried out audits to monitor patient outcomes in relation to surgical procedures.
- There were no unplanned returns to theatre from April 2016 to March 2017.
- Nursing, medical and administration staff had completed annual appraisals. Senior nurses and managerial staff oversaw competencies to ensure that staff remained up to date and competent in their role.
- The service demonstrated effective multidisciplinary working as part of a team. The service regularly communicated with the referring healthcare professional to ensure that outcomes of treatment and surgery were being shared amongst professionals.
- All medical records that we reviewed contained documented consent. Staff were clear in their responsibilities in relation to consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs).

Are services caring?

Outstanding ☆

We rated caring as good because:

- Patient feedback cards and surveys provided consistently positive feedback about the service and its staff. Patients told us that they felt well cared for, respected and that staff had treated them in a professional manner.
- During our inspection, we saw that staff interacted with patients in a kind and professional manner. The services ensured that there were processes to maintain the patient's privacy and dignity.
- Patients had access to information that explained their care and treatment. All patients we spoke with reported feeling well informed on the care and treatment.
- Staff were highly motivated to provide high quality care.

Are services responsive?

Good

We rated responsive as good because:

- Senior managers were driven to provide an efficient service for the local population.
- Access to both outpatient and surgical services was seamless. Patients were seen in a timely manner for both surgical and outpatient appointments.
- The service met the demands of the local community.

Summary of this inspection

- The individual needs of patients were being met. The service provided access to translation services. In addition, public transport routes had been adapted to provide a bus stop directly at the service's location.
- The building and surrounding grounds had been purpose built to ensure all access was on one level. There were wheelchair accessible toilets within the building.
- The service handled complaints within designated timeframes. The service had clear processes and policies for the handling of complaints.

Are services well-led?

Good

We rated well-led as good because:

- The service's vision was to continuously improve the service that they delivered in line with NHS guidelines.
- There was an effective governance framework. Staff reported a positive culture within the service and that senior managers were approachable, supportive and respectful to all staff.
- Clinical governance meetings took place on a regular basis. A broad range of staff attended meetings and team meetings demonstrated a good attendance.
- Staff engagement took place on a regular basis. All staff were encouraged to forward their views and ideas to improve the service that was provided.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Outstanding	Good	Good	Good
Overall	Good	Good	Outstanding	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

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

We rated safe as **good.**

Incidents

- The service had an incident reporting policy. Staff could easily access this policy either electronically or on paper. We reviewed this document and saw it clearly identified the action to take in the event of an incident, with clear lines of responsibility for the reporting and investigation processes.
- The service used a paper-based system to report incidents. The registered manager and nominated individual oversaw all incident investigations. We spoke with six members of staff of various grades that were all able to say what constituted an incident and the incident reporting process.
- The service had no never events reported from April 2016 and March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic barriers, are available at a national level, and should have been implemented by all healthcare providers.
- From April 2016 to March 2017, there were no reported clinical incidents or non-clinical incidents within the surgery department.
- The registered manager held monthly meetings with staff and used this opportunity to discuss and share learning from incidents from both the surgery and outpatient departments. We reviewed meeting minutes for June, July and August 2017 and saw that discussions around incidents had taken place and staff had received a presentation on serious incidents. In addition, discussion around incidents and significant events took place at bi-monthly clinical governance meetings.
- The incident reporting policy outlined requirements for the 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 staff we spoke with knew their responsibilities regarding the duty of candour. However, the mandatory training rates for duty of candour were not included in the information provided. There were no working examples of the duty of candour being used, as there had been no incidents at the time of our inspection.
- A clinical outcome form was included and completed in all the patient records reviewed. Post-surgery complications were documented and reported as an incident if picked up at the post surgery appointment. There were no reported infection rates or complications reported between April 2016 and March 2017.

Clinical Quality Dashboard or equivalent

The service 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'.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control (IPC) policy. We reviewed the policy and saw that it was within its review date and reflected national guidance. The policy clearly outlined responsibilities of all staff to prevent and control the risk of infection. The service provided was in line with Royal College of Ophthalmologists (RCOphth) professional standards and guidance.
- 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 service level agreement (SLA) with an external company to provide general cleaning services. Over the course of our two-day inspection, all areas and equipment were observed to be visibly clean.
- We saw evidence that the deep cleaning of waiting areas had taken place in both April 2017 and August 2017.
- Requested data demonstrated that deep cleaning of theatre environments had taken place in all months from October 2016 to September 2017. However, no data was submitted for the months of November 2016, February 2017 and March 2017.
- Intraocular surgery was performed in a minimal access ophthalmic operating theatre environment. Electronic systems were in place to check the humidity and temperature within the theatre area. This meant that the temperature and humidity levels could be set to ensure consistency. This was an automated central electronic system, which alarmed should normal ranges be exceeded. The system then 'self-corrected' to ensure that humidity and temperature were kept within range, backed up by generator in the event of loss of mains power.
- All clinical and non-clinical areas in the surgery department had appropriate flooring which enabled effective cleaning and was in line with the Department of Health's, Health Building Note 00-09: Infection control in the building environment.
- 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.
- A registered nurse was the lead infection prevention and control nurse with the registered manager having overall responsibility for the prevention and control of infection.
- Infection prevention and control was a standard agenda item at the bi-monthly clinical governance meetings. We reviewed the minutes of these meetings from May 2017 and June 2017 and saw that discussion had taken place around deep cleaning and IPC training. We also reviewed the minutes of the monthly team meetings from June 2017 to August 2017 and saw that IPC had been discussed. The minutes demonstrated that topics such as environmental cleanliness, IPC training and air quality had also been discussed.
- As of September 2017, 94% of staff had received training in infection prevention and control as part of their mandatory training.
- The service did not carry out MRSA screening prior to surgery. We raised our concerns with the nominated individual for the service and registered nurse who confirmed that all patients were treated as if they had MRSA, with the use standard precautions such as aseptic no touch technique to prevent the spread of infection.
- The service was housed in purpose built premises. All clinical and non-clinical areas were visibly clean and free from clutter.

- Hand washing facilities, including access to liquid soap, paper towels and hand cleansing gel were available in clinical and non-clinical areas for both staff and patient use.
- Hand hygiene audits were carried out on a monthly basis. Data showed 100% compliance for the months of January, May and August 2017. However, data from the months of February (80%), June (90%) and July (70%) demonstrated non-compliance from staff. The registered manager told us that should concerns be identified, staff were challenged on the spot to rectify non-compliance with hand hygiene policy.
- In line with the National Institute of Clinical Excellence (NICE) guidance [CG139] guidelines, most staff were compliant with the need to be 'bare below their elbows' . However, we saw one member of staff wearing jewellery that was non-compliant with service's hand hygiene policy. We escalated our concerns to the registered manager who immediately addressed our concerns with the staff member concerned. On the second day of our inspection, we saw that all staff were compliant with the need to have their arms bare below the elbow.
- The service carried out infection control audits every four months. We reviewed audit results for the months of February 2017 and June 2017 which demonstrated the service were mostly compliant. Audited areas included, but were not limited to: compliance with IPC training for staff, cleanliness of clinical and non-clinical areas, theatre and consultation room environmental checks. Audit results were not provided as a percentage in relation to compliance however, there were clear documented actions in place if any area was found to non-compliant.
- The service outsourced air quality testing to a third party. The annual report, from April 2017 showed no growth of bacteria or fungus in the surgical preparation room or on air plates in the theatre environment.
- The theatre trolley had an intact mattress without breaks or splits, therefore controlling and preventing the spread of infection.
- The service had adopted a waste management policy in June 2017. This provided information for staff on what constituted hazardous, clinical, non-clinical waste and sharps (needles). There was clear guidance for the handling of different types of waste and segregation with specifically coloured bags and sharps boxes in use.
- During our inspection, we saw that all clinical and non-clinical waste had been stored in correctly coloured liners.
- From April 2016 to March 2017, the service reported no cases of methicillin resistant staphylococcus aureus (MRSA) or methicillin sensitive staphylococcus aureus (MSSA). MRSA and MSSA are infections that can cause harm to patients. MRSA is a bacterial infection that is resistant to antibiotics and MSSA is a bacteria that is sensitive to antibiotics.
- There were no reported surgical site infections from April 2016 to March 2017.
- We observed that staff cleaned and disinfected all medical devices after each use. For example, the theatre trolley and patient chair to ensure good standards of hygiene. Staff discarded single use equipment in appropriately labelled waste bags and equipment requiring full decontamination was sent to a third party for sterilisation.
- All staff working within the theatre area wore dedicated specialist clothing such as scrub suits, clogs and disposable hats. The surgeon and theatre nurse removed and replaced single use disposable gowns and masks after each patient contact.

Environment and equipment

- Patients entered the surgical waiting area via automatic doors. In the waiting area there was a reception desk and an area for patients to sit and wait for both surgical and outpatient appointments. Surgical patients were placed together nearest to the theatre entrance.
- All areas including corridors to the operating theatre, theatre rooms and utility rooms were free from clutter with accessible exit routes.
- Patients and relatives had access to toilets, including wheelchair accessible toilets.
- The service had access to two phacoemulsification machines for use during cataract surgery. Both machines had received a service within the recommended period. The microscope used during cataract surgery had also received a service within the recommended period.
- The theatre trolley had been serviced within the recommended period.

- Air changes within the theatre environment were set to take place at 20-25 air changes per hour. A senior clinician told us that monitoring of air changes took place twice a year and demonstrated how this process was carried out with testing equipment stored on site.
- Staff had access to sterilised equipment. Sterilised equipment packs were clearly labelled with pack contents and date of sterilisation.
- 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 maintained a lens implant traceability register. We reviewed the register, it was complete, with cross-referencing to the patients' medical records. This enabled the recall of lenses should this be required.
- Emergency resuscitation equipment and anaphylaxis medicines were located in the waiting area. This enabled easy access for staff to respond to a cardiac arrest or allergic reaction from both the outpatient and surgical areas.
- Resuscitation equipment checks including oxygen, suction and defibrillator took place daily. We reviewed check sheets from 19 July 2017 to 5 September 2017. We saw that resuscitation equipment had been checked on all days the service was open.
- Detailed checks of emergency resuscitation equipment took place monthly, which included check of medicines and consumable items such as needles.
- Additional resuscitation equipment including oxygen cylinders, oxygen masks, resuscitation masks and tubing were in date and accessible within the theatre area. We reviewed this equipment and found all items to be well organised and easily accessible.
- The service had access to a patient hoist, which had a service contract in place and was up to date with servicing requirements. Staff had received training in the use of the hoist through manual handling training.

Medicines

- Staff had access to an up-to-date medicines management policy. This was easily accessible to staff in either paper or electronic format. The policy referenced national legislation and guidance, for example the Medicines Act (1968, amended 2003). We reviewed the policy, which contained relevant guidance for staff on the administration, supply and disposal of medicines. In addition, the policy directed staff to a chief pharmacist; based in a local trust should further guidance or advice be required.
- Access to medicine storage areas were secured either by electronic key code or eye recognition systems. Refrigerated medicines were stored securely, with only authorised personnel having access to stock.
- Medicines were correctly labelled and dispensed to patients, as required following surgery from stores held on site.
- The service did not store controlled drugs, as the use of these was not required during the surgical procedures offered.
- We reviewed 12 sets of medical records and saw that patient allergies or no known allergies were documented within each of the patient's medical records.
- An electronic system was used to monitor medicines refrigerator temperatures. An alarm notified the registered manager if the temperature fell below, or rose above recommended levels. We reviewed the system and saw that it identified changes in temperature, for example, when the fridge door was open. The registered manager received an electronic notification if safe temperature levels for the storage of medicines had been breached.
- If a breach was identified, the registered manager checked CCTV recordings to ascertain the reason for breach, for example if a fridge door had been left open. Affected medicines would then be disposed of if a temperature breach meant that the integrity of medicines could not be ensured.
- We reviewed the automated record of daily checks from January 2017 to 5 September 2017, which showed no omissions or triggers outside of the normal range.
- A designated member of staff oversaw medicine stock levels. We saw that medicines were stored securely, with only authorised personnel having access to this area.
- All medicines in the main storage area were within date, clearly labelled and well organised.
- There was no formal documented process to monitor stock levels of medicines.. We spoke with the member of staff responsible for the ordering of medicines. The staff member told us that stock levels were overseen on a visual basis. Theatre staff documented which medicines had been used during surgery so staff knew what to order to replenish used stock.

- The service carried out monthly audits to ensure deliveries of medicines reflected the stock that had been ordered from the medicines supplier. The audit showed clear actions taken in the event of deliveries being incomplete to ensure that replacement medicines could be obtained in a timely manner.
- The emergency oxygen supply was in date. The service had a contract in place for the replacement of cylinders when required.
- The service held a log of medication errors. We reviewed this log and saw there had been no documented medication errors in the four months prior to our inspection.
- The service stocked cytotoxic medicines in the medicine storage area. This sort of medicine can be applied to the eye to prevent scarring and improve the success rates of glaucoma surgery. The use of such medicines during eye surgery are 'off label'. Off label medicines are used for a different purpose to that stated on the licence.
- The service rarely used cytotoxic medicines. We were told that in the 12 months prior to our inspection, mytomycin C had been used on approximately two to three occasions. Cytotoxic medicines were pre-mixed however, we were not assured that there were appropriate safety measures in place for the use of these medicines.
- We did not see any documented safety procedures for staff to follow that ensured cytotoxic medicines were handled, prepared, administered and disposed of safely. We were not assured that patients were aware that they were receiving an 'off label' medication.
- The registered manager confirmed that only registered practitioners who had received additional training were permitted to administer cytotoxic medicines.
- We raised our concerns with the registered manager and nominated individual on the day of our inspection. The service removed the use of cytotoxic medicines pending the implementation of appropriate risk assessment and other precautionary measures being put in place.
- We checked emergency medicines stored within the theatre area. Contents included emergency medicines for chest pain and allergic reaction. We saw that medicines within this area were stored securely and were in date.
- We checked emergency medicines stored within the resuscitation trolley and found that chlorphenamine, used to treat allergic reactions had passed its expiry date of July 2017. We immediately escalated our findings to the registered manager who arranged for immediate replacement of this medicine. We were not assured that effective medicines checking processes in were in place. Medicines within this area should have been checked on a monthly basis. Our review of check sheets found that no monthly checks had been carried out in June, July and August 2017. We were not assured that the checking processes in place were robust.
- On the second day of our inspection, we saw that a new process had been introduced to ensure the effective checking of medicines contained in the resuscitation trolley. The new process included having a named registered nurse who would be responsible for checking this area.

Records

- There was an up to date records management policy which was accessible to staff. We reviewed this policy, which contained relevant guidance and highlighted key responsibilities for staff.
- The service had a Caldicott Guardian in place to provide further guidance and advice to staff if required. A Caldicott guardian is responsible for protecting the confidentiality of patient information and enabling appropriate information sharing.
- Medical records were paper based and created after referral to the service from another healthcare professional, for example; an optometrist or general practitioner (GP). Referrals came in to the service electronically or by letter.
- Medical records were stored securely onsite. Access to this area was restricted to allow authorised personnel only. If patient records needed transportation to other ACES locations, medical records were stored in a locked case during transportation.
- Upon completion of treatment, medical records were securely held on site. Records were then electronically scanned, prior to being securely shredded.
- We reviewed the healthcare records of 12 people who had attended the service for surgery. All records were complete, legible and up to date.
- The service carried out a monthly audit of 10 medical records. The audit paid particular attention to the completeness of medical records. From the data provided, we were unable to ascertain if records pertained to the surgery or outpatient department. Whilst the audit did not provide an overall percentage compliance figure, the audit showed that records were

complete. The registered manager and clinical director had oversight of medical record audit results and took action in the event of any concerns identified such as incomplete records.

- The service reported that a consultation with patients did not take place unless the treating clinician had access to all relevant medical records. Records were transported from other clinical sites, if required, prior to the time of surgery.

Safeguarding

- Staff had access to a safeguarding policy named "Protecting vulnerable patients from abuse". We reviewed the policy and saw it was in date and accessible to all staff either electronically or in a paper-based format. Policies included information on access to local authority guidance. In addition, there was a "child protection policy" in place**.** We saw this policy was in date.
- 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 competences 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.
- At the time of our inspection, 100% of staff had received level one safeguarding adult training and 83% had received level one safeguarding children training.
- The registered manager and one of the consultants were the named safeguarding leads for the service. Safeguarding advice and guidance was displayed in all consulting rooms and waiting areas. The safeguarding lead had received level one training in safeguarding adults and level one for safeguarding children. Whilst the service did not see or treat patients under the age of 18 years, patients may accompany children in to the premises. In March 2014, the Royal College of Paediatrics and Child Health published the Safeguarding children and young people: roles and competences for health care staff, Intercollegiate Document. This document defines the level of child safeguarding training that is required for various staff groups. Staff received safeguarding adults' level one and safeguarding children level one training.
- The provider had a "Protecting Vulnerable Adults from Abuse Policy" dated 30 June 2017, and a "Child Protection Policy" dated 30 May 2017. Both policies were in date for review and contained information to signpost staff to local safeguarding boards. Although the policies indicated that safeguarding training was necessary, they did not stipulate the level of training required. This means the child protection policy was not written in line with the Royal College of Paediatrics and Child Health Safeguarding children and young people: roles and competences for health care staff, Intercollegiate Document.
- All staff we spoke with were able to clearly say what constituted a safeguarding concern and how to follow the reporting processes.

Mandatory training

- Mandatory training was provided to staff through either electronic learning methods or face-to-face sessions. Staff had protected time to access training within their working hours and reported that learning was actively encouraged within the service.
- Training compliance was overseen by the registered manager and the nominated individual. Training records were kept with staff personal files and were up dated on the staff electronic file.
- Staff told us they had completed mandatory training through e-Learning and face-to-face training sessions. Subjects included but were not limited to; health and safety, fire safety, moving and handling, infection control, safeguarding adults and children and basic life support.
- Overall compliance with all mandatory training subjects, for both medical and nursing staff was at 86% as of 4 September 2017.The service used a dashboard to monitor compliance with mandatory training. Overall, mandatory training completion rates were rated as 'amber' as they fell between 75% and 89%.

Assessing and responding to patient risk

- The service had an acceptance and exclusion criteria 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.
- There was no service level agreement with the local NHS trust to transfer a patient whose condition had deteriorated. Staff contacted the emergency ambulance service if transfer to the local hospital was required. All patients received the 24 hour on call contact number prior to discharge following treatment.
- Patients received marking for the planned site of surgery prior to entering the theatre area. Additional surgical site checks took place once the patient was inside the theatre area to remove the risk of wrong site surgery. We saw the practice of site marking taking place on the day of our inspection.
- During surgery, lens size was checked prior to implantation and recorded in both the patients' medical records and lens implant register.
- The service used the World Health Organisation (WHO) Surgical Safety Checklist Five steps to safer surgery for Cataract surgery. The WHO checklist is a tool for clinicians to improve the safety of surgery by reducing deaths and complications. The service was therefore using evidence-based practice to ensure safety during surgical procedures.
- We observed that staff adhered to the WHO checklist and our review of 12 sets of medical records showed that this process had been completed in all records.
- The provider did not audit compliance with the World Health Organisation (WHO) surgical safety checklist for cataract surgery and five steps to safer surgery. This meant the service may not have complete oversight that these safety checks were always completed.
- The service had access to medicines in the event of an allergic reaction. In the event of patient deterioration or collapse, staff called emergency services whilst providing basic life support. All staff we spoke with were able to tell us what action would be taken in the event of a deteriorating patient.
- Staff trained in basic life support were available during all theatre sessions. The service did not have staff trained in advanced life support. One of the lowest completed training courses was basic life support, with 66% of staff having completed this course on 4 September 2017. The registered manager told us that staff had planned protected work time to complete this training in November 2017.
- After surgery, patients were provided with an emergency telephone number in the event of deterioration once at home. We spoke with eight patients who were clear on how to access this number in the event of deterioration and told us this information had been provided after surgery.

Nursing and support staffing

- The nursing and support staffing was suitable to meet the demands of the service and the needs of patients.
- The service employed registered nurses (RNs) and healthcare assistants (HCAs) in the surgery department. Data supplied by the service revealed there were two RN and four HCA full time equivalent (FTE) staff employed at the service as of 1 April 2017. The service did not use bank or agency staff.
- A dedicated team of planning staff ensured staffing levels and skill mix was planned to meet the needs of patients. The registered manager told us staff were very accommodating in working where demand was greater, which included sites across various clinical locations.
- The registered manager told us staffing was calculated to meet surgical workload and if demand increased, staffing levels were flexed accordingly. Surgical lists were reviewed one week in advance and again the day before to ensure adequate staffing was in place.
- There was a further 11.5 FTE staff in post to provide support in other areas such as administration and managerial roles.
- Staff were trained in multi skilled roles, such as theatre and outpatient care, to enable the use of staff in any area dependent on demand in surgical activity.
- As of 1 April 2016, all posts were fully staffed with no vacancies.
- From April 2016 to March 2017, staff sickness varied between 0% and 3%.

Medical staffing

- There were sufficient medical staff to meet the needs of patients.
- There were nine doctors employed in the service to provide care and treatment. Staff did not have practising privileges as they were not employed by other healthcare providers. Staff were employed directly by ACES.

Good

Surgery

- A surgeon was available on-call for a 24-hour period after surgery. This ensured that patients had access to advice and support in the event of an emergency or deterioration in their condition.

Emergency awareness and training

- The service had a business continuity plan. This provided guidance on the appropriate response in the event of an incident, maintenance in delivery of critical activities and services during an incident and also included information on the resumption of business following an incident.
- The building contained appropriate fire exit signage and 89% of staff had received fire training. Staff had recently completed a practical building evacuation exercise. There was an emergency evacuation chair for use in the event of building evacuation
- The on-site back-up generator provided a continuous electricity supply in the event of loss of mains power during surgery.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- To ensure that care and treatment reflected current evidence based practice we reviewed a number of policies including but not limited to: hand hygiene, infection prevention and control, chaperones and safeguarding children. Policies referenced national guidance and were evidence based.
- The service provided clear information on current best practice to ensure care and treatment met national standards. Guidance and information for patients was based on Royal College of Ophthalmologists (RCOphth) guidelines.
- The service carried out local audits including but not limited to; hand hygiene and environmental audits (infection prevention and control).

Pain relief

- The service provided local anaesthetic pain relief prior to surgery. Records demonstrated additional medicines were prescribed for patients to take home to prevent dry eyes and reduce post-operative pain.
- Patients received both verbal and written advice in relation to pain management after the completion of surgical procedures. Staff offered advice on additional pain relief such as paracetamol.
- During surgical procedures, we observed theatre staff asking patients if they were experiencing pain. A staff member explained how they look for subtle signs of when a patient might be experiencing pain, such as the clenching of teeth. We spoke with eight patients during our inspection, none of which reported discomfort or pain during their surgery.
- Patient information booklets and leaflets contained additional information on pain management and a contact number to call in the event of pain relief not being effective.

Nutrition and hydration

- Patients had access to free hot and cold drinks before and after surgical procedures.
- The service offered all patients refreshments and biscuits after surgery prior to leaving the premises.

Patient outcomes

- The service had recently started data collection for participation in the Royal College of Ophthalmologists (RCOphth) national ophthalmology database audit. This audit provides a snapshot audit of cataract surgery quality. Audit results were not available at the time of our inspection due to ongoing data collection.
- The service monitored patient outcomes through the use of audit. In December 2016, the service had carried out an audit to assess the efficacy of selective laser trabeculoplasty (SLT) in reducing intraocular pressure in patients with ocular hypertension and open angle glaucoma. The audit revealed improvements in intra-ocular pressure post treatment. The audit was used to inform the service of patient suitability for this treatment.
- Staff audited rates of capsular eruption (a complication of cataract surgery) which were submitted to the RCOphth. Audit results showed that from April 2016 to March 2017, 1.46% of patients had experienced this complication which is within the 2% benchmark.

- There had been no cases of unplanned return to theatre from April 2016 to March 2017.
- Post-operative assessments were carried out by registered nurse practitioners who fed back any complications or patient feedback to the surgeon responsible for each patient's care.

Competent staff

- Appraisals were carried out on a rolling year basis. During the months of April 2016 to March 2017, 100% of staff had received an appraisal. For the current year of April 2017 to March 2018, no theatre nursing and healthcare assistance staff had received an appraisal, however, all staff had a planned date for appraisal to take place in the current appraisal year.
- Staff appraisals included records of specific competencies including visual field testing and biometry. Visual field testing is used to measure central and peripheral vision. Biometry is used to measure the size and shape of the eye.
- Records demonstrated that from April 2016 to March 2017, the General Medical Council registrations had been validated for all nine doctors who worked at the service.
- The two medical directors held specialist ophthalmic qualifications and as such were listed on the general medical council's (GMCs) Specialist Register for Ophthalmology.
- The medical directors were both employed on a full time basis for this service and were responsible for the revalidation of all medical staff and ensuring continuing professional development activity.
- Yearly appraisals and revalidation processes were monitored and the registered manager maintained a log of General Medical Council registration and indemnity insurance for all medical staff working at the service. The registered manager told us that all staff had suitable Disclosure and Barring Service certificates checked at recruitment and checked again every three years.
- The use of laser policy identified the members of staff competent and trained in the use of laser procedures. The policy outlined training requirements including staff attendance to a 'Core of knowledge' course for the use of laser. Data showed that 67% of staff had completed this training. The staff awaiting this training had been previously examined and tested on the theory and practice of laser use during ophthalmologist examinations and deemed competent.
- All nursing and healthcare assistant staff we spoke with told us they felt supported in their role and were encouraged to develop and learn. At the time of our inspection, the service was funding a member of staff to complete full optometrist training.
- Senior registered nurses oversaw healthcare assistant and nurses' competencies. Records were held on internal computer systems and documented in staff files.
- During our inspection, we observed a senior registered nurse checking HCAs dual role competencies whilst carrying out the role of scrub nurse. Staff were employed as both administrative staff with provision of further training to enable them to work in any clinical environment in the service.
- Staff were encouraged and supported to attend national conferences to ensure care and treatment reflected up to date guidance. We spoke with a range of staff including doctors, nurses and healthcare assistants who confirmed senior staff encouraged learning.

Multidisciplinary working

- We saw effective communication took place between all staff including the surgeon, registered nurse and healthcare assistant in the theatre area.
- Staff in the surgical waiting area effectively communicated with theatre staff whilst maintaining the flow of patients through this area.
- The service maintained regular communication with local referring optometrists. An audit carried out from January 2017 to April 2017 had engaged local optometrists to evaluate how the local optometrist population to identify if they were aware of all the treatment and facilities that the service had to offer.

Access to information

- All medical records were always readily available and securely held on site. If the need to transfer medical records to other ACES locations was required, records were transported in locked cases.
- Medical records for surgical patients contained discharge information, which was shared with the referring optometrist and the patient's GP.

Good

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a policy for consent to examination or treatment. We reviewed this policy and saw it referenced national guidance and provided clear information to staff on consent procedures. Staff could easily access to this policy.
- The consent process was the responsibility of the surgeon who performed the surgery. Consent was obtained in the pre-operative clinic and checked between the patient and surgeon prior to transfer into the treatment area.
- We reviewed 12 sets of medical records for surgical patients. All records contained documented consent, which had been obtained prior to surgery being carried out.
- Staff had access to a policy providing information and 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.
- Staff we spoke with understood the principles of the MCA and DoLs.
- Consent was obtained prior to surgery at a pre-operative clinic appointment. At this time, the consultant also discussed the risks, benefits and possible complications following surgery. Patients were given time to think about their decision. This meant patients had a 'cooling off' period to consider their decision before surgery took place.

Are surgery services caring?

Outstanding ☆

We rated caring as **outstanding.**

Compassionate care

- There was a strong, visible person-centred culture within the service. Staff were motivated and inspired to offer care that was kind and promoted dignity. Relationships between people who use the service, those close to them and staff were caring and supportive.
- We saw that patients experienced continuity of care during their pre and post-surgical appointments. The same surgeon saw patients both prior to, during and after surgery to ensure that supportive relationships were established.
- The service had systems to ensure the patient was the focus for all staff. The reception team greeted all surgical patients on arrival. During our inspection, we observed a patient arriving in a wheelchair, staff were seen to assist and support the patient throughout their visit.
- During our inspection, we spoke with five patients. Patients described staff as: 'lovely and friendly, welcoming and kind, helpful and brilliant'. We received no negative comments about the service.
- Staff introduced themselves to patients. During our inspection, we saw staff interacting with patients in a polite and courteous manner in the theatre environment. The privacy and dignity of patients was maintained at all times.
- The service provided privacy screens in surgical waiting areas, for use in the event of a patient becoming unwell so patient dignity could be maintained.
- Patient dignity was maintained during surgical procedures. Patients remained fully clothed during operations.
- The service carried out an annual patient satisfaction survey during September 2016 with a return rate of 68%. The survey addressed 12 areas in relation to various aspects of a patient's care and treatment including questions on the environment, nursing staff, surgery and friendliness of staff. All patients responded with 'good' or 'excellent' when asked if staff made them feel at ease and if they felt listened to.
- Feedback from people who used the service was continually positive about the way staff treated patients. We sought feedback through various methods including comments cards, feedback forms and speaking with those that had used the service.
- We collected 133 comments cards from people who had used the service. All responses were positive and included comments from patients who had received eye surgery at the service.
- Patient comments included: "I am very impressed, staff were kind and my eye surgeon was very sympathetic". Another patient said: "first class service in every respect, care has been delivered in an empathetic way".

Good

Surgery

- We reviewed a further six comments, concerns or compliments forms that the service offered to patients for completion. All feedback was positive, giving the service a rating of 'excellent'. One patient had written, "it could not have been better, everyone in the clinic is friendly, professional and has gone the extra mile to ensure my appointment was the best it could be".

Understanding and involvement of patients and those close to them

- We spoke with five patients who had received treatment at the service. All patients reported they had received adequate information prior to and after surgical treatment.
- Patients told us that they were given adequate surgical appointment times to enable them to raise questions about their care or treatment without feeling rushed.
- During our inspection, we saw that staff spoke with patients to explain treatments and during surgical procedures.
- The service provided information to patients, prior to surgery informing the patient that they would need to be accompanied after surgery and unable to drive.

Emotional support

- Family members or carers praised the professionalism of the staff and confirmed that they were given appropriate and timely support by the staff.
- The waiting area was arranged so surgical patients sat together. The registered manager reported patients frequently spoke with each other about their experiences which provided support for each other in a relaxed environment.
- The service actively encouraged patients to speak with each other before and after surgery for support. We saw that the waiting area configuration aided this process as all surgical patients were seated together. We saw patients speaking with each other on the day of our inspection.
- The service welcomed relatives to stay with patients prior to and after surgery.
- Patients we spoke with told us that they felt reassured and supported by staff. One example seen from patient feedback was from a carer who praised staff for the extra time provided to discuss their emotions prior to and after treatment. This demonstrated that the staff were highly motivated to ensure that the patient's emotional and social needs were valued.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- All services were commissioned by local clinical commissioning groups (CCGs) and the service provided NHS treatment only. Senior managers were driven to provide an efficient service that met the needs of the local population.
- Surgery was offered two days per week and on alternate Wednesdays between the hours of 8am and 5pm dependent on patient demand.
- Follow up appointments were offered to all patients, one week post-surgery. These appointments involved aftercare advice, assessment for risk of infection or side effects and the possibility of the need for enhancement procedures to refine outcomes.
- The service worked with the local CCGs to understand the local community and deliver the services required on a demand basis.
- The building was purpose built and appropriate for the services that were planned and delivered. There was adequate space in both the waiting areas and theatres.
- Patient feedback had revealed that the service had addressed a comment from a patient that the distance from the car park to the building was long. The service had purchased and two wheelchairs for patients to use.
- The service received feedback that patients were experiencing difficulty accessing the service by public transport and that there was a lack of road signage indicating where the service was located. Arrangements were made to enable a bus stop adjacent to the building and a new road sign was positioned on the main road to clearly indicate where the entrance to the service was located.

Access and flow

- Patients accessed the service following a referral from an optometrist or their general practitioner (GP).
- The service had an acceptance and exclusion criteria 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.
- Upon receipt of a referral letter, the service contacted patients within 24 hours to book an appointment for consultation. If surgery was required, this was booked at the time of initial consultation with bookings taken up to six weeks in advance to ensure surgeon and theatre staff availability.
- 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 weeks for surgery. For the months of January 2017 to March 2017, patients waited on average eight to nine weeks for surgery.
- The service had monitored wait times from March 2016 which resulted in several practice changes such as, shared workload. The data submitted showed patient waiting times of more than 15 minutes between June 2016 and June 2017 had decreased to 9% from 17% in January 2017.
- When the service detected a rise in requests for theatre availability, additional theatre slots were provided to meet demand.
- The service had not cancelled any procedures due to a non-clinical reason from April 2016 to March 2017.

Meeting people's individual needs

- The service had access to an interpreting telephone service. All staff we spoke with knew how to access the interpreting service.
- Interpreting services were offered on all appointment letters to ensure that patients were aware this service was available. On the day of our inspection, we witnessed a member of the booking team actively arranging the presence on an interpreter for an upcoming appointment.
- The service provided an induction hearing loop in the reception area. A hearing loop is a sound system for use by people with hearing aids.
- The premises offered free car parking at the service. The car park had been designed with extra wide bays and clear signage was in place for those with visual impairment.
- The service had wheelchair accessible toilets. The entrance and all clinical and non-clinical areas were located on a single level for ease of access.
- Staff did not receive specific training on providing care for patients living with dementia or learning difficulties. However, staff described a good working knowledge of caring for patients who had additional needs.

Learning from complaints and concerns

- The service had a complaints policy. We reviewed the policy, which demonstrated clear processes and there were procedures for dealing with complaints.
- There had been three complaints from April 2016 to March 2016. We reviewed one complaint file and saw that the complaint had been appropriately investigated and referred to the Parliamentary Health Service Ombudsman (PHSO). This complaint was not upheld by the PHSO.
- The service provided comments, concerns or compliments forms for patients to complete. We saw these on display in waiting areas. In addition, patients were able to complete a surgery experience survey at their post-operative visit, if willing to participate.
- There were clear processes to handle complaints. In the event of a complaint not being resolved at a local level, it was escalated to the appropriate patient advice and liaison (PALS) department at the relevant clinical commissioning group (CCG).
- We reviewed the service's monthly team meeting minutes from June 2017 to August 2017. Complaints and compliments were a standard agenda item to enable the service to share the learning from complaints.
- Minutes showed that there were no new complaints to feedback to staff at these meetings. The minutes from June 2017 demonstrated that staff had been kept up to date with one ongoing complaint, which was fully resolved at the time of our inspection.

Are surgery services well-led?

Good

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

Leadership / culture of service related to this core service

- The service was led by the nominated individual, responsible officer and registered manager. In addition, staff had access to senior registered nurses for support.

- All staff told us clearly about their lines of reporting to senior management and told us they felt valued, supported and respected in their roles.
- Staff informed us that managers were proactive and that they felt confident to approach their immediate manager with any concerns. Staff told us they were regularly praised and given positive feedback from senior management.
- The service employed an optometrist who had a significant role dedicated to offering training and development for staff in the surgery teams, which included the management of post-operative side effects and complications.
- We spoke with two members of medical staff who told us the medical director was supportive and available to offer medical advice when required.
- All staff we spoke with thought highly of the management team. Staff told us that managers created a positive team culture, which resulted in it being a lovely place to work.
- The registered manager was responsible for four locations over the ACES group. The registered manager had already identified the challenges posed by oversight of multiple locations and was and told us they were in the process of recruiting an additional registered manager for other ACES locations.

Vision and strategy for this core service

- The vision and strategy for the service was not to expand, but to continuously improve the service and provide high quality care to patients, delivered in line with NHS guidelines.
- The registered manager had a clear strategy going forward with an oversight of the aims of the service and a shared commitment from senior leaders. This was in line with the Royal College of Ophthalmologists clinical guidelines.
- We saw that senior managers actively engaged staff in achieving the service's vision. Team meeting minutes from July 2017 demonstrated the registered manager actively sought staff input on what the vision should include.
- All staff we spoke with demonstrated a clear patient focus when providing care and treatment, which was reflected in all the feedback we reviewed.
- Staff understood how their role and quality of work contributed to achieving the service's vision of continuous improvement and patient safety and satisfaction.

Governance, risk management and quality measurement

- The service had an effective governance framework. The senior management team oversaw all governance processes for the service and was led by the nominated individual, responsible officer and registered manager. The senior team consisted of consultants and staff with qualifications in business management.
- We reviewed the service's risk register and saw it did not contain dates for risk entry, review or a named person for each action. This meant the provider might not have had clear documentation of the ongoing management of each risk.
- The register did not include the use of a potentially hazardous medicine. We raised our concerns with the registered manager. Following our inspection, the service voluntarily suspended use of this medicine pending implementation of further safety precautions.
- Clinical governance meetings took place bi-monthly. We reviewed meeting minutes from May 2017 and July 2017, which demonstrated a good attendance from the senior management team and other lead clinicians.
- Clinical governance meetings demonstrated a standard agenda items including but not limited to; significant events, complaints, health and safety, information governance and infection control. The service had an Equal Opportunities and Diversity Strategy, which detailed strategic priorities for 2017 to 2020. This document referenced the Equality Act (2010).

Public and staff engagement

- Team meetings took place monthly and were attended by clinical and non-clinical staff. We saw that meetings between June 2017 and August 2017 were well attended with representation from a broad range of staff working at the service.
- The service held yearly evening out to encourage staff engagement outside of the work-based setting. Staff confirmed this happened.
- The service carried out a staff survey in April 2017, which asked staffed about their opinions on communication, management, patient safety and staffing in the service.

Good

Surgery

Responses were received from 29 out of 40 staff. Survey results showed that staff feedback, in relation to management communication within the service was positive.

- The ACES group produced a staff briefing newsletter sharing information and learning across the wider organisation.
- The service engaged the public through annual patient surveys. The service actively sought patient feedback to improve services and facilities that were offered.
- The ACES website provided information for patients about the services offered and contact details for the service.

Innovation, improvement and sustainability

- The service used eco-friendly solar panels to generate electricity for the building and had an eco-friendly wood pellet boiler system in place.
- At the time of our inspection, a bespoke information technology system was under development to provide all data and performance outcomes for the service. This meant that all information would be held centrally to enable oversight of performance outcomes by senior managers in a 'real time' manner, meaning issues could be identified and rectified in a timely manner.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Incidents

- The outpatient service had no never events reported from April 2016 to March 2017.
- From April 2016 to March 2017, seven clinical incidents were reported within the outpatient service. All were classed as no harm. We reviewed all incidents from September 2016 and found no themes. Records demonstrated that discussion around each incident had taken place at clinical governance and team meetings.
- Between April 2016 and March 2017, the service reported 27 non-clinical incidents in the outpatient department.
- We reviewed one non-clinical incident relating to the outpatient department. This incident involved a letter being sent to a patient to attend an appointment however; the wrong location was communicated to the patient. As a result of this incident, new processes were introduced which included medical staff reviewing all appointment letters prior to them being sent.
- The senior manager shared an example of when the service had used the duty of candour for a patient whose referral form had not been received and immediate laser treatment could not be completed.
- For our detailed findings on incidents, please see the safe section of the surgery report.

Cleanliness, infection control and hygiene

- All clinical and non-clinical areas within the outpatient department were visibly clean and free from clutter.
- Sanitising hand gel, liquid hand soap and paper towels were available throughout the outpatient department.
- All equipment was visibly clean. Personal protective equipment (PPE) such as gloves and aprons were available in each consultation room. Patient restroom areas were visibly clean and contained liquid hand soap, sanitising hand gel and paper towels. Hand washing areas provided guidance for visitors on the 'Five steps of hand hygiene'.
- Clinical waste bins were clearly identified, and located throughout the department. Sharps (needles) containers were correctly labelled, dated, signed and had been replaced within one week of our inspection.
- The service carried out monthly hand hygiene and environmental audits three times per year across both the surgery and outpatient department. For our detailed findings, please see the safe section of the surgery report.

Environment and equipment

- Patients entered the outpatient department through automatic doors. The waiting area was spacious with chairs. All consultation and assessment rooms were within a short distance of the waiting area All clinical and non-clinical areas were well lit and had clear signage in place to signpost patients to various areas within the department. All exits were accessible.
- The laser treatment room was secure and access was for authorised personnel only. We saw that keys to this area were stored securely, with the key clearly marked as 'laser key'.
- Equipment was maintained and serviced in accordance with manufacturer's guidance. The YAG laser (a laser

used after surgery) and Selective Laser Trabeculoplasty (SLT) laser were clean and well maintained. We reviewed servicing records, which demonstrated lasers had been serviced in accordance with manufacturer's recommendations. We reviewed servicing records for two slit lamps and visual field testing equipment. All had received a service within the recommended period. The laser treatment room was well organised and free from clutter. Staff had access to personal protective equipment (PPE) required for the safe use of lasers.

- The laser treatment room had received a safety inspection in February 2016. This was carried out by the local NHS Trust whom staff could contact in the event of query in relation to the use of lasers.
- Clear signage showed where lasers were located and in use in clinical areas.

Medicines

- All medicines stored within the outpatient service were secure and accessible by authorised personnel only.
- Prescription pads (FP10s) were stored securely. We reviewed the audit trail of prescription pads. Each prescription was accounted for and there were records to indicate who had written the prescription against the corresponding prescription number.
- For our detailed findings on medicines, please see the safe section of the surgery report.

Records

- We reviewed 12 sets of medical records and found them to be complete and legible. Surgical pre-assessment was carried out at an outpatient appointment prior to surgery. We saw this process had been completed in all of the records we reviewed.
- During our inspection, we saw that a clinic list, containing patient identifiable information had been left on the reception desk. We raised our concerns to the registered manager who immediately took corrective action and discussed our findings with staff to reduce the risk of reoccurrence.
- Laser records were complete and up-to-date. We reviewed records from October 2016 to September 2017 and saw that records demonstrated the documentation of patient name, date of birth, reason for laser usage, strength of laser used, laser operator and the outcome. We saw that appropriate records had been maintained each time a laser procedure had taken place in both the laser log and the patient's medical records.
- Lens implant numbers were recorded in patient medical records, and shared with the referring clinician, for example an optometrist or general practitioner (GP). This enabled the recall of lenses if required. All records we reviewed demonstrated implant numbers had been recorded, where applicable.

Assessing and responding to patient risk

- The service had an acceptance and exclusion criteria to ensure that only clinically safe patients had access the outpatient service. This document clearly outlined patients who were unsuitable for treatment at the service including; certain pre-existing medical conditions, those requiring general anaesthetic or under 18 years of age.
- All patients received a pre-assessment prior to surgery. We reviewed 12 medical records, which showed a pre-assessment had taken place, and that patient allergies and complications of surgery were discussed.
- The service had access to emergency medicines in the event a patient experienced an allergic reaction. In the event of patient deterioration or collapse, staff called emergency services whilst providing basic life support. All staff we spoke with were all able to tell us what action would be taken in the event of a deteriorating patient.
- A Radiation Protection Advisor (RPA) support was provided by a local NHS trust as part of a service level agreement (SLA). Staff told us the trust were very responsive and accessible for help and advice. We saw that contact details of the RPA were visible in treatment areas of the service

.

- For our detailed findings on assessing and responding to patient risk, please see the safe section of the surgery report.

Safeguarding

- ACES staff worked in both the surgery and outpatient departments of the service. For our detailed findings on safeguarding, please see the safe section of the surgery report.

Mandatory training

Good

Outpatients and diagnostic imaging

- Staff worked in both the outpatient and surgical departments of the service. For our detailed findings on mandatory training, please see the safe section of the surgery report.

Nursing staffing

- The service employed registered nurses (RNs) and healthcare assistants (HCAs). Data provided by the service demonstrated there were two RNs and 5.5 HCA full time equivalent (FTE) staff employed in the outpatient department as of 1 April 2017. Staff worked in both the surgery and outpatient areas of the service in dual roles.
- The registered manager told us that staffing was calculated to meet outpatient workload and if demand increased, staffing levels were flexed accordingly. Outpatient lists were reviewed one week in advance and again the day before to ensure adequate staffing was in place.

Medical staffing

- For our detailed findings on medical staffing, please see the safe section of the surgery report.

Emergency awareness and training

- For our detailed findings on emergency awareness and training, please see the safe section of the surgery report.

Are outpatients and diagnostic imaging services effective?

Good

We do not currently rate effective for outpatient and diagnostic imaging services.

Evidence-based care and treatment

- There was a policy named 'use of laser'. We reviewed the policy and found it to be in date. The policy provided clear guidance for staff on the safe use of laser equipment.
- For our detailed findings on evidence-based care and treatment, please see the effective section of the surgery report.

Pain relief

- For our detailed findings on pain relief, please see the effective section of the surgery report.

Nutrition and hydration

- Patients and visitors to the outpatients' department had access to drinking water and complimentary hot beverages.
- The outpatient service did not offer food to patients due to the transient nature of stay in this area.

Patient outcomes

- For our detailed findings on patient outcomes, please see the effective section of the surgery report.

Competent staff

- We reviewed appraisal rates for staff working in the outpatient department. During the months of April 2016 to March 2017, 100% of staff had received an appraisal. For the current year of April 2017 to March 2018, we saw records that demonstrated 20% of outpatient healthcare assistants and no nursing staff had received an appraisal, however, all staff had a planned date for appraisal to take place, which were completed on a rolling year basis.
- The use of laser policy clearly identified which members of staff were competent and trained in the use of laser procedures. The policy clearly outlined training requirements including staff attendance to a 'Core of knowledge' course for the use of laser. Data showed that 67% of staff had completed this training. The staff awaiting this training had been previously examined and tested on the theory and practice of laser use during ophthalmologist examinations and deemed competent.
- For our detailed findings on competent staff, please see the effective section of the surgery report.

Multidisciplinary working

- The service communicated effectively both internally as part of a team, and externally with other healthcare professionals including community optometrists and general practitioners.
- We observed staff, including receptionists, healthcare assistants, registered nurses and consultants communicating and sharing information in an efficient and appropriate manner in the outpatient clinic setting.

Good

Outpatients and diagnostic imaging

- Following discharge from the outpatient clinics, the service maintained communication with the local referring optometrist.
- For our detailed findings on multidisciplinary working, please see the effective section of the surgery report.

Access to information

- Medical staff had access to paper based and electronic medical records. This ensured that medical staff had access to records during all consultations.
- For our detailed findings on access to information, please see the effective section of the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 12 sets of medical records. All records had documented that consent had been obtained prior to surgery or treatment being carried out.
- For our detailed findings on consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs), please see the effective section of the surgery report.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

We rated caring as **outstanding.**

Compassionate care

- Outpatient service staff consisted of members of the team that also covered the surgery department. For our detailed findings on compassionate care, relating to both the outpatient and surgery departments, please see the caring section of the surgery report.
- Compassionate patient care was the focus for all staff. The reception team made all patients feel welcome on arrival. Throughout our inspection, we saw that all patients were greeted in a warm and friendly manner.
- The service provided privacy screens in outpatient waiting areas, for use in the event of a patient becoming unwell so patient dignity could be maintained.
- Prior to consultation, we saw staff introducing themselves to patients by name. During consultation, we observed that clinic room doors were closed to ensure the privacy and dignity of patients was maintained at all times.
- Staff were seen to knock on doors prior to entering consultation rooms, thereby protecting each patient's privacy prior to entering.

Understanding and involvement of patients and those close to them

- For our detailed findings on the understanding and involvement of patients and those close to them, please see the caring section of the surgery report.
- Patients were provided with appointment times of a suitable length to ensure that they had adequate time to raise any questions they might have about their care or treatment. This enabled patients to be active partners in their own care.
- During our inspection, we saw staff taking time to explain to patients what they might expect during consultation and examinations.

Emotional support

- For our detailed findings on emotional support, please see the caring section of the surgery report.
- A member of staff gave us an example of where emotional support had been given to a patient who was recently bereaved. This patient was provided with an extended appointment time to ensure they had adequate time to discuss their upcoming treatment in a supportive manner.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- Outpatient facilities and premises at the service were appropriate for the services that were planned and delivered.
- Outpatient appointments were offered a maximum of six weeks in advance to ensure adequate staffing on the day of consultation.
- The registered manager had taken additional steps to ensure patients could access the service using public transport.

Good

Outpatients and diagnostic imaging

- For our detailed findings on service planning and delivery, please see the responsive section of the surgery report.

Access and flow

- All patients we spoke with reported receiving outpatient appointments in a timely manner.
- Patients were given a choice through the choose and book system.
- The service monitored referral to treatment times (RTT) for outpatient appointments. For the months of October 2016 to December 2016, patients waited on average three to four weeks for an outpatient appointment. For the months of January 2017 to March 2017, patients waited on average five to seven weeks for an outpatient appointment.
- For our detailed findings on access and flow, please see the responsive section in the surgery report.

Meeting people's individual needs

- The service provided information for patients on how to access a 'talking newspaper'. This service was free of charge to those with a visual impairment, and those who had restrictions in their ability to read due to visual impairment.
- Patients were given a treatment booklet, specific to the condition they were experiencing, for example cataract treatment. Booklets contained clear information and explanation in plain English and enabled the patient access to information demonstrating the care and treatment received to date.
- Staff were able to provide examples of improvements that had been made following patient feedback. For example, a wheelchair was placed adjacent to the car park to assist patients with reduced mobility and therefore reduce the walk into the clinic area.
- For our detailed findings on meeting people's individual needs, please see the responsive section in the surgery report.

Learning from complaints and concerns

- For our detailed findings on complaints and concerns, please see the responsive section in the surgery report.

Are outpatients and diagnostic imaging services well-led?

Good

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

Leadership and culture of service

- The outpatient service was led by the nominated individual, responsible officer and registered manager.
- Outpatient staff were clear about lines of reporting to senior management and told us they felt well supported and respected in their roles.
- For our detailed findings on the leadership and culture of the service, please see the well-led section in the surgery report.

Vision and strategy for this core service

- For our detailed findings on the vision and strategy, please see the well-led section in the surgery report.

Governance, risk management and quality measurement

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

Public and staff engagement

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

Innovation, improvement and sustainability

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

Outstanding practice and areas for improvement

Outstanding practice

- The service was patient focussed and had liaised with the local council to agree a specific bus stop adjacent to the building with improved road signage.
- The service building was purpose built to be as eco-friendly as possible.

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 introduce effective processes to monitor medicine stocks.
- The provider should consider formalising a service level agreement with a local hospital so that in the event of a complication, patients can be transferred without delay.
- The provider should continue to monitor and oversee the newly implemented safety procedures in relation to the use of cytotoxic medicines.
- The provider should continue to oversee newly implemented checking processes to ensure that medicines are checked on a regular basis.
- The provider should ensure that the risk register is dated for risk review, with a named person for each action.
- The provider should oversee compliance with the completion of the World Health Organisation (WHO) surgical safety checklist for cataract surgery and five steps to safer surgery.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury 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: {cke_protected_1}· 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 competences for health care staff, Intercollegiate Document. Regulation 13(2)

This section is primarily information for the provider

Enforcement actions

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.