BMI Southend Private Hospital

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

BMI Southend Private Hospital is operated by A. K. Medical Centre Limited. The hospital has three beds. Facilities include the Ophthalmic outpatients suite comprising of three consulting rooms, laser room and treatment room, main reception area. As well as a theatre suite comprising of two theatres, recovery area with one bed, ward with three trolleys and sub-ward with ambulatory chairs. Within theatre two there is uses the femto laser cataract machine. The first floor comprises a further three consulting rooms, treatment room, and the administration offices, staff rooms and theatre changing facilities.

The hospital provides surgery and outpatients services. We inspected both surgery and outpatients using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17 October 2016, along with an unannounced visit to the hospital on 26 October 2016.

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.

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

We rated this hospital as requires improvement overall.

We found areas of practice that require improvement in surgery and outpatient services:

- The hospital did not have access to translations services.
- The hospital did not have an identified lead for learning disabilities or dementia. Staff at the hospital had not received training on learning disabilities.
- Only 78% of patients were offered another surgery date within 28 days of the cancellation.
- Hand hygiene was not always observed to be undertaken in line with the service policy, though this had improved by the time of our unannounced inspection.
- The rate of use of bank and agency nurses working in theatre departments averaged at 65% and up to 50% in outpatients.
- There was inconsistent use of risk assessments for venous thromboembolism prior to surgery.
- The undertaking of surgical pre-assessment for local anaesthetic procedures was not consistent.
- Training rates for safeguarding adults and children level two was low in surgery. Data provided showed that 0% of theatres nursing staff completing any level two training. Patient moving and handling training rates were low across all staff groups except theatres nurses. Ward based nurses, theatre healthcare assistants and operating department practitioners (ODPs) were recorded with a 0% compliance rate for this training.

We found areas of practice that were inadequate in surgery:

- We identified several areas of risk during our inspection, which had not been identified by the service. The quality and illegibility of records, the inconsistent practice around VTE, low training rates for moving and handling and safeguarding, inconsistent use of surgical pre-assessment for local anaesthesia were all identified through the inspection not by the service. The risks around not monitoring outcomes, providing dementia and learning disability support

Summary of findings

and language support were also risks identified by the inspection, not by the service. This was despite the hospital conducting and passing hand hygiene, and record management audits.
- The hospital risk register was not fit for purpose. There was a lack of date that the risk was added, no review date specified, no control measures, no forward plans for mitigation and we were unable to identify who the lead for identified risk was.

We found areas of good practice in surgery and outpatients:

- We saw low rates of surgical site infections, which was positive.
- Staff were passionate and proud of their service. We saw compassionate and caring interactions with patients.
- Patient satisfaction surveys were consistently high. In April 2016 100% of patients described their overall care as very good or excellent.
- Overall response to treatment times (RTT) rates for admitted patients for surgery and non admitted patients were within expectations. The outpatient RTT for NHS patients and access for private patients through outpatients was excellent.
- Complaints management processes were well embedded and utilised well.
- There was good practice noted around incident reporting, though there were areas where this could improve.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements to help the service improve. We issued the provider with one requirement notice and one warning notice that affected surgery and outpatients. Details are at the end of the report.

Ted Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	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. There were 2,087 inpatient and day case episodes of care recorded at the hospital in the reporting period (July 2015 to June 2016). Of these 77% were NHS funded and 23% were other funded. No patients stayed overnight at the hospital during the same reporting period. The hospital did not provide surgery for anyone under the age of 18 years. The most commonly performed surgery types at this hospital were refractive eye surgery, cataract surgery, lens revision, dermatology and skin excisions, varicose vein surgery, hernia surgery and orthopaedic surgery.
Outpatients and diagnostic imaging	Requires improvement 	There were 6,805 outpatient total attendances in the reporting period (July 2015 to June 2016); of these 56% were NHS funded and 44% were other funded. The hospital did not provide outpatients for anyone under the age of 18 years. The service comprised of three consulting rooms, and one treatment room. Outpatient services offered included Ophthalmology, Dermatology, General Surgery, Laser Skin Clinic, Orthopaedics, Plastic Surgery, and Podiatry.

Summary of findings

Contents

Requires improvement

BMI Southend Private Hospital

Services we looked at
Surgery and Outpatients

Summary of this inspection

Background to BMI Southend Private Hospital

BMI Southend Private Hospital is operated by A. K. Medical Centre Limited. The hospital opened in 2005. It is a private hospital in Southend, Essex. The hospital primarily serves the communities of the Southend area. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 2010.

The hospital does not provide Diagnostic imaging procedures.

The hospital also offers cosmetic procedures such as dermal fillers, laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services because we have no public commitment to rate or inspect these services. The undertaking of some of these procedures also falls outside the scope of our regulatory powers.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,two inspectors and a specialist advisor with expertise in surgery.

Information about BMI Southend Private Hospital

The hospital has one ward and outpatient clinics is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Surgical procedures

During the inspection, we visited the day surgery unit and outpatient service. We spoke with seven staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We spoke with three patients.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in December 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- There were 2,087 day case episodes of care recorded at The Hospital; of these 77% were NHS-funded and 23% other funded.
- There were 6,805 outpatient total attendances in the reporting period; of these 44% were other funded and 56% were NHS-funded.

There were 30 doctors who work at the hospital under practising privileges, of which 25 undertook regular practice. There were no resident medical officers (RMO) working at the hospital due the service being a day surgery hospital. The service employed 2.8 whole time equivalent (WTE) nurses, and 3.3 WTE care assistants and operating department practitioners (ODPs). The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (July 2015 to June 2016):

- No never events
- Clinical incidents 19 no harm, zero low harm, zero moderate harm, zero severe harm, zero deaths
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)

Summary of this inspection

- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Five complaints

Services accredited by a national body:

- No accreditations.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Decontamination Services
- Facilities Maintenance
- Histology, Pathology and Pharmacy
- The service does not employ RMOs due to being a day surgery hospital.

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?

Requires improvement

We rated safe as requires improvement because:

- We found poor management of patient records, some of which were illegible in surgery. We were unable to identify consultants or nurses who were involved in the patients care, due to illegible signatures and not providing a printed name.
- There was inconsistent use of risk assessments for venous thromboembolism prior to surgery. The undertaking of surgical pre-assessment for local anaesthetic procedures was also not consistent.
- Training rates for safeguarding adults and children level two was low in surgery. Data provided showed that 0% of theatres nursing staff completing any level two training.
- Patient moving and handling training rates were low across all staff groups, except theatres nurses. Ward based nurses, theatre healthcare assistants and ODPs were recorded with a 0% compliance rate for this training.
- There was a policy in place at provider level for the management of the deteriorating patient. However, staff did not know what it contained. There was no local SLA in place with a hospital or the ambulance trust in relation to safely transferring a deteriorating patient out. However, the hospital used the National Early Warning Score (NEWS) system and staff could describe a suitable and safe process for the management and transfer of a deteriorating patient.
- Equipment including defibrillators were not checked daily as per service policy.
- We have detailed action the provider must take in relation to the safe care and treatment in accordance with Regulation 12 (1)(2)(a)(b)(c) at the end of this report.

However:

- There was a good awareness of incident reporting and duty of candour.
- Equipment was regularly serviced and checked.
- The service used a clinical dashboard to monitor outcomes with safe care.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Hospital policies and procedures were written in line with best practice guidelines and information from relevant professional boards.
- The hospital was not eligible to partake in national audits, but did undertake local audits.
- The hospital monitored outcomes against recognised performance indicators such as PROMS.
- Consent was taken appropriately from patients in line with best practice guidelines.
- Staff were trained to be competent in their roles. Practicing privileges were monitored through the Medical Advisory Committee (MAC), on an annual basis.

However:

- Some policies and procedures, such as those for VTE were not clear on the position statement for VTE on local anaesthetics procedures.

Are services caring?

Good

We rated caring as good because:

- Friends and family test (FTT) data for the period of January 2016 to June 2016 showed that between 90% and 99% of patients would recommend the hospital.
- Patient feedback was consistently positive.
- Patients felt informed about their care, the cost of treatment and understood their care and treatment choices.

However:

- Further work was needed to improve the area where patient confidential information is discussed, to ensure the privacy and dignity of patients.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Only 78% of patients were offered another appointment within 28 days of the cancelled surgery.
- The hospital did not have access to translations services for patients whose first language was not English.
- The service does not have a learning disabilities or dementia lead, nor had staff received training on learning disabilities.

However:

- RTT rates for surgery and outpatients on NHS patients were mostly meeting the recommended 92%. Outpatients was performing well against this indicator.

Summary of this inspection

- No patients were delayed or had to wait for prolonged periods in outpatients or surgery for their treatment.
- Access for private patients was usually within one week of referral.
- Learning took place following complaints raised.

Are services well-led?

Inadequate

We rated well-led as Inadequate because:

- We identified several areas of risk during our inspection, which had not been identified by the service. The quality and illegibility of records, the inconsistent practice around VTE, low training rates for moving and handling and safeguarding, inconsistent use of surgical pre-assessment for local anaesthesia were all identified through the inspection not by the service. The risks around not monitoring outcomes, providing dementia and learning disability support and language support were also risks identified by the inspection, not by the service. This was despite the hospital conducting and passing hand hygiene, and record management audits.
- The hospital risk register was not fit for purpose. There was a lack of date that the risk was added, no review date specified, no control measures, no forward plans for mitigation and we were unable to identify who the lead for identified risk was.
- Innovation was limited in outpatients.

However:

- There was a vision and strategy for the service.
- Staff reported an open culture in the service and were supportive of local and senior leaders.
- The service sought to engage with staff and patients through a variety of methods.
- There were regular reviews by the MAC on practicing privileges.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement

Requires improvement

Surgery

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- There were no deaths, serious injuries, or never events relating to the surgery service between July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- During July 2015 and June 2016 there were 19 clinical incidents, all were categorised as no harm.
- Staff confirmed that during this same reporting period, there had been no reported serious incidents other than the identification of a potential or 'near miss' incident. We reviewed the root cause analysis (RCA) for this incident, and found it to be comprehensive, including evidence of lessons learnt and that learning was shared to all relevant staff in an incident review meeting. Staff informed us that improvements to procedures, such as signing records when they have been double checked, had been made following this meeting.
- Nursing staff were able to explain what constituted an incident and how to escalate incidents using the electronic reporting system. This was in line with the hospital's incident reporting policy.
- Staff understood the principles of duty of candour. The Duty of Candour is a legal duty on the hospital to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful. information from health providers..
- A member of staff explained the importance of investigating incidents, having honest communication with patients and apologising if mistakes were made. We reviewed an RCA investigation, for an incident regarding a near miss on the ophthalmology list. There was documented evidence of support and an apology to the patient involved.
- We requested to see training compliance in relation to incident reporting. At the time of our visit the hospital did not carry out formal training relating to the reporting of incidents. We were told that this training was due for implementation in November 2016.

Cleanliness, infection control and hygiene

- There were no cases of surgical site infections (SSIs) between July 2015 and June 2016.
- Staff had received infection control training as part of their mandatory training.
- The hospital employed cleaning staff through an external contract. We observed that all areas within the surgery department were visibly clean.
- During our announced inspection, we observed housekeeping staff completing cleaning duties without appropriate personal protective equipment such as an apron. We also observed that one housekeeping staff member moved between departments with dirty gloves on and without decontaminating their hands. We raised our concerns to senior hospital managers who took immediate action and by the unannounced inspection had ensured that housekeeping staff had received further training in infection control and were monitoring staffs compliance.

- We looked at the recovery room's cleaning logbook and this confirmed that the cleanliness of 20 areas of the room were checked weekly. However, we noted that a clinical waste bin was located adjacent to a hot drinks machine, causing a possible risk of infection and cross contamination. We raised this issue to a senior manager who told us they would take appropriate action.
- Staff within the surgery department wore uniforms that adhered to 'bare below the elbow' guidelines and had short nails, with no jewellery. Movement within the theatre was kept to a minimum. These precautions kept patients safe by reducing the risk of surgical site infections. This was in line with the National Institute of Health and Care Excellence (NICE) guidelines CG74, for the preoperative stage of surgery.
- Best practice for the intraoperative stage was followed. We saw use of incise drapes around the surgical site and the use of sterile gowns and gloves. The theatre had a designated nurse for scribing to ensure all swabs, needles and blades used, were accounted for during and after the surgery. This further reduced the risk of surgical site infections and the risk of retained instruments and equipment post-surgery.
- We observed dressings being applied post operatively and the surgeon and theatre nurses giving advice to patients to reduce the risk of infection when returning home.
- Theatre staff complied with NICE guidelines QS61 that ensured patients received care from staff that decontaminated their hands immediately before and after every episode of direct contact. This was done by washing hands between each patient and using new sterile gloves each time. However in the waiting and recovery areas, hand-disinfectant gel was available at each doorway, all five members of staff we observed entering the department, did not use it. We raised this concern with the hospital manager. When we returned to the hospital for an unannounced inspection, we observed all staff decontaminating their hands regularly.
- Screening for MRSA was carried out for NHS and private patients on a risk basis. We checked the healthcare records of five patients who were undergoing surgery and found that they had all been risk assessed for MRSA and had screening completed as required.
- Reusable medical devices were sent to a local NHS hospital's central sterile services department (CSSD) for cleaning, decontamination and sterilisation. There was a Service Level Agreement (SLA) in place to support this arrangement.
- The surgery department participated in hand hygiene audits. We were provided with data of a hand hygiene audit carried out in January 2016. The audit observed five members of clinical staff and showed them to be observing and adhering to correct hand hygiene procedures.
- We observed that there were collections of dust on the exterior of the ophthalmic laser machine, in between joining sections of the plastic. We raised this to a senior manager who told us that they would speak with the cleaners and resolve this matter prior to the equipment being used.

Safety thermometer

- The hospital completed a quality dashboard to give clinical updates on the effectiveness of the service. We reviewed the most recent dashboard from June 2016. This confirmed data provided by the hospital including, that there was no unplanned returns to theatre, no patient falls and no serious incidents.

Environment and equipment

- Access to the surgery department was via key code. This kept people safe and ensured only patients and authorised personnel could enter this area. We noted that patients were escorted by staff when moving around the department.
- Theatre equipment was visibly in good working order. We confirmed this by looking at servicing records and confirming all equipment had up to date checks and yearly servicing. This conformed to the safety standard guidelines by The Association of Anaesthetists in Great Britain and Ireland (AAGBI) and the Royal College of Surgeons good surgical practice guidelines 2014.
- We did however note that one of the theatre beds had an old headrest, where the cover was not intact and therefore the inside of the headrest was exposed. This posed an infection control risk. We escalated this to senior hospital managers, who took immediate action to ensure that a new headrest was ordered and in the interim the old headrest was covered appropriately to ensure minimal risk of infection of patients.

- We observed a recording system for equipment and implants used in surgery. Stickers from the implant packaging were adhered to the patient and surgeons notes, as well as the operations register. This ensured details of specific implants and equipment could be provided rapidly to the health care products regulator, if requested, for example if a product was recalled or faulty.
- Staff we spoke to felt confident in using equipment safely. They stated that additional equipment advice was always available and gave an example of equipment manufacturers attending to give specific training. This included recent training on the ophthalmic equipment in theatre.
- Staff stated that faulty equipment would be reported to the appropriate person. We also heard of an example where faulty blades were returned to the manufacturers.
- The surgery department had its own trolley with resuscitation equipment on. We noted that this was securely tagged to ensure contents were kept safe and opening of the trolley could be audited. Records showed that this equipment was checked every working day between 29 July 2016 and 14 October 2016. This ensured the trolley was complete and safe to use. All resuscitation electrical equipment also had up to date safety testing. We checked 30 pieces of sterile equipment on the resuscitation trolley, all were in date and sealed correctly, other than one that was missing an expiry date sticker.
- Waste was managed in line with national guidance. Clinical waste was segregated from domestic waste and sharps were disposed of in plastic sharps bins, that were clean, fully labelled and within safe fill limits.
- There was entry inclusion criteria that needed to be met prior to patients being accepted for surgery. For example, only patients with a Body Mass Index (BMI) less than 40 were operated on, because the hospital did not have surgical facilities to accommodate bariatric patients.
- We looked at the checking history records for the anaesthetic machine for July to October 2016. These showed that this equipment had been thoroughly checked both regularly and before use.

Medicines

- There were no medication incidents reported between July 2015 and June 2016.
- Pharmacy services were provided by the local general hospital via a service level agreement (SLA). We reviewed the SLA document and noted it was in date.
- Medication could only be prescribed by consultants, this helped keep prescribing mistakes to a minimum and patients safe. Theatre nurses we spoke with confirmed they followed the prescribing process for controlled drugs as per the hospital policy.
- Controlled drugs were stored in line with the Nursing & Midwifery Council Standards for medicine management. These were locked in the theatre and the keys were only available during a surgery list. The registered manager was the named controlled drugs accountable officer for the hospital.
- All controlled drugs checked were stored correctly and within their expiry date. We reviewed the checking history of these drugs for August, September, and October 2016, which showed that these were checked daily when the theatre was open and that all drugs were accounted for.
- Patients were prescribed antibiotics with the use of local antibiotic formularies in line with NICE guidelines QS61. The hospital had access to a microbiologist for specialist advice.
- Allergies were clearly documented in all of the five patient's healthcare records we checked. Patients with allergies wore red wristbands to highlight that they had an allergy. We noted that this was identified during the preoperative stage of surgery and that allergies were read out to the theatre team and confirmed with the patient before surgery commenced.
- New medications were talked through with the patient following surgery. We observed this being done by both theatre and nursing staff. Staff stated that they would give advice on previous medication use and disposal, if they felt relevant.

Records

- Patient medical records were paper based and remained on the hospital site. This was in line with the Records Management Code of Practice for Health and Social care 2016.We saw that when notes were not in use, they were stored securely on hospital premises in a designated medical records storage facility.
- We looked at two sets of surgical notes during our announced inspection. The operation records completed by the surgeon were illegible due to poor handwriting; and the perioperative medicine chart,

which indicated what medicine had been given during the patient's operation, was incomplete. It was not clear what dose of medicine the patient had been given or via what route of administration.

- In one set of notes, there was evidence of a "frailty tool", however, this was not signed or printed by the healthcare professional undertaking the assessment; there was also no record that any further pre-operative assessment had been carried out prior to this and the VTE assessment mentioned. We escalated this to the clinical service lead who confirmed our findings.
- Subsequent to our findings at our next visit, an unannounced visit on 26 October 2016 we found that the hospital manager had written to consultants and staff about legibility and completeness of patient records. They had also put a new records management policy in place. We checked three further surgery healthcare records to determine if improvements had been made.
- In two of these records we were unable to identify who the consultant was who performed the operations as the consultant had signed but not printed their name. On these patient's consent forms, the registered nurse had signed but not printed their name under the section, "statement of healthcare professional". Furthermore, on the perioperative record, it was not clear what dose of medicine or via what route it had been administered. This included normal Saline and Videne. These patients also had a completed frailty tool in place; however this assessment had not been signed or printed by the member of staff undertaking the assessment.
- In the third set of these records, we were unable to identify who the operating consultant was, since this consultant's signature was not legible and the consultant did not print their name. The type of anaesthesia used for this patient was also not recorded on the consent form.
- There was no signature list for doctors working in the service for signatures in records to help with identifying clinical professionals.
- We discussed these findings with the hospital manager and clinical services lead, who agreed further work was required to improve record keeping practice.

Safeguarding

- There had been no safeguarding concerns reported to CQC in the reporting period of July 2015 and June 2016.
- Surgery staff told us they had completed training for safeguarding vulnerable adults level one and two and safeguarding children level one and two. Training data provided by the service showed that ward based nurses were 100% compliant for safeguarding adults and children level two.
- Ward based healthcare assistants were 66% compliant for safeguarding adults level two and 33% compliant for safeguarding children level two. Theatre nurses were 0% compliant for safeguarding adults level two, and 0% compliant for safeguarding children level two. Theatre operating department practitioners (ODPs) and healthcare assistants were 50% compliant for safeguarding adults level two, and 50% compliant for safeguarding children level two. We asked the theatre lead about this and they stated it was probably due to time restraints.
- Staff we spoke with were able to identify the clinical nurse manager as the adult safeguarding for the hospital. They stated that if they had any safeguarding concerns they would go directly to this person for advice if required. There was also a national lead for safeguarding within BMI, they could contact if the manager was absent.
- Staff understood their responsibilities regarding safeguarding. There was a safeguarding policy in place, which was up to date.

Mandatory training

- Mandatory training included basic life support, infection prevention and control, conflict resolution, dementia awareness, safeguarding, fire safety and information governance.
- Managers told us that the management of sepsis was covered during the basic life support section of mandatory training.
- Data provided by the hospital showed that the majority of staff were 100% compliant on all mandatory subjects, with the exception of safeguarding and patient moving and handling. Patient moving and handling training rate has a target compliance of 100%. However, for ward based nurses (0%), theatre nurses (100%) ODPs and healthcare assistants in theatres (0%), healthcare assistants in the ward area (66%) that the service was not achieving this target. Patient moving and handling

training is a statutory requirement in healthcare services where surgery is undertaken. By not ensuring staff competence in moving and handling this could potentially place patients at risk of harm.

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

- Data provided by the hospital stated that the VTE screening rate was 100%. We looked at two sets of surgical notes during our announced inspection. These were patients having surgery under local anaesthetic. There were no records to show that a venous thromboembolism (VTE) had been carried prior to surgery for either patient. This was not in line with the National Institute of Health and Care Excellence, standard QS3 or best practice recommendations from the Royal College of Ophthalmologists. There was no completed position statement from the service on why this best practice was not being followed.
- We checked the healthcare records of five patients undergoing general anaesthetic, of which all had completed VTE risk assessments in place. This was in line with the National Institute of Health and Care Excellence, standard QS3.
- There was a policy in place at provider level for the management of the deteriorating patient. However, a senior hospital manager told us that there was a draft standard operating procedure (SOP) in place, which was to be agreed at the hospital's next governance committee meeting. We saw records, which confirmed this.
- The hospital used the National Early Warning Score (NEWS) system. An Early Warning Score (EWS) system is based on a simple scoring system whereby a score is allocated dependent on certain physiological measurements, such as blood pressure. Scoring high will trigger concern and action is required. We checked the NEWS charts of five patients and found that NEWS scores were fully completed and calculated accurately. We asked three members of staff about NEWS scoring and all demonstrated they could use this system and knew when and how to escalate concerns.
- Surgical pre-assessment for general anaesthetic patients was in place. Staff informed us of a recent surgical procedure that had been cancelled. The surgeon sat with the patient and informed them why the operation had been cancelled, due to them having high blood pressure and recommended they visited their GP. We reviewed the records of this patient, which supported what we were told. This was positive, as it was identification of patient risk throughout pre-assessment, which minimised the risk of harm to the patient.
- We spoke with five members of staff all of which could describe a suitable and safe process for the management and transfer of a deteriorating patient. This included NEWS calculations, close monitoring and the emergency transfer of the patient via ambulance to the local NHS Trust.
- The service had one anaesthetic machine, which was based within theatres. The service did not have a portable ventilator for transfer or transport of patients. The senior managers were not aware of the need to discuss arrangements with the ambulance service regarding a ventilated patient for transport and how these should be reported to them as calls to ensure the right equipment and crew arrive to support the patient.
- A senior manager confirmed that there was no SLA in place in relation to transferring a deteriorating patient out; however, that there was a non-formalised "verbal agreement" between the hospital and a local NHS trust. We were not assured of the senior clinical leads understanding of the requirements of this procedure when we spoke with them about this. They acknowledged that all areas of cover required by this policy had not been thought of but they would ensure they were covered.
- We observed a notice in the theatre department, which provided information about the signs of sepsis for staff.
- The hospital utilised the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist and staff were observed completing this appropriately during a procedure. We checked five records in total and found the checklist was fully completed in all five records. This checklist was designed to keep patients safer, aimed to decrease errors and improve teamwork.
- We witnessed the five steps to safer surgery in practice during our observation of a minor eye surgery procedure. Theatre staff introduced themselves to the patient; they were prepared for the surgery and all instruments and equipment were ready. The surgical site was identified before entering the theatre. The patient's name, site of surgery and allergies were confirmed with the patient and read to the team. The surgeon explained to the patient how long he thought the procedure would last. Finally, all equipment and

swabs used, were counted by two members of staff, to ensure all were accounted for. Although we did not see a formal debrief, staff told us this would happen for larger operations.

- There was a WHO surgical checklist in place for cataract patients, which was embedded in the patients care pathways. We noted that between January 2016 and June 2016 the checklist had been audited monthly which showed 100% compliance with the tool.
- The theatre had a large white board entitled the 'swab board' this allowed all staff to see what procedure was taking place, for what patient and contained intraoperative information such as swab counts.
- Staff we spoke to felt they could always get medical input from a consultant by contacting the local NHS trust or the consultant's secretary, if required.
- After care was readily available and patients were given 'next step' information. There was a 24-hour helpline provided by BMI hospitals and patients could make a follow up outpatient's appointment if they wished. A nurse also told us that they would advise patients to call the local general hospital if they felt they needed immediate care or assistance.

Nursing and support staffing

- The hospital employed three registered nurses, one operation department practitioner and four health care assistants. The hospital manager told us there were long-term issues recruiting staff to nursing positions, one of which had been advertised for ten months. At the time of our inspection, there was one part time healthcare assistant and one theatre practitioner vacancy within the surgery department.
- Staffing levels were reviewed and planned on a weekly basis. Each Monday, theatre sessions were identified for the following week and the required safe staffing level and mix scheduled.
- Due to shortage of staff, the hospital had recently ceased to provide general anaesthetic surgery. Staff felt shortages did not affect patient safety as agency staff covered the vacancies.
- The rate of use of bank and agency nurses working in theatre departments averaged at 65% in the reporting period between July 2015 to June 2016. This was higher than the 20% average of other independent acute hospitals we hold data for.
- There were also 0% sickness rates for theatre health care assistants and ODPs in the same reporting period, except for in January 2016 and February 2016 when the rates were higher than the average of other independent acute hospitals we hold this type of data for.
- There were 0% sickness rates for theatre nurses in this reporting period, except for in November 2015, January 2016 and April 2016.
- There was no use of bank and agency ODPs and health care assistants working in theatre departments in the same reporting period, with the exception of March 2016 and April 2016.
- The same agency staff were used each time whenever possible, this enabled continuity of care and familiarity with the theatre surroundings.
- Agency staff completed an induction checklist prior to commencement of work at the hospital. This induction included familiarisation with fire exits, medicines management and emergency paging systems. We checked five agency staff records and found this record complete. However, the list only included the registered nurse's pin number, rather than their name. We raised this to a senior manager who told us they would correct the forms.

Medical staffing

- The hospital employed consultants and anaesthetists from the nearby NHS hospital. At the time of our inspection, there were 30 consultants with practising privileges working at the hospital.
- The consultant and anaesthetists would stay on hospital grounds until their patients were medically stable. Following this, they were available via telephone and could attend the hospital within 30 minutes if required.
- The hospital did not employ a Resident Medical Officer (RMO) due to the service providing day surgery only. We were informed that there would always be a member of staff on site who was trained in intermediate or advanced life care. We confirmed this by requesting data after our inspection, which showed 100% of theatre registered nurses had received intermediate life support training.

Emergency awareness and training

- The hospital had a business continuity policy in place, which outlined the necessary procedures in the event of an emergency, for example a fire incident. This policy was in date and due for review in August 2018.

Requires improvement

Surgery

- We reviewed this document and found that it clearly outlined what was defined as a major clinical or non-clinical incident. In addition, staff could access a variety of business continuity action cards for a variety of situations including; bomb threat, loss of power and fire.
- There was fire equipment throughout the hospital, all pieces of equipment were clean, accessible and had up to date servicing and checks. We noted clear fire exit signs, evacuation route maps and there was an appointed fire officer.
- The hospital had an emergency generator that would start up in the event of loss of power. This would provide power to lighting, socket outlets and essential theatre equipment.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Hospital policies and procedures for surgery were written in line with best practice guidelines and information from relevant professional boards, such as the Royal College of Ophthalmologists.
- However, policies for the assessment of venous thromboembolisation (VTE) were not detailed enough to reflect the requirements of VTE for ophthalmology patients or those undergoing local anaesthetic procedures in line with NICE clinical guideline CG92 (2010, updated 2015) 'Venous thromboembolism: reducing the risk for patients in hospital'.
- Patients were asked to complete a patient pre-admission questionnaire; this included questions such as medical history, smoking status and alcohol consumption, as outlined in the NICE guideline NG45. This also assisted the hospital to provide appropriate care and meet any special needs that a patient may have. This questionnaire was then reviewed by a consultant and signed.
- We reviewed the policies relevant to surgery. The pre-operative assessment policy used guidelines from organisations like NICE, Royal College of Anaesthetists, and the World Health Organisation.
- Staff felt up to date equipment, such as that used for eye surgery, was used to enhance delivery of treatment. For example, the hospital provided a Femtosecond laser room. The hospital manager informed us this was only the second hospital in the country to provide this.
- The hospital completed local audits such for medicine storage. These were based on and in line with national guidelines and current regulations.
- The service did not qualify to participate in any national audits based on the types of surgery undertaken.

Pain relief

- We saw that pain assessments were recorded on national early warning score charts. These were present in all surgery notes we looked at. Patients were also asked if they were comfortable during procedures by the surgeon and theatre staff.
- Consultants could prescribe pain relief medication for patients to take home, if it was required. This was considered good practice by the Royal College of Anaesthetists core standards for pain management (2015).
- We observed that theatre staff, including the surgeon, asked patients if they were comfortable at regular intervals. The surgeon explained each stage of treatment whilst checking if the patient was comfortable.

Nutrition and hydration

- Dietary requirements formed part of the patient's self-completed pre-admission questionnaire. The hospital only performed day surgery, so did not offer meals or specialised dietician advice. Light snacks were available post-operatively.

Patient outcomes

- The surgery department had no readmissions or unplanned transfers to other hospitals between July 2015 and June 2016.
- The hospital did not participate in the Royal College of Surgeons cosmetic surgery Q-PROMS data (patient reported outcome measures). They did however participate in PROMS relating to varicose veins and hernias. However, there were only 16 of these procedures carried out between July 2015 and June 2016 and therefore, no scores could be calculated for patient confidentiality.

- Patient Reported Outcome Measures (PROMs) in elective surgery for cataract surgery were being collated. The hospital manager told us that due to this the hospital planned to submit data regarding cataract procedures as this was a larger sample size of 1225 for the same period. No outcomes were ready for these at the time of the inspection.
- The hospital contributed to the Commissioning for Quality and Innovation (CQUINs) payments framework. This allows care providers to share and continually improve how their care was delivered.
- Audit information was sent to the provider's head office to produce a centralised quality dashboard that was issued on a monthly basis. We reviewed the quality dashboard from June 2016, although not surgery specific, it contained information such as incidents and unplanned returns to theatre. This allowed the hospital to identify trends and benchmark against other BMI hospitals.

Competent staff

- Consultants who expressed an interest in obtaining practising privileges contacted the hospital manager for a meeting to discuss their plans and the services that they were able to undertake. They then provided an application form with evidence of their CV, proof of right to work in the UK, general medical council (GMC) registration, indemnity arrangement, education and training certificates, college membership and a copy of their latest appraisal or revalidation documentation.
- Consultants then had a disclosure and barring service (DBS) check, practice restrictions check and references were sought. Suitable applicants were then presented to the medical advisory committee (MAC) to seek approval to grant practising privileges.
- Practising privileges were renewed after an annual review by the hospital. Senior managers told us that practising privilege rights would be suspended if the consultant could not provide evidence for renewal as requested. Data supplied by the hospital confirmed that seven consultants were permanently suspended for not updating their practising privileges in the 12 months leading up to the inspection. This showed that the hospital took appropriate action where required.
- Appraisals for theatre staff between October 2015 and September 2016 were all complete, except one. The lead theatre nurse stated that poor performance would be discussed with the clinical lead during appraisals, with additional training and actions discussed. She could not recall an occasion when this was needed and felt poor performance was identified as it arose.
- There was 100% validation rate of professional registration for theatre staff.
- There were no role specific competencies in place for registered nurses for surgery. However, a senior manager told us that competencies for healthcare assistants in relation to eye surgery, were going to be introduced soon. This was subsequent to an incident report involving eye drop medicine being administered in the wrong eye.
- Two members of staff, out of the four in theatre said they did not have time to complete additional training, due to staff shortages. All felt they had received enough basic training to perform their role safely.
- We spoke with one registered nurse who told us they had received additional training in the set-up of the ophthalmic laser machine in one of the theatres. Staff told us that only trained nurses were able set up the machine prior to laser eye surgery. The hospital told us that four members of staff had received training in relation to the set up of this equipment. There was also access to an allocated laser protection supervisor for this service through BMI nationally.

Multidisciplinary working

- We witnessed handovers between ward staff, theatre staff and a surgeon. All gave updates on the patient's progress and explained to the patients who would be taking responsibility for their care.
- We witnessed good communication between theatre staff, and all were aware of their roles and responsibilities. A theatre nurse said the surgery team worked well together because they were a small team who knew each other well.
- Staff described good working relationships with the local NHS trust. They felt they could call them if they required medical consultant advice or assistance.

Access to information

- Data provided by the hospital showed that 100% of patients were seen with their relevant medical records available.

Requires improvement

Surgery

- The hospital had the facility to request NHS medical records from the local NHS Trust. A senior manager described a good working relationship with secretaries based at the trust to enable timely access to medical records if required.
- Surgery policies were stored on a computer system. During our inspection, we asked to view some policies relating to surgery. Staff stated they were too busy with patients, and would have to locate a computer to gain access. There was a lack of mobile computers available for staff to access on a routine basis when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood consent and decision making requirements in line with hospital policy.
- The hospital policy on consent referred to the Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (DoLs, 2007).
- We were provided with a copy of the hospital's consent policy and noted the document was past the review date of March 2016. We raised this to a senior manager who reported this was the most recent version available. After our announced and unannounced inspection we were told that the corporate consent policy review date had changed to end of September 2016 and that it was currently being processed.
- We reviewed five sets of surgery notes and all contained evidence of valid patient consent. We also witnessed the surgeon sitting with the patient before the operation, confirming consent. This was considered best practice by the Royal College of Surgeons (RCS) good surgical practice 2014.
- Mental capacity to consent was assessed. We asked the theatre lead when this was done, they stated that in day surgery settings it is assumed when a completed pre admission questionnaire was completed. If the patient was thought to lack capacity they would seek guidance from the hospital's clinical services manager.
- We spoke to a member of staff about the Mental Health Act (MHA) and they demonstrated they understood the principles of the MHA.
- Any patient who underwent a cosmetic procedure was provided with a two week 'cooling off' period following their initial consultation. This was to ensure that they were happy to continue with the procedure. The service had not had many consultations for cosmetic surgery within the last two years.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Friends and family test (FTT) data for the period of January 2016 to June 2016 showed that between 90% and 99% of patients would recommend the hospital with the exception of March 2016 for which no data was submitted. This data referred to NHS patients only. The response rates for BMI Southend fell below the average of other independent hospitals we hold data for. There was a response rate of 10% against an average of 14%.
- We spoke with the hospital manager about the low response rates and were told the FFT survey was lengthy to complete. As a result of this, the hospital had reduced the length of this survey in the aim to increase response rates.
- Overall, the hospitals FFT scores were slightly below the England average of NHS patients across the period of January 2016 to June 2016. For the month of July 2016, 129 surgery department responses were received. Results showed that 75% were extremely likely to recommend the service they had received at the hospital, 21% were likely to recommended and 2% either likely or unlikely.
- Data collected by the hospital for private patients, between the months of April 2016 and June 2016, revealed a 96% to 98% overall score for a patient satisfaction survey which was disseminated to all patients.
- We observed that interactions between staff and patients were respectful and considerate. Staff asked patients if they could use their first name or what their preferred name was. We spoke to one patient waiting for surgery; they told us that they felt fully informed and described all the staff as "very nice".
- We observed staff offering to help patients with wheelchairs and coats, in a compassionate manner that supported the independence of patients.
- We found that NHS patients were admitted to a small waiting area, with six chairs, prior to going to theatre. In

this area patients were pre-assessed including the discussion of the patient's self-completed health questionnaire directly next to other patients. This meant that people's confidentiality was not always maintained.
- We raised our concerns to senior managers and by the unannounced visit found that this area was now limited to two patients at a time and that all personal questions were discussed at pre-assessment clinic. There were also curtains around the chairs to further increase patient's privacy and dignity. A senior manager told us that this arrangement was short-term and that the hospital was looking at developing a dedicated pre-assessment area.
- The service was working on a more permanent long term solution at the time of our unannounced inspection.

Understanding and involvement of patients and those close to them

- We saw staff introducing themselves to patients. Staff names and job roles were displayed on a notice board in the waiting area within the theatre department. We observed patients and staff addressing each other by first name. Staff we spoke to in the waiting area said it was easy for patients to identify them, as they were always with them and worked within a small team.
- Conversations between staff and patients were clear and concise. Staff checked to make sure the patient understood what was being discussed. Staff ensured patients were able to access information by providing a 'next step' leaflet and contact details for after care advice. One patient we spoke with said they felt fully informed.
- We spoke to a patient in the initial waiting area of the hospital. They felt fully informed and felt they had received all the relevant information in the post prior to attending the hospital for treatment.

Emotional support

- Patients were given support during their procedure, and anxiety was addressed by confirming the patient was prepared and comfortable. This was in line with NICE guidelines QS15.
- We saw one theatre nurse offering emotional support by holding the patient's hand during a procedure.
- The service could access support services and specialist nurses for NHS patients through the local NHS hospital trust. Private patients could be referred for specialist support.
- Counselling services were not provided by the hospital. Any patients who would potentially require counselling we were referred to an appropriate NHS or private service dependent on circumstance or need.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of local people

- The surgery service was supporting local NHS services by providing 77% of their service capacity to NHS patients. This figure pertained to the period of July 2015 to June 2016.
- There were separate waiting areas for NHS and private insured or self paying patients.
- During our inspection, there were only NHS funded patients receiving treatment. The hospital clinical manager informed us that although the waiting areas are separate, private and NHS staff receive the same quality of treatment and care.
- The hospital told us that theatre lists were scheduled in the mornings and afternoons. This meant that patients had access to treatment at a variety of times.

Access and flow

- The NHS consultant-led referral to treatment waiting times (RTT) follows the NHS constitution that all patients should be seen and treated within 18 weeks of referral. The indicator for the number of patients to achieve this is 92% nationally.
- Between July 2015 and June 2016 the service achieved 92% or higher on five of the 12 months. The lowest reported month was February 2016 with 83%.
- The hospital reported they had cancelled 63 procedures for non-clinical reasons in the last 12 months. Of these 78% (49 patients) were offered another appointment within 28 days of the cancelled appointment.

Requires improvement

Surgery

- Data provided by the hospital showed that shortage of staff had, in the past, resulted in a procedure cancellation, but it did not say how many times this had impacted upon care.
- The hospital worked to a referral to treatment (RTT) access policy outlined by the BMI healthcare group. This provided a framework for management of NHS funded elective access to consultant-led care and treatment at the hospital.
- During our visit, we noted that the theatre list had run on time. No patients were delayed or had to wait for prolonged periods. Staff noticed that a patient had been waiting for a taxi and volunteered to phone to ensure it was correctly booked.

Meeting people's individual needs

- Hospital policies included an equality impact assessment. This ensured services and procedures did not affect one group less or more favourably than another based on race, age, gender, culture, sexual orientation, disability, religion or ethnic origin.
- The hospital had an up to date equality and diversity policy. This explained and promoted equality to staff, public and service users. It also outlined how it is monitored and staff's responsibilities.
- The hospital did not have access to translations services, for patients whose first language was not English. We asked a manager for theatres about this and they said they have not had a situation when this was needed. The population of Southend on Sea, and surrounding areas, according to the 2011 census, showed that 3% of all households had no person over the age of 16 who spoke English. Senior hospital managers confirmed the absence of this service and told us they would look into this immediately following our visit.
- Senior managers also told us that the hospital does not have a learning disabilities lead, nor had staff received training on learning disabilities. This meant that there was a risk that people's individual's needs could not be met if specialist nursing care was required.
- Waiting areas in the hospital had wheelchair access and signage, regarding hearing loop availability, was evident on the reception desk.
- Patients had access to hot and cold drinks in the waiting room areas. We witnessed staff collecting hot drinks for patients after their procedure.
- We saw that patients were helped with their discharge home, staff involved the families to ensure patients were collected safely and helped with their coats and belongings
- Discharge procedures were discussed as part of the pre admission questionnaire. This ensured that support was available for the 24 hours post procedure and that suitable transport was available for the journey home.
- Cost of care and treatment was discussed openly with the patient at initial contact with the service, via secretaries. Throughout the hospital there were notices outlining details about further costs, such as that medicine and further investigations were additional fees.

Learning from complaints and concerns

- The hospital received four complaints in the six months leading to the inspection, none of which were related to the surgery department.
- The hospital had a complaints policy in place. The policy outlined timeframes for dealing with complaints and with whom responsibility lay to oversee the complaints process. A senior manager told us that complaints were discussed on a monthly basis at senior management team meetings. All raised complaints were sent to the hospital manager. If clinically related the hospital's clinical services manager would initiate an investigation and response. The hospital manager dealt with non-clinical complaints.
- We saw evidence that learning took place following complaints raised. For example, there had been a previous complaint regarding consultation fees. Subsequently patient information signs had been placed in waiting areas throughout the hospital, to clearly explain to patients what the initial consultation fee included and excluded. We saw this signage on the day of our inspection.
- Patients and relatives had access to information on how to complain. We saw comments cards in waiting areas in both the ground and first floor waiting areas. In addition, the hospitals website clearly detailed the complaints process with contact addresses and telephone numbers.

Are surgery services well-led?

Requires improvement

Surgery

Inadequate

We rated well-led as Inadequate.

Vision and strategy for this this core service

- The hospital worked to the BMI national vision and a local hospital specific vision. The BMI vision was to aspire to deliver the highest quality outcomes, best patient care and the most convenient choice for their patients and partners.
- The local hospital vision was for their patients to be at the centre of all that they do, ensuring that effective treatments are delivered by appropriate staff within facilities that are equipped to do what is required. Staff will work flexibly to meet patient expectations and there is a commitment to providing care in an environment in which their staff can excel in order to exceed patient expectations. The hospital manager felt the vision had been developed with the input of staff.
- There was a strategy for achieving set priorities. This was evidenced in the BMI Business Plan 2016. This also contained evidence of regular view, which measured progress against strategy.
- This plan was reviewed and discussed at regional meetings. The hospital manager was responsible for sending regular progress updates to head office, as well as a weekly regional telephone conference to discuss updates on action plans.

Governance, risk management and quality measurement

- The hospital manager led a governance committee monthly meeting. We reviewed the minutes from the last two meetings which detailed the content of the meetings, and who attended. The hospital had adopted a standard agenda for all committee meetings; this was introduced in January 2016.
- The hospital also had other committees such as, the health and safety committee and the medical advisory committee (MAC).
- Data provided by the hospital outlined a process for the regular review of consultant's practising privilege rights. We reviewed the supporting policy and confirmed this included oversight by the MAC. This included DBS checks, insurance validity and training compliance. The hospital manager told us that this was a system, which they were proud of.
- Service level agreements, such as those with the NHS hospital were not always documented. We reviewed two SLA agreements and found them to be up to date. However, there were no SLAs in place for the transferring of unwell patients between the hospital and the NHS or the ambulance service who would provide the transfer support.
- There was a hospital-wide risk register in place which contained a description of risks, a risk score and some brief comments. However, the information presented was minimal. There was a lack of date that the risk was added, no review date specified, no control measures, no forward plans for mitigation and we were unable to identify who the lead for identified risk was. A senior manager confirmed that this risk register was a new governance system and described it as, "work in progress".
- Risk management training was covered through mandatory training. The provider also delivered in house risk assessment training, we asked the hospital manager about this and they confirmed three of their senior staff had attended this training. However, a senior manager confirmed that the hospital was yet to risk assess each department for departmental specific risk, and therefore potentially there were unknown risks not on the risk register. The hospital risk register was in its infancy and did not reflect current departmental risks.
- We identified several areas of risk during our inspection, which had not been identified by the service. The quality and illegibility of records, the inconsistent practice around VTE, low training rates for moving and handling and safeguarding, inconsistent use of surgical pre-assessment for local anaesthesia were all identified through the inspection not by the service. The risks around not monitoring outcomes in relation to cosmetic surgery, providing dementia and learning disability support and language support were also risks identified by the inspection, not by the service.
- We identified a number of concerns during our inspection. These included concerns related to hand hygiene, and records. This was despite the hospital conducting and passing hand hygiene, and record management audits. We were not assured that the

governance system utilised within the service was effective at identifying and managing risk. However, the management team were keen to address issues we raised and took steps to improve many of these issues.
- There were 0% sickness rates for theatre nurses in this reporting period, except for in November 2015, January 2016 and April 2016.
- Monthly clinical governance bulletins were compiled by the BMI corporate leads and cascaded to all departments. These include a summary of shared learning, actions to be taken by all sites in response to learning's, national patient safety alerts, medical device and medicines alerts and contained a summary and links to the latest NICE Guidance.

Leadership / culture of service related to this core service

- Overall leadership for the surgery department was from the theatre lead and clinical services manager. However, the theatre manager was soon leaving and this post was out to advert.
- The hospital manager told us they felt well supported in their role by senior regional managers, and was enthusiastic and "loved" their job. This manager told us they had an open door policy for all staff and carried out a walk around the hospital at least once daily.
- In the past year two senior managers had resigned, one clinical and one deputy clinical lead. The theatre lead had also recently left the hospital. One member of staff told us there had been many managerial changes in recent months.
- Surgery staff we spoke with were proud to work in a small team, they understood they were short of staff and used bank and agency, but felt supported by each other and senior managers. They raised no concerns to us as to why there had been a high number of managers leaving post.
- When we reviewed the reasons for people leaving, there was no correlating trend or pattern. It was unfortunate timing as to why turnover rates had increased in the previous year.
- There were no whistleblowing concerns reported to CQC in the reporting period July 2015 to June 2016.

Public and staff engagement

- Staff took part in a local survey named 'BMI Say'. The aim of this survey was to gain insight and feedback from staff. In the months prior to our inspection staff feedback had highlighted a decline in communication as a result of senior management changes. In response to this feedback, communication meetings were implemented on a daily basis to provide engagement with staff. We saw a communication meeting on the day of our inspection and noted staff representation from each department.
- Staff also had the option to share their voice at monthly departmental meetings, or directly to their managers. Staff we spoke to confirmed they felt able to do this.
- There was no record of public engagement undertaken at the service.

Innovation, improvement and sustainability

- We asked senior managers to demonstrate innovation, improvement and sustainability within the outpatient department, however, we were not provided with any evidence.

Requires improvement

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- There had been no never events reported between July 2015 and June 2016 in the outpatients department. Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been fully implemented by all healthcare providers.
- There were no reported clinical or non-clinical incidents between July 2015 and June 2016 in relation to the outpatients department.
- We spoke with one member of staff who was clear on the process of incident reporting and stated that further guidance was available from senior staff if required. The staff member clearly articulated a previous incident that related to the surgical department and how learning had taken place across departments to prevent recurrence of this incident.
- Incidents were reported on paper and then transferred onto an electronic system. A new electronic incident reporting system was planned for the future, however we were not provided with an estimated implementation date for this.
- Staff had access to a policy relating to incidents. We reviewed this document and noted it was in date with processes to follow on how to report an incident.
- Due to the outpatient department not having any clinical incidents, we reviewed two investigations in relation to incidents in the surgery department. Both demonstrated that investigations had taken place with subsequent learning points identified. Learning was shared amongst departmental staff, so when incidents occurred in surgery learning was shared with outpatient staff members. For further details, please see the surgery section of the report.
- We requested to see training compliance in relation to incident reporting. At the time of our visit the hospital did not carry out formal training relating to the reporting of incidents. We were told that this training was due for implementation in November 2016.
- The duty of candour is a regulatory duty that relates to openness and transparency, and require providers of health and social care services to notify patients of certain 'notifiable safety incidents', and provide responsible support to that person. The hospital's incident policy referred to the duty of candour. One of two members of staff were unable to tell us what this term meant.

Cleanliness, infection control and hygiene

- Between July 2015 and June 2016 the hospital had no reported cases of Methicillin Resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), E-Coli or Clostridium difficile (C-diff).
- Staff within the outpatients department were observed to be adhering to 'bare below the elbow' guidelines.
- Training records revealed that 100% of registered nursing staff within the outpatients department had received training in infection prevention and control.

Requires improvement

Outpatients and diagnostic imaging

- Staff had access to policies named 'standard infection control precautions' and 'hand hygiene'. We viewed both policies and noted they were in date and provided guidance in relation to infection prevention and control.
- The outpatient department mainly used disposable, single use equipment. All reusable equipment for decontamination was outsourced to a local NHS trust.
- Cleaning and domestic staff were employed by the hospital. All areas within the outpatients department were visibly clean.During the course of our inspection, we observed a housekeeping member of staff walking around waiting areas and moving between clinical and non-clinical areas wearing disposable gloves. We observed that the gloves were not removed after actively cleaning a floor area prior to touching and pushing a door open. This practice was not in line with the service's policy on infection control.
- A member of housekeeping staff was also seen to wear disposable gloves and descend down two flights of stairs holding the hand rail. We escalated our concerns to senior managers about this who told us they would take immediate action.
- Gloves were available in all treatment and consultation rooms. Hand gel was placed at regular intervals in and around the outpatient department. During our announced visit one consultant was working. We did not see active hand cleaning or washing taking place, and we noted that staff were moving between clinical and non-clinical areas without decontaminating their hands.
- The outpatients department participated in hand hygiene audits. We were provided with data of a hand hygiene audit carried out in January 2016. The audit observed five members of clinical staff and showed them to be observing and adhering to correct hand hygiene procedures.
- Disinfectant hand gel was available on a wall mounted bracket adjacent to the reception desk. We saw two patients arrive at reception prior to their appointment; neither visitor was asked to make use of the gel by hospital staff.
- All clinical and non-clinical areas were visibly clean. Containers for the disposal of sharps (needles) were correctly labelled and assembled and within safe fill limits. Hand washing sinks areas displayed notices on hand hygiene.
- All areas within the outpatient department consisted of hard flooring to enable effective cleaning to take place.
- Infection prevention and control was discussed on a monthly basis at governance meetings. All consultation and treatment rooms appeared visibly clean. We noted concerns that in one treatment room there was an abundance of electrical wiring that could pose difficulty in relation to effective cleaning.
- We found two oxygen masks, located by oxygen cylinders for use in an emergency, that were open to air and therefore posing a risk to the prevention and control of infection.

Environment and equipment

- The outpatient department was located adjacent to the hospitals main entrance. Patients were required to book in at the main reception desk prior to being directed to outpatient specific waiting areas on the ground and first floor.
- The outpatient department consisted of five outpatient consultation rooms, two treatment rooms, one laser treatment room and a visual field test room. Clinical areas were located on ground and first floor levels.
- Access to the ground floor waiting room was unrestricted and the waiting area had no allocated member of staff in this area. This area had no direct oversight from main reception staff. The first floor waiting area was also unsupervised. During our unannounced visit we were shown a risk assessment that had been undertaken in relation to observations of this area. The hospital had placed signs in waiting areas to inform patients that this area was unstaffed and who to call for assistance if required. However, when clinics ran staff were in and out of the clinical rooms and could see patients waiting so risks to patient's was minimal.
- All rooms not in use were locked therefore restricting access to unauthorised personnel and medical equipment.
- Treatment rooms had signage in place to indicate when laser treatment was in use.
- All clinical waste bins and sharps containers were clearly identified using correctly coloured liners. Clinical waste and sharps containers were segregated from patient areas.
- The ground flood outpatient area utilised resuscitation equipment based in the adjacent theatre suite. For information relating to this equipment please see the surgery section of the report.
- The first floor outpatient department had an automated external defibrillator, stored in a wall mounted position

in the corridor. Checks of this equipment should have taken place on a daily basis when the department was open (excluding weekends).We reviewed checklists associated with this equipment and noted that no checks had taken place on the 5th, 6th and 7th of October 2016. We requested copies of previous checks for the months of July 2016 to September 2016 after our inspection but were not provided with this data. We were told that daily checking of this equipment had commenced in September 2016.

- We reviewed documented checklists for a medicines fridge located within the ground floor outpatient treatment room. No documented checks had taken place on eight days in May 2016, two days in June 2016, three days in July 2016 and eight days in August 2016.Therefore, the safety of medicines within this area was not ensured. BMI Policy 'Safe management of medicines', section 16.3 (g) states fridge temperatures should be checked and documented on a daily basis.
- We saw that one oxygen cylinder within the ground floor treatment room had passed its expiry date of 23 October 2015. This meant it was out of date by 11 months at the time of our inspection. We immediately escalated our concerns to a member of staff who took action to replace this cylinder immediately. During our subsequent unannounced visit we were told that oxygen cylinder checks now formed part of a weekly hospital maintenance check.
- We inspected equipment within the consultation rooms and treatment rooms. Equipment lacked signage as to whether or not it had been serviced due to out of date stickers being present. We requested to see servicing records for equipment within this area which was provided to us on the day of our inspection. Records showed that maintenance agreements with private contractors were in place for equipment within the department and that laser equipment had been serviced in May 2016.

Medicines

- Pharmacy services were provided via an existing service level agreement (SLA) in place with the local NHS Trust. We reviewed the SLA document and noted that it was in date. The outpatient department did not store controlled drugs (CDs). There was no on-site pharmacy at the hospital.
- Consultants had access to NHS prescription pads within the outpatient department. Each prescription pad was signed in and out, prior to and at the end of clinic lists. Prescription numbers were logged with the specific prescription number and relevant patient number, by the prescribing clinician/nurse, to prevent the misuse of prescription paperwork and maintain an audit trail.

Records

- All referrals for NHS patients were received and held by the hospital. Private patient referrals were held by the consultants and handled by secretaries.
- All medical records within the outpatient department were paper based. Consultants did not remove medical records from the hospital premises and if records were required at other clinics, notes would be copied in advance.
- The hospital did not utilise a notes tracking system. Reception staff reported that notes very rarely went missing. In the case of missing notes, staff tracked back to the location of where the patient was last seen and attempted to locate notes from that point.
- Prior to outpatient clinics, medical records were pulled in advance of appointments to identify any that were missing or to request the recall of medical records that were held offsite, for example returning patients whose records were stored in secure facilities. We spoke with a member of the reception team who stated that a new process of scanning records has been recently implemented, to allow access to electronic records in a timely manner should the need arise.
- During our visit we noted that the medical records storage room was locked and restricted to all unauthorised personnel. Therefore, medical records were stored in line with the Records Management Code of Practice for Health and Social Care 2016.
- All patients seen in the department had a referral letter prior to consultation from a GP, optician or other healthcare professional.
- We reviewed five sets of outpatient medical records during our announced inspection. We found that doctors handwriting was illegible with inconsistent paperwork in use. We could not interpret plans of care or the reasons for patient consultations and outcomes. In addition, paperwork lacked patient identifiable information, which meant that the we could not be sure the records we were reviewing linked to the correct patient in all cases. We raised this with the senior

management team. At the unannounced visit, we looked at three further records and found that similar concerns existed. Doctors handwriting was still illegible and plans of care were not clear.

- The hospital participated in monthly medical records audits. We were provided with audit data for the months of April 2016 to June 2016. Data from these months showed that all the records examined lacked a date, time and signature from consultants. We saw that this audit did not look at whether or not medical records were legible.
- Prior to our announced inspection, there was no records management policy in place. During our unannounced inspection, we were told that a policy had been compiled and was in place as of 25 October 2016.

Safeguarding

- Training records provided by the hospital revealed that 100% of nursing staff within the outpatient department had received safeguarding vulnerable adults' level one and two and safeguarding children level two training. Safeguarding training was incorporated into mandatory training for staff.
- We spoke with one member of staff within the outpatient department who reported that safeguarding training included awareness of female genital mutilation (FGM). They stated that they had access to a safeguarding policy and could articulate how they could raise a safeguarding concern. We were told that senior staff were approachable for advice should this be required. We saw a safeguarding policy within the outpatient waiting area and noted this policy was in date.
- The hospital's clinical lead was the named safeguarding lead. At the time of our inspection, this member of staff was awaiting level three safeguarding children training. It is to be noted however that the outpatients department did not offer consultations to persons under the age of 18 years of age.

Mandatory training

- The majority of mandatory training was delivered via an electronic system called 'BMI Learn'. Manual handling, medical gases and basic life support training took place on a face-to-face basis.
- We were provided with data in relation to mandatory training compliance. Subjects included infection prevention and control, medical gasses, basic life support, fire safety, dementia awareness and consent. Records showed that 100% of outpatient registered nurses and support staff had received training in all subjects with the exception of patient manual handling, which was 0%. However, this is based on one employed staff nurse.

Assessing and responding to patient risk

- The outpatients department participated in exercises simulating patient collapse. These scenarios were provided by an external company and ranged from cardiac arrest to other medical emergencies. The outpatient lead reported these were carried out approximately six times per year.

Nursing staffing

- The hospital employed one full time equivalent (FTE) registered nurse in the outpatients department. Staffing levels in the outpatient department were planned in conjunction with theatre staff.
- The hospital did not use a specific tool to determine nursing staffing numbers. We were told that outpatient activity was reviewed one week in advance to ensure an adequate and safe nurse staffing presence. Activity was then reviewed on a daily basis to ensure that any changes in planned activity were taken into account.
- For the period of July 2015 to June 2016, the use of bank and agency nurses was 50% between the six months of January 2016 and June 2016. This is above the rate of other independent acute hospitals that we hold data for. However, for context the service employs two nurses for outpatients and when additional clinics were run additional staff were booked to support this. This explained why the calculated percentage of agency use was high, it was not linked to short staffing.
- Between July 2015 and June 2016, nursing staff sickness was below the average of other independent acute hospitals we hold data for.

Medical staffing

- At the time of our inspection, 30 consultants held practising privileges at the hospital, 25 (83%) of which worked there on a regular basis. The majority of consultants working at the hospital held substantive posts within NHS organisations.
- During times when consultants were not in the department, hospital staff were able to make contact with consultants via their secretaries if required.

Requires improvement

Outpatients and diagnostic imaging

Major incident awareness and training

- The hospital had a business continuity policy, which was in date and due for review in August 2018.We reviewed this document prior to our announced inspection, which outlined what was defined as a major clinical or non-clinical incident. In addition, staff could access a variety of business continuity action cards for a variety of situations including; bomb threat, loss of power and fire. During our inspection, we spoke with the outpatient department lead who was unaware of these action cards.
- The outpatient department took part in a fire alarm test on a weekly basis. Outpatient registered nurses participated in 'fire safety in a hospital environment' training session. Data provided by the hospital revealed that 100% of registered nurses within the department had received training.

Are outpatients and diagnostic imaging services effective?

At present we do not rate the effectiveness for outpatient and diagnostic imaging services in acute independent hospitals.

Evidence-based care and treatment

- Policies and procedures relating to outpatients reflected national guidance and best practice from The Royal College of Ophthalmologists. For example, the policies relating to treatment reflected the NICE pathways on glaucoma.
- The outpatient department took part in local audits including hand hygiene, medical records and consent. Hand hygiene audits were based on the World Health Organisation (WHO) 'five moments for hand hygiene'. The hospitals hand hygiene policy was based on national guidance.
- Consent and safeguarding policies in use were based on national guidance and current regulations.
- Local audit results have been detailed throughout this report for hand hygiene, consent and records.

Pain relief

- Out of the five sets of medical notes we reviewed, pain relief was not applicable in the outpatient setting.

Patient outcomes

- The hospital did not participate in the Royal College of Surgeons cosmetic surgery Q-PROMS data (Patient Reported Outcome Measures) because the service had not undertaken cosmetic breast surgery within the last 12 months. The hospital did however participate in PROMS in relation to varicose vein and hernia. Please see the surgery section of the report for further information.
- The hospital utilised a clinical dashboard to monitor patient outcomes. This provided the ability to compare statistics with other BMI hospitals in the country and monitor for signs of improvement or deterioration. The dashboard mainly related to surgical care and therefore we have reported on this further under the surgery section of the report.
- The service did not qualify to participate in any national audits due to the type of service offered to patients. However, the provider would have informed the service if they were to qualify to participate in any new national audit.

Competent staff

- Data provided by the hospital stated that 100% of registered nurses within the outpatient department had received an appraisal.We spoke with the outpatient lead who reported they had received an appraisal within the two months prior to our inspection.
- Nursing staff within the outpatients department had achieved 100% compliance with all mandatory training subjects, with the exception of patient moving and handling training.
- We were told that agency staff received a local induction prior to the commencement of work in the outpatients department. Whilst they did not partake in BMI mandatory training, they were required to provide mandatory training certificates prior to the commencement of work at the hospital.
- The medical advisory committee (MAC) were responsible for the granting and renewal of practising privileges, which were reviewed on an annual basis. Consultants were required to provide evidence of ongoing registration, indemnity insurance and appraisal. The MAC would review all relevant criteria and determine if the doctor was suitable to work at the service or not.
- Data provided by the hospital stated that nurses who had been in post longer than six months had their validation checked in 100% of cases.

Requires improvement

Outpatients and diagnostic imaging

- We spoke with one member of staff who reported that they felt developed in their role, with the hospital funding further education in relation to ophthalmology training in the outpatient setting.

Multidisciplinary working

- During our inspection, we observed a good working relationship and communication between consultants, nurses and the surgery department. In addition, the reception team were seen to advise staff when patients had arrived in the department.
- The outpatient lead told us that all staff worked well together as a team. Due to the small size of the hospital everyone knew each other well. This was evident on the day of our visit. Effective staff communication was also seen between departments.
- Senior managers described a good working relationship with the local NHS trust with regards to the transfer of patients and the request for medical records if required.

Seven-day services

- The hospitals' outpatient department was not open seven days a week. Outpatient department opening hours were variable and depended on the demand for clinic. Typically, clinics ran Monday to Friday between the hours of 9am to 5pm however later appointments up to 9pm were offered if required. Some weekend clinics were also provided upon request.

Access to information

- Paper based medical records were created at the point when the hospital administration and booking team received a referral letter. The clinical services lead was the named Caldicott lead for the hospital. A Caldicott lead is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing.
- The hospital had the facility to request NHS medical records from the local NHS Trust. A senior manager described a good working relationship with secretaries based at the trust to enable timely access to medical records if required.
- Data provided to us prior to our inspection revealed that in the three months prior to our inspection, less than 0.5% of patients in the outpatient clinic were seen without access to all relevant medical records.
- After patient consultation, consultants dictated their findings, which were typed up on the hospital site and then forwarded to the patient's GP.
- In between clinic appointments, patients were provided with emergency contact details to make contact with hospital should the need arise.
- During our inspection, we spoke with a senior member of staff and asked how staff were able to access policies within the outpatient department. We were told "there are not enough computers to go around; some computers do not allow access to the policies to which we refer to". We requested to see the dementia policy on a computer located within a ground floor outpatient's consultation room. The member of staff was unable to locate this specific policy. We could therefore not gain assurances that staff were able to access information when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to a policy named 'Consent'. This policy referenced the Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (DoLs 2007). We spoke with one member of staff who also reported that the adult safeguarding policy detailed both the MCA and DoLs. We were provided with a copy of the consent policy and noted the document was past the review date of March 2016. We raised this to a senior manager who reported this was the most recent version available. We were told by senior management at the hospital that the corporate consent policy review date had changed to September 2016 and was being processed at the time of our unannounced visit.
- Consent, MCA and DoLs training were included in staff's annual safeguarding training sessions. Data provided by the hospital revealed that 100% of registered nurses within the outpatients department had received safeguarding vulnerable adults level one and two training.
- We reviewed five sets of outpatient medical records, which all contained documented patient consent.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- Friends and family test (FTT) for the hospital data for the period of January 2016 to June 2016 demonstrated that 90% - 99% of patients would recommend the hospital with the exception of March 2016 for which no data was submitted. This data was not broken down into specific departments. For further information please see the surgery section of the report.
- Overall, the hospitals FFT scores were slightly below the England average of NHS patients across the period of January 2016 to June 2016. For the month of July 2016, 129 outpatient department responses were received. Results showed that 75% were extremely likely to recommend the service they had received at the hospital, 21% were likely to recommended and 2% either likely or unlikely.
- Data collected by the hospital, between the months of April 2016 and June 2016, revealed a 96% to 98% overall score for a patient satisfaction survey. This data pertained to the outpatients department specifically. We reviewed monthly governance meeting minutes and noted that patient satisfaction was a standard agenda item.
- BMI Southend had a specific policy outlining the roles and responsibilities of a chaperone. The department offered chaperones to all patients that requested this service. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw information offering chaperones was available to patients in waiting areas. We spoke with a member of outpatients staff who reported that should a chaperone be required, a staff member would be flexed from another area or the clinical lead would assist.
- We spoke with two patients during our visits. One patient stated, 'Staff here are lovely and very friendly; this isn't the first time I have been to this hospital'. Another patient stated 'I have no negative comments, the staff are so helpful and kind, I would recommend the hospital to my family'.
- During our announced visit we noted one member of nursing staff speaking with a patient who had returned for a follow up appointment. The member of staff spoke with the patient in a kind and caring manner, enquiring as to how they were. We noted that due to the small size of the hospital, patients were able to recognise staff throughout their treatment journey.
- Patient confidentiality was maintained in consultation rooms. All doors were closed when consultations were taking place on the day of our inspection. We saw a member of staff knocking, prior to entry to a room therefore maintaining patient dignity and privacy.

Understanding and involvement of patients and those close to them

- Consultation costs were discussed with patients at the first point of contact. There was signage in place throughout the outpatient department indicating what the initial cost to a patient would be and that this figure excluded medicines and further investigations. Information on costs were sent to the patient and also displayed in the hospital and on their website.
- We spoke with one patient who reported they had received adequate written information in relation to their appointment and condition. They reported feeling well informed in relation to their care.

Emotional support

- People accompanying patients were welcomed in to consultation rooms for emotional support if required.
- The service could access support services and specialist nurses for NHS patients through the local NHS hospital trust. Private patients could be referred for specialist support.
- Counselling services were not provided by the hospital. Any patients who would potentially require counselling were referred to an appropriate NHS or private service dependent on circumstance or need.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

Outpatients and diagnostic imaging

Requires improvement

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of local people

- The outpatient service was supporting local NHS services by providing 56% of their service capacity to NHS patients. This figure pertained to the period of July 2015 to June 2016.
- The ground floor housed the ophthalmic outpatients suite (three consulting rooms, laser room and treatment room). The first floor comprises a further two consulting rooms, visual field room and a treatment room.

Access and flow

- The outpatients department exceeded its set performance indicator of 92% for referral to treatment (RTT) for the period of July 2015 to June 2016. During this time, of the outpatients seen on the RTT 18 week pathway, 100% were seen within 18 weeks. These figures pertained to NHS patients only.
- The service was also able to demonstrate that all private patients were seen quickly following referral. Private patients were offered an appointment within one week. When private patient referrals were received, administration staff would make contact directly with the patient to book an appointment, providing a choice of available times and dates. The service could also accommodate urgent appointments within 72 hours.
- During our announced visit we spoke with administration staff in relation to waiting times. We were told that NHS patients were booked for an outpatient appointment within three weeks of receipt of referral or via the NHS choose and book system. Patients attending for NHS care were able to call the hospital and amend their appointment time or date if this was required.
- We were told that the hospital was able to offer short notice appointments for the next day if required. In addition, late evening clinics were provided up to 9pm depending on the demand for appointments.
- We spoke with two patients who reported that they had been seen on time for their appointment. We saw that clinics ran to time and people were not waiting to be seen for prolonged periods.

Meeting people's individual needs

- The hospital did not have access to translation services, for patients whose first language was not English. We asked a manager for theatres about this and they said they have not had a situation when this was needed. The population of Southend on Sea, and surrounding areas according to the 2011 census, showed that 3% of all households had no person over the age of 16 who spoke English. Senior hospital managers confirmed the absence of this service and told us they would look into this immediately following our visit. This had not been resolved by the time of our unannounced inspection.
- Senior managers also told us that the hospital did not have a learning disabilities lead, not had staff received training on learning disabilities. This meant that there was a risk that people's individual's needs could not be met if specialist nursing care was required.
- Hospital policies included an equality impact assessment. This ensured services and procedures did not affect one group less or more favourably than another on the basis of race, age, gender, culture, sexual orientation, disability, religion or ethnic origin.
- The outpatient department provided equipment that was suitable for bariatric patients.
- The reception area was accessible for those with disabilities and clearly signed the presence of hearing loop facilities should this be required.
- The hospital had a lift to provide access to the first floor consultation and treatment rooms.
- Seating in both waiting room areas contained chairs with arms to support patients when sitting and rising. The provision of chairs with arms was a direct result of the hospital acting on patient feedback.
- Patients and visitors had access to both hot and cold drinks within the outpatient waiting rooms areas. Due to the transient nature of stay in the outpatient department, food was not provided.
- Patients had access to a variety of information leaflets located within the outpatients waiting areas to enable them to understand their medical condition(s).Information included cataract literature, payment options and other procedures and consultations that the hospital offered.

Learning from complaints and concerns

Requires improvement

Outpatients and diagnostic imaging

- The hospital had a complaints policy in place; we reviewed this document and noted it was in date. The policy outlined timeframes for dealing with complaints and with whom responsibility lay to oversee the complaints process.
- We were told that complaints were discussed on a monthly basis at senior management team meetings. All raised complaints were sent to the hospital manager. If clinically related the hospital's clinical services manager would initiate an investigation and response. Non-clinical complaints were dealt with by the hospital manager.
- We requested the number of complaints the outpatient department had received in the 12 month period prior to our visits. The hospital received four complaints in relation to the outpatient department between January 2016 to April 2016. Review of these complaints revealed none had been referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and all complaints were dealt with at a hospital level. Two complaints related to treatment and consultation costs, the remaining two complaints were pertaining to consultant attitude and poor communication regarding the referral process.
- We were told that learning had taken place as a result of a previous complaint regarding consultation fees. Patient information signs had been placed in waiting areas to explain to patients what the initial consultation fee included and excluded. We saw this signage on the day of our inspection.
- Patients and relatives had access to information on how to complain. We saw comment cards in waiting areas in both the ground and first floor waiting areas. In addition, the hospitals website detailed the complaints process with contact addresses and telephone numbers.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement.

Vision and strategy for this this core service

- The BMI Healthcare group vision was to provide the best patient experience, whilst being the most cost effective and providing the best outcomes.
- Staff we spoke with understood the vision for the hospital in relation to the service they provided to patients.

Governance, risk management and quality measurement for this core service

- For specific detail on the governance processes for the hospital please see the surgery section of this report.
- We identified a number of concerns during our inspection that related to outpatient services as well as surgery. These included concerns related to hand hygiene, equipment checks, and records. This was despite the hospital conducting and passing hand hygiene, cleanliness and record management audits. We were not assured that the governance system utilised within the service was effective at identifying and managing risk. However, the management team were keen to address issues we raised and took steps to improve many of these issues.
- The outpatient lead attended monthly governance meetings which fed directly into the medical advisory committee (MAC). MAC meetings took place on a quarterly basis. We viewed the minutes of governance meetings and noted they addressed key areas including clinical practice and audit, resuscitation, infection control and risk management.
- Practising consultants were required to provide proof of adequate insurance on a regular basis. We were told that one consultant's practising privileges had been suspended due their insurance expiring. Practising privileges were reviewed on a regular basis with oversight from the MAC.
- We were told that four members of senior management staff had undergone risk assessment training. In addition, risk management was covered in mandatory training for all staff.

Leadership / culture of service

- The outpatient department was led by an outpatient lead who reported to the clinical services manager.
- We spoke with one member of the reception team who reported a good working relationship with all consultants, outpatients and theatre staff.

Requires improvement

Outpatients and diagnostic imaging

- One member of administrative staff we spoke with described that there had been a lot of senior managerial change in recent months. They told us that despite this, they felt listened to and that the hospital manager always maintained a visual presence in the hospital.

Public and staff engagement

- Staff took part in a local survey named 'BMI Say'. The aim of this survey was to gain insight and feedback from staff. In the months prior to our inspection staff feedback had highlighted a decline in communication as a result of senior management changes. In response to this feedback, communication meetings were implemented on a daily basis to provide engagement with staff. We saw a communication meeting on the day of our inspection and noted staff representation from each department.
- There was no record of public engagement undertaken at the service.

Innovation, improvement and sustainability

- We asked senior managers to demonstrate innovation, improvement and sustainability within the outpatient department, however, we were not provided with any evidence.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that risks to patients are identified through surgical pre-assessment prior to surgery being undertaking under local anaesthetic.
- The provider must ensure that the need for VTE screening is assessed by the service and administered to patients as per the service's policy in line with national best practice.
- The service must ensure that there are safe processes in place for monitoring of the deteriorating patient. Including the safe transfer of a patient to another healthcare facility.
- The provider must ensure that governance and risk management processes are effective in identifying risks.
- The provider must ensure that there is an effective process for the monitoring and management of risk within the service.
- The provider must improve training rates for safeguarding adults, safeguarding children and patient moving and handling.
- The provider must improve the quality and legibility of patient records.

Action the provider SHOULD take to improve

- The provider should ensure that equipment monitoring and checks are undertaken as required by service policy.
- The provider should improve hand hygiene practices within the service.
- The provider should undertake further work to improve the area where patient confidential information is discussed to ensure the privacy and dignity of patients.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was inconsistent use of risk assessments for venous thromboembolism prior to surgery. The undertaking of surgical pre-assessment for local anaesthetic procedures was not consistent. Staff were not sufficiently trained in moving and handling or safeguarding to minimise the risk of harm or abuse to patients. There was no policy in place for the management of the deteriorating patient. There was no SLA in place with a hospital or the ambulance trust in relation to safely transferring a deteriorating patient out. Regulation 12 (1)(2)(a)(b)(c)

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.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was poor management of patient records, some of which were illegible. Existing governance processes were not effective. Concerns identified during the inspection had not been identified by the service through a risk management process. The risk register was not fit for purpose. Regulation 17(1)(2)(a)(b)(c)