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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Southend Private Hospital is operated by BMI Southend Private Hospital Limited. The hospital offers day case surgery and an outpatients department. There are no overnight beds. Facilities include two operating theatres, a ward and recovery area and an outpatient department.

The hospital provides minor surgical procedures under local anaesthetic only – the majority being ophthalmic surgery. As well as the ophthalmic work the hospital also offers minor orthopaedic, podiatry and dermatology surgery and minor cosmetic procedures such and laser skin and hair removal. We inspected all services.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 9 October 2018.

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

Services we rate

We rated this hospital as good overall.

We found good practice in relation to surgery and outpatient care:

- The service ensured it had enough staff who completed mandatory and safeguarding training to keep people safe.
- The environment and equipment were suitable for use and staff ensured patients were protected from infection by using the appropriate infection, prevention and control measures.
- Risk assessments were completed for people who used the service and confidentiality was protected with well organised and managed individual care records.
- Staff knew how and when to record incidents and there were systems to identify, monitor and share learning from incidents.
- The service delivered evidence based care according to national guidance, performed local audits and measured patient outcomes.
- Staff were competent for their roles and were encouraged to develop further.
- Complaints were low and dealt with in a timely manner and according to corporate policy.
- The service ensured that patients were treated with kindness, dignity, respect and compassion and supported in making decisions about their treatment.
- The service was well-led, with effective leadership, management and governance of the organisation.
- Senior staff supported learning and innovation, and promoted an open and fair culture.
- There were clear and effective processes for managing risks, issues and performance.

Summary of findings

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

- Some medical records within the outpatient department lacked legibility.
- The service did not meet the 90% target for patients admitted within 18 weeks of referral for seven out of the 12 months reviewed and were lower than the England average.
- The service did not follow its own procedure with regard to 48-hour post-operative follow up telephone calls.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	Good 	Outpatient services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery services section. We rated this services as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

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Services we looked at
Surgery and Outpatients

Summary of this inspection

Background to BMI Southend Private Hospital

BMI Southend Private Hospital is operated by BMI Southend Private Hospital Limited. The hospital is an independent hospital in Southend-on-Sea, Essex which originally opened in 2005 under a different name and provider. It partnered with BMI in 2010. The hospital primarily serves the communities of the Southend-on Sea and surrounding areas. It also accepts patient referrals from outside this area. The hospital sees and treat patients aged 18 years old and over.

The hospital's registered manager has been in post since the service re-registered on 9 August 2018.

The surgery department consists of an operating suite with two operating theatres, a recovery area/ward area and a specialist surgical laser room.

The outpatient service consists of three ophthalmic consulting rooms, an ophthalmic visual testing room, and two other consulting rooms (one of which is a treatment room).

As well as ophthalmic surgery the hospital also offers minor orthopaedic, podiatry and dermatology surgery and minor cosmetic procedures such and laser skin and hair removal.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in surgery. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Why we carried out this inspection

We undertook an unannounced inspection following a new registration of the hospital.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology and carried out an unannounced inspection on 9 October 2018.

During our inspection, we visited all clinical areas including theatres, the ward area and the outpatient clinic areas.

We spoke with three patients and 12 members of staff including, nurses, health care assistants, operating department practitioners, consultants, and managers. As part of our inspection, we looked at the hospital's policies and procedures, staff training records and audits. We reviewed 20 sets of patient care records and the environment and equipment.

Information about BMI Southend Private Hospital

The hospital is registered to provide the following regulated activities:

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

Summary of this inspection

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 has not been inspected under its current registration although it has been inspected under a previous registration.

There were 15 surgeons/consultants at this hospital working under practising privileges. There was no resident medical officer (RMO) in post as the hospital did not admit patients overnight. The service employed 4.5 full time equivalent registered nurses, 2.8 full time equivalent health care assistants and operating department practitioners. The service did not have an accountable officer for controlled drugs (CDs) as no controlled drugs were held onsite.

Activity (August 2017 to July 2018)

- In the reporting period August 2017 to July 2018, there were 2875 day case episodes of care recorded at the hospital; of these 76% were NHS-funded and 24% other funded.
- In the reporting period August 2017 to July 2018, there were 9039 outpatient first attendances and follow up appointments held at the hospital; of these 71% were NHS funded and 29% other funded.

Track record on safety for the reporting period August 2017 to July 2018.

- Zero never events
- Zero serious injuries

Clinical incidents; 63 no harm, four low harm, zero moderate harm, zero severe harm, zero death

- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- Nine complaints were received from August 2017 to July 2018

Services provided at the hospital under service level agreement:

- Medical gases quality assurance testing
- Sterile services provision
- Pharmaceutical services
- Provision of blood and blood components
- Pathology and histology services
- Laser protection adviser services
- Agency and locum services
- Confidential waste disposal
- Radiation Protection Advisor
- Maintenance of medical equipment
- Interpreting services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Are services safe?

We rated safe as **Good** because:

- There were effective processes in place to plan, deliver and oversee compliance with mandatory training.
- There were effective systems and processes in place to identify safeguard vulnerable patients from abuse.
- The service had systems and processes in place to prevent and control the spread of infection.
- Equipment in outpatient areas was clean and regularly maintained.
- Staff effectively assessed patients for the risk of clinical deterioration.
- There was adequate nursing and medical staffing in place.
- Medicines were stored securely, well organised and all within expiry dates.
- There were effective processes in place to identify, report and share learning from clinical and non-clinical incidents.

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

- A small number of medical records within the outpatient department lacked legibility.
- The corporate policy 'procedure for the management of medicines when temperatures are out of range' was overdue for review in May 2018.

Are services effective?

Good

Are services effective?

We rated effective as **Good** because:

- Polices were evidence based and referenced national guidance.
- The service carried out several local audits to ensure compliance with key procedures and policies.
- There were systems and processes in place to ensure that staff were competent within their role.
- There were systems and processes in place to facilitate effective communication amongst staff and other healthcare professionals.
- Staff obtained and documented consent, where clinically appropriate.

Summary of this inspection

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

- The service record audit of June 2018 identified that only 35% of patient's records showed 'evidence of being completed 48 hours post discharge follow-up telephone call'.

Are services caring?

Good

We rated caring as **Good** because:

- Friends and family test data was consistently positive.
- Patients described the service as 'efficient' and praised staff for their care.
- Patients received adequate information prior to treatment to enable them to make informed decisions about their care.

Are services responsive?

Good

Are services responsive?

We rated responsive as **Good** because:

- The service offered flexibility of appointments to NHS-funded and self-funding patients.
- Staff received training in dementia awareness and had access to a telephone translation line to meet the individual needs of patients.
- The service offered access to consultation and treatment in a timely manner for both NHS-funded and self-funding patients.
- The service acknowledged and responded to complaints in a timely manner.

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

- Information supplied following our inspection showed the service failed to meet the target of 90% for NHS patients admitted within 18 weeks of referral for seven out of the 12 months reviewed (August 2017 to July 2018). The lowest percentage being 64.4% in April 2018. They achieved an overall 84.6% for the 12-month period.

Are services well-led?

Good

We rated well-led as **Good** because:

- There was a clear leadership structure in place within the outpatient department.
- The service had a clear vision in place. Staff were aware of the vision and passionate about providing the best patient care possible.

Summary of this inspection

- Staff described an open, supportive and transparent culture, feeling valued in their role.
- Risks were regularly reviewed both locally and service wide.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Information about the service

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

The surgery service is comprised of; two operating theatres, a specialist laser room, and two admission and recovery rooms referred to as 'the ward'. The main type of surgery provided is ophthalmic surgery under local anaesthetic for NHS and privately funded patients. As well as the ophthalmic work the hospital also offers minor orthopaedic, podiatry and dermatology surgery and minor cosmetic procedures such and laser skin and hair removal. There are no general anaesthetics used at the hospital or overnight facilities.

Summary of findings

- The service ensured it had enough staff who completed mandatory and safeguarding training to keep people safe.
- The environment and equipment were suitable for use and staff ensured patients were protected from infection by using the appropriate infection, prevention and control measures.
- Risk assessments were completed for people who used the service and confidentiality was protected with well organised and managed individual care records.
- Staff knew how and when to record incidents and there were systems to identify, monitor and share learning from incidents.
- The service delivered evidence based care according to national guidance, performed local audits and measured patient outcomes.
- Staff were competent for their roles and were encouraged to develop further.
- Complaints were low and dealt with in a timely manner and according to corporate policy.
- The service ensured that patients were treated with kindness, dignity, respect and compassion and supported in making decisions about their treatment.
- The service was well-led, with effective leadership, management and governance of the organisation.

Good

Surgery

- Senior staff supported learning and innovation, and promoted an open and fair culture.
- There were clear and effective processes for managing risks, issues and performance.

We found areas of practice that require improvement in the surgery service:

- The service did not meet the 90% target for patients admitted within 18 weeks of referral for seven out of the 12 months reviewed and performance was lower than the England average.
- The service did not follow its own procedure with regard to 48-hour post-operative follow up telephone calls.

Are surgery services safe?

Good

We rated safe as **good.**

Mandatory training

- The service used the corporate BMILearn education scheme to ensure staff received mandatory training. The training was delivered through e-learning and face to face and covered a range of subjects including, but not limited to; infection prevention and control, recognition of sepsis, basic life support, conflict resolution, safeguarding adults and children and information governance.
- The target for mandatory training compliance was 100%, and at the time of inspection compliance was 95%. The service had a plan to ensure it met its 100% target.
- Senior staff within the service monitored mandatory training compliance and arranged both external courses and in-house training to provide multiple platforms for learning.
- The service had identified that it was difficult to book external trainers to provide sessions in a reasonable timeframe and introduced on-site manual handling, basic life support and deteriorating patient trainers to improve compliance during August and September 2018.
- Staff were trained in adult basic life support (BLS) and adult immediate life support (ILS). At the time of our inspection, 100% of clinical staff had completed BLS training and 100% of eligible staff had completed ILS.
- Staff spoke positively of two unannounced resuscitation simulations from an external company which had helped improve their confidence when dealing with an emergency situation and there was an agreement in place to provide six scenarios annually to build staff confidence and competence.
- Surgical consultant staff completed mandatory training within the NHS trust they worked for as part of their appraisal process and practising privilege. Records of this training were part of the review of practising privileges agreement and records we reviewed confirmed this took place.

Safeguarding

- The service had effective systems and processes to protect and safeguard vulnerable patients from abuse.
- There had been no safeguarding concerns raised within the reporting period of September 2017 to July 2018.
- The service had a corporate safeguarding policy which incorporated Mental Capacity, Deprivation of Liberty Safeguards and PREVENT advice. PREVENT training aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. The policy was in date and referenced relevant legislation and national guidance.
- All staff we spoke with were knowledgeable about safeguarding and understood their responsibilities to report concerns. Staff adhered to the safeguarding policy and procedures, including working in partnership with other agencies.
- Staff were trained to level two safeguarding for adults and children with compliance at 97.3%. The safeguarding training was comprehensive including but not limited to; arrangements to safeguard adults and children from abuse and neglect, female genital mutilation and detection of child sexual exploitation.
- A senior member of the management team who acted as the local safeguarding lead had a booked safeguarding level three course the week after the inspection and there was a corporate level four lead. The service did not treat children or young people under the age of 18.
- Safeguarding flow charts were displayed around the hospital detailing the safeguarding lead and providing instructions for staff to follow regarding any concerns.
- All staff were subject to Disclosure and Barring Service (DBS) checks. DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Cleanliness, infection control and hygiene

- The service had effective processes in place to prevent and control the spread of infection.
- There were no surgical site infections during the reporting period August 2017 to July 2018 and no reported infections of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus (MSSA), Escherichia coli (E.coli) or Clostridium difficile (C. diff) in the same period. MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.diff is a type of bacteria, which can infect the bowel and cause diarrhoea.
- The theatre and admission/recovery area, known as the 'ward', contained equipment that was visibly clean. Staff had a good understanding of responsibilities in relation to cleaning and infection control.
- All clinical storage areas and sluices were visibly clean and tidy and all clinical storage was well organised, labelled and appropriately managed. Storage was off the floor to enable effective cleaning to take place.
- The housekeeper performed a daily cleaning schedule and the theatre and ward area cleaning schedule was complete and up to date. The theatre manager confirmed that they followed a six-monthly deep cleaning programme for the operating theatres and we saw evidence of completion of this within the previous two months.
- Staff adhered to the 'bare below the elbow' policy in clinical areas and used personal protective equipment (PPE) where appropriate. PPE is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.
- Staff followed handwashing procedures in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene' and we saw posters displayed which explained the hand hygiene steps. Antibacterial hand gel dispensers were available at the entrance to the theatre and ward and in the main reception area. We observed staff using hand gel and undertaking hand washing between patient contacts to reduce the spread of infection or cross contamination.
- Senior staff audited hand hygiene bi-monthly. We reviewed the audits for June and August 2018, which demonstrated all staff were 100% compliant.
- The service used mainly disposable surgical procedure sets in the operating theatre. Where a reusable set was needed (very occasional use), this was decontaminated by the local NHS trust under a service level agreement (SLA) to comply with national guidance such as the Department of Health's Technical Memorandum on decontamination. There was an effective process for tracking reusable sets with regular twice weekly delivery and collections available and separate individual collections if required.

- The hospital had a newly designated infection prevention and control (IPC) lead. They were responsible for undertaking surveillance of surgical site infection (SSI), audit of hand hygiene compliance and also led on nurse competency in hand hygiene technique.
- Infection control training was mandatory for all staff groups and was undertaken on induction and then yearly. Data supplied to us by the hospital showed that 91% of required staff had completed infection control awareness training level one, and 85% of required staff had completed infection control and high impact intervention/care bundle training and aseptic non-touch technique. This meant the majority of staff had the necessary up-to-date training to understand the principles of infection control.
- There were clean and dirty utility areas to ensure the risk of transmission of infection was minimised.
- The disposable privacy curtains around each patient chair in the ward area were all within their renewal date and the ward area had new wipe clean seating for patients to ensure chairs could be easily cleaned.
- The service had an annual legionella testing programme and the service was compliant with this programme. Legionella is water borne bacteria that can be harmful to people's health.
- Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of pseudomonas and Legionella bacteria. Pseudomonas is a common type of bacteria found in soil and water that can cause infections.

Environment and equipment

- The surgery suite consisted of two operating theatres with associated clean and dirty utility areas, storage and sluice rooms, one laser room and two admission/ recovery areas. All were situated on the ground floor which was easily accessible from the ward area ensuring patients did not have to be transferred significant distances to and from theatre.
- Access to the operating theatres was restricted with a keycode lock to avoid unauthorised people entering the area.
- One theatre was permanently set up for ophthalmology (eye) surgery and the other theatre was used for minor orthopaedic and podiatry surgery and dermatology procedures. The service had a third room which contained a specialist laser machine that enabled them to offer self-funding or private funded patients a more precise and predictable corneal incision.
- Single use items such as syringes, needles, and dressings were readily available on the ward and in theatres. The storage rooms within the service for supplies and equipment were well organised, labelled and tidy. This meant equipment was easy to locate in an emergency.
- The theatre and ward emergency resuscitation trolley was secured with a numbered tamper proof tag. Records showed that staff checked the trolley daily, including the automatic defibrillator and suction equipment, and performed a comprehensive check weekly, replacing the tag on the trolley after checking the contents. All drawers had the correct, within date, consumables and medicines in accordance with the checklist. This meant staff had access to equipment in the event of a medical emergency and according to the hospital resuscitation policy which was in line with the Resuscitation Council guidelines.
- Staff complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 for sharps management. The two sharps bins were correctly assembled and clearly labelled to ensure appropriate disposal and to prevent risk of cross infection. Neither of these bins was more than half-full, which reduced the risk of needle-stick injury. Posters were displayed which outlined what action must be taken if a member of staff sustained a sharps injury.
- There were arrangements for managing waste and clinical specimens to keep people safe with separate foot operated clinical and generic waste bins. There were service level agreements (SLAs) with external contractors for collection and disposal of both clinical and general waste. Specimens were stored in a designated specific specimen fridge prior to transport to the local NHS facility where there was an SLA for pathology and histology services.
- The service had a facilities and environment manager who oversaw the maintenance and servicing of equipment.
- Stickers were visible on equipment, which indicated it had been serviced and where appropriate electrical tested. These labels showed electrical equipment, had been tested and were safe to use.

- Specialist equipment was serviced by specialist contractors with the appropriate service level agreements. All equipment was recorded and tracked and an asset list was held by the facilities manager. The list was regularly updated with alerts when equipment was due for servicing. We reviewed the list and found it was comprehensive and up to date.
- The hospital had a contract with an external provider that completed most of the equipment maintenance in the hospital. This meant the service had assurance that all pieces of medical equipment were tested for electrical safety.
- None of the staff we spoke with had concerns about equipment availability. If any equipment required repair, they reported it and it told us it was fixed quickly. Staff were aware of the process for reporting faulty equipment.

Assessing and responding to patient risk

- The service had systems and processes to identify and respond to patients at risk of clinical deterioration.
- The service had an admission policy setting out safe and agreed criteria for selection and admission of people using the service. Patients with severe health concerns and under 18 years of age were excluded.
- A theatre communications meeting (huddle) took place each morning prior to surgery starting where any issues were discussed which might affect the proposed procedures that day. Items included the theatre running order of lists, incidents relating to theatres and information from the daily 'comms cell'. The comms cell was a meeting of key members of staff from each department and allowed for communication of a number of key issues, regarding patients, procedures and operational issues.
- A designated member of theatre staff monitored patient's vital signs to detect for deterioration during surgery. The service used the National Early Warning Score 2 (NEWS2) to assess patients post-operatively to identify and respond appropriately to changing risks to patients following surgical procedures. Admission to the hospital was always planned with at least five days' notice and staff used an ambulatory minor operations patient pathway for all patients.
- The service carried out risk based pre-operative assessments in line with guidance on pre-operative assessment (day cases/inpatient) from the Modernisation Agency. Patients completed a pre-operative questionnaire and on receipt the service contacted all patients by telephone to complete the telephone pre-operative assessment.
- Venous thromboembolism (VTE) risk assessments were not routinely completed as all patients were mobile and at low risk of thromboembolism. A risk assessment was completed where it was identified there was a high risk such as familial history, high body mass index (BMI) and known bleeding risks. There had been no requirement to complete VTE assessment during the reporting period.
- The service used the Surgical Safety Checklist for Cataract Surgery for all cataract surgery patients and this formed part of the patient pathway document for all cataract patients.
- The service used a modified World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery 'surgical checklist' including marking of the surgical site for all other procedures. We reviewed the WHO Surgical Safety Checklist and five steps to safer surgery monthly audits from April to September 2018 and saw that they achieved an average of 98.5%.
- We observed preparation for the surgical procedures, which demonstrated an appropriate handover from a ward nurse to the theatre staff. A full check of the patient's details and consent was carried out, prior to leaving the ward area. The pre-operative checklist was reviewed between the theatre staff and the patient, including confirmation of the procedure to be performed and consent.
- Staff were trained in adult basic life support (BLS) and adult immediate life support (ILS). The service provided information prior to our inspection which showed that 100% of clinical staff had completed BLS training and 100% of eligible staff had completed adult immediate life support training.
- The service had developed a service level agreement (SLA) for the transfer of people using services to the local NHS hospital in the event of complications or deterioration following surgery. At the time of inspection this was still awaiting sign off by the NHS provider but we reviewed the draft contract and found it to be comprehensive and appropriate for purpose.

- The service had a standard operating procedure (SOP) for the use of the local ambulance service to transfer patients in the event of an emergency. The SOP was in date and set out actions and responsibilities, should a patient become unwell and require transfer to an acute NHS hospital. Staff we spoke with were familiar with the escalation process and where necessary, patients were transferred by ambulance. This had happened on two occasions during the reporting period.
- Staff undertook conflict resolution training. Data provided by the service prior to our inspection showed that 100% of staff had received this training.
- There was a Radiation Protection Advisor (RPA) provided by the local NHS trust as part of an SLA. Staff reported that they were responsive and accessible for advice. Contact details were readily available along with posters containing information around laser safety.

Nursing and support staffing

- There were sufficient numbers of nursing staff to keep patients safe in the surgical and ward area at the time of our inspection.
- Data supplied by the service showed there were no unfilled shifts between May and July 2018. The service employed two regular bank staff who were familiar with the procedures and environment. Between August and December 2017 100% of staff in theatres were agency or bank. This improved to 75% for January to June 2018 and further to 50% in July 2018. The executive director confirmed there was a drive to employ substantive staff and reduce reliance on bank staff further.
- Senior staff told us they recognised the use of agency staff had been high in previous years due to difficulty in recruitment. Within the reporting period January 2018 to July 2018 a single agency staff member was regularly employed. This meant that agency staff were familiar with the service's policies and procedures. This provided continuity of care for patients and ensured this member of staff could work safely as they were familiar with the systems and processes of the hospital.
- The surgical department (both ward and theatres) had 3.3 whole time equivalent (WTE) staff which included a registered nurse, operating department practitioner (ODP) and health care assistant (HCA). Some staff moved between the ward and outpatient department which had a further 3.5 WTE registered nurses and a 0.5 WTE HCA. At the time of inspection, the surgical department were established for 5.3 WTE, with the main vacancies in theatres. A registered nurse had been recruited and was awaiting a start date and staff told us that they were actively trying to recruit into a further ODP role.
- The surgical staffing levels followed recommendations from the Royal College of Ophthalmologists regarding theatre and outpatient staffing. This mirrored the National Institute for Health and Clinical Excellence (NICE) and the Association for Perioperative Practice (AFPP) guidelines. There were plans to introduce the Theatre Utilisation Tool (TUT) within the next few weeks which is used in operating theatre departments across the BMI organisation. The tool is designed to automate analysis of a number of key theatre department process measures. The TUT increases the efficiency of the department by refining staff allocation to patient numbers and procedure mix and therefore reducing staffing costs, creating capacity for additional caseload, improving patient safety and ultimately increasing satisfaction for patients, consultants and staff.
- The executive director retained competency as an ODP and the clinical lead as a surgical nurse and both were able to step in to assist in theatres in an emergency if staffing impacted on patient flow.

Medical staffing

- There were 15 consultant surgeons who worked at the hospital under practising privileges. A practising privilege is, "Permission to act as a medical practitioner in that hospital" (Health and Social Care Act, 2008). All but one (who had very recently retired) held substantive posts with local NHS organisations. There were no junior medical staff employed.
- The executive director and the Medical Advisory Committee (MAC) had oversight of the practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- All patients were admitted under the care of a named consultant.
- Consultants were contactable through their secretaries when not at the hospital, if for example advice was required regarding a patient's condition.

Good

Surgery

Records

- All patient care records were in paper format and kept on site for a period of one year following discharge. They were then removed to a secure facility where they were scanned and then destroyed. This meant that patients data was protected but that the service still had access to scanned notes if needed.
- There were effective processes in place to create, maintain and securely store medical records. The service had a purpose adapted, locked storage room and had employed a dedicated medical records officer with responsibility for the filing, storing and maintenance of medical records.
- Patient's confidential data was securely managed with no notes left unattended.
- During our inspection we reviewed ten sets of patient care records. The records we viewed were accurate, fit for purpose, and in line with the Royal College of Physicians Standards for the clinical structure and content of patient records, 2013. All records were well organised and entries were signed, dated and legible. The appropriate assessments including pre-op assessments and patient plans were completed and filed correctly.
- The service completed medical records audits bi-monthly. We reviewed the audit data, which included both surgical and outpatient records for June and September 2018 which showed compliance at 97%. The record audits covered a range of areas such as legibility, completeness, signed and dated entries, pre-assessment and consent. However, the 48-hour post-operative call had not been completed in 65% of notes audited. This had been identified as an area for improvement but at the time of inspection there were no action plans in place.
- Discharge letters were completed on the day of procedure to ensure that patients' General Practitioners (GPs) were informed which meant that they were aware of the procedure should any complications occur which required monitoring.
- The service recorded details of specific implants used for patients so that this could be provided rapidly to the health care products regulator if needed for example; lens recall.

Medicines

- Medicines were stored securely and handled safely. Only nursing, medical and operating department staff had access to the medicines which were stored in the locked cupboards and medicine fridges within the theatre and ward area.
- Staff completed daily medicine fridge temperature checks, which provided assurance the hospital stored refrigerated medicines within the recommended temperature range to maintain their function and safety. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range such as rechecking the temperature after 30 minutes, alerting pharmacy and moving items to alternative medicine refrigerator. We also checked the records for the ambient temperatures of the medication room, which showed these, had been completed correctly.
- The corporate policy 'procedure for the management of medicines when temperatures are out of range' was overdue for review in May 2018. We were told that some procedures and policies were awaiting update at a BMI wide corporate level and that staff adhered to the most recent procedure in place.
- The service did not use or store controlled drugs (CDs) therefore none were kept at the hospital. CD's are medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription, and administration.
- Medicines used within the theatre and ward area were supplied under the service level agreement (SLA) with a local NHS Trust. The service's registered manager had oversight and monitoring of the SLA in conjunction with the link pharmacist from the local NHS trust.
- The storage, preparation, availability and other aspects of medicines management was audited, with the most recent audit taking place in August 2018. Data showed compliance at 96%.
- We reviewed four prescriptions for patients receiving procedures, all prescriptions were signed and dated, with allergies documented.
- Medical gases were stored securely and all were within their expiry date. At the time of our inspection, 100% of eligible staff had received medical gases training.
- Medicines management was part of mandatory training for all clinical staff. This was part of induction and then updated every three years by e-learning. All staff who required this training were up to date.

Incidents

Good

Surgery

- The service reported no never events during the reporting period from August 2017 to July 2018. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- The service reported no expected or unexpected deaths or serious injuries within the same reporting period.
- There were no reported non-clinical incidents and 67 clinical incidents relating to the both the surgery and outpatient department from July 2017 to June 2018. Of which, 94% were declared as no harm and 6% were classed as low harm.
- During our inspection we reviewed incidents reported between October 2017 to September 2018. We saw that 74 incidents were reported during this period of which 68 were within the surgical department. Of these, the highest rating was low harm (three in total). Also recorded were one return to theatre, four surgical complications and three deteriorating patients. The most commonly reported incidents (32) related to patients' procedures being cancelled on the day of procedure. This was during a period of bad weather and unexpected staff absence. There were no other specific themes or trends and the type of incidents included but was not limited to; clinical communication and clinical equipment/instruments.
- Staff we spoke with were clear on how they would report incidents on the electronic reporting system and had no hesitation in reporting them. Some staff expressed concern that there was a lack of computer terminals that were available to access the corporate incident reporting system but this did not deter staff from reporting. Senior staff were investigating the possibility of obtaining a laptop to improve this.
- Incidents, accidents, and near misses were reported. Staff were able to give us examples of the type of incidents they reported.
- There was clear guidance available on incident reporting processes and individual responsibilities available for staff in an Incident Management Policy which was within its review date and version controlled.
- The service had effective processes in place to report, investigate and share learning from clinical and non-clinical incidents and although the senior level staff had not completed root cause analysis training to investigate incidents, they were in the process of looking at options for this.
- Staff shared incident occurrence and outcome at the comms cell meeting each morning and this was shared with staff who were unable to attend.
- All clinical and non-clinical incidents were reviewed at the clinical effectiveness committee meetings, governance meetings and we saw evidence of this in meeting minutes.
- Staff we spoke with had a good understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The service provided care and treatment based on national guidance such as the Royal College of Surgeons, National Institute for Health and Clinical Excellence (NICE) guidance and the Royal College of Ophthalmology.
- We reviewed 10 corporate polices prior to and during the inspection. All were found to be within their review date and referenced current national guidance. The service also had local standard operating procedures (SOPs) for example; the transfer of patients to and from theatre and by the local ambulance service to an NHS hospital in the event of an emergency.
- Staff accessed current policies and guidance on the hospital's intranet. New policies were shared with staff in rest-room areas to ensure awareness of policy updates or changes.
- Senior staff shared policy changes through a monthly clinical governance bulletin, which included action

plans. The Clinical Governance Committee (CGC) and the Medical Advisory Committee (MAC) discussed changes to policies and this was seen in meeting minutes.
- Senior staff monitored compliance with local audit in the daily comms cell meetings which took place at 10am. A representative of the theatre team attended where operating schedules allowed but items discussed were shared to enable feedback to staff within the theatres and ward department.

Nutrition and hydration

- Due to the ambulatory nature of the surgery provided, local anaesthetic was administered so there was no restriction on diet or fluids prior to surgery. This meant that patients were free to eat and drink as normal both prior to and post-surgery. The service provided hot and cold drinks and snacks post operatively.

Pain relief

- All patients received local anaesthetic prior to procedures. For ophthalmic surgery, patients received anesthetising eye drops.
- Dermatology, podiatry and orthopaedic patients received local anaesthetic injections prior to surgery and patients said that they had adequate pain relief.
- The service gave advice on oral analgesia should patients require it post operatively and supplied prescribed To Take Away medicines (TTA') for pain relief. In September 2018 the service introduced a new pain management care plan within the ambulatory minor operations patient pathway.

Patient outcomes

- During the reporting period August 2017 to July 2018, there was one unplanned return to theatre and two unplanned transfers of unwell patients to the local NHS hospital. The unplanned transfers were both unrelated to surgical procedures and the return to theatre was investigated and found to be unavoidable.
- The service measured clinical indicators such as assessment compliance, national early warning score documentation, infection control, consent and adherence to the World Health Organisation (WHO) and five steps to safer surgery checklist. These were discussed at their Clinical Governance Committee and governance meetings.
- The service's participation in national audits was in its infancy and patient reportable outcome measures (PROMs) for cataract patients were not yet regularly reported. We noted that this was a subject of discussion in the senior management team meeting minutes.
- The service monitored patient outcomes by performing post-operative phone calls. The post-operative call back service was audited as part of the records audit. The audit of 25 June 2018 identified that evidence of the completed 48 hours post discharge follow-up telephone call was 35%. The audit identified that the post-operative calls were not being made and there was a plan to improve and re-audit this when staffing improved.
- The service had recently developed local information leaflet for ophthalmic patients along with a set off facts and questions (FAQs) that were given on the day of procedure. There was a plan to audit how effective patients found this information by asking for their feedback with a plan to use this to improve the service. This was taken from guidance from the Royal College of Ophthalmology.
- The service achieved the Commissioning for Quality and Innovation (CQUIN) improving staff health & wellbeing staff flu vaccination target. This was agreed with local commissioners to promote improvement in patient care.
- The 10 surgical patient records we reviewed all showed evidence of regular patient clinical observations, for example, blood pressure, and oxygen saturation, to monitor the patient's health during and post-surgery. Staff had completed all observations in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.
- The service contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- The parent organisation (BMI) had a performance dashboard which ensured consistency across the organisation with the services offered. This allowed the hospital to benchmark its performance against hospitals of a similar size within the group. At the time of inspection the service was performing within the expected parameters.

Competent staff

- The service ensured that all staff were competent and those working under practising privileges also held posts at the local NHS trusts apart from one consultant who had recently retired. All staff had received a disclosure and barring service check (DBS) within the last three years. The executive director had oversight of this with the use of a tracker spreadsheet.
- There were specific induction processes for substantive and bank/agency staff with periods of supernumerary working dependent on role.
- New consultants enquiring about practising privileges were directed to the executive director. Applications had to include demonstration of relevant clinical experience relating to clinical practice and provision of supporting documents including; curriculum vitae, certificates of qualification, annual appraisal, GMC specialist register registration, medical indemnity certificate and Information Commissioners Office (ICO) certificate evidencing registration as a data controller. References, immunisation status and an enhanced DBS check were also required.
- The executive director made individual decisions on progressing the application in line with the criteria set and the commercial need for the speciality in question. The application was then progressed through to the Medical Advisory Committee (MAC) for it to be fully ratified. The final decision was based on the applicant's credentials, qualifications, experience, competence, judgement, professional capabilities, knowledge, current fitness to practice, character and good standing.
- Consultants were also required to provide updated documentation annually as part of their practising privileges. As most of the consultants held NHS contracts, they had their appraisals completed by their NHS Medical Director. The service had made provision for the one consultant who no longer worked for the NHS to receive appraisals within BMI.
- The service reminded consultants of upcoming expiration of their documentation and failure to provide it following a second reminder resulted in suspension of privileges
- All staff were required to complete a number of competencies dependent on their role and nursing staff had access to BMI corporate online guidance to support with the revalidation process. Data showed all nurses were within their revalidation period at the time of our inspection. Revalidation is the process that all registered nurses and midwives need to go through in order to renew their registration with the Nursing and Midwifery Council.
- Staff received an annual appraisal which ran on a yearly basis, January to December. Data provided prior to our inspection showed that 100% of staff in the surgery department who were eligible had received an appraisal. Staff that we spoke with confirmed that appraisals were meaningful and identified progression opportunities.
- The registered manager told us of opportunities for staff to develop including seconded training to develop from healthcare assistant, to associate practitioner and then registered nurse.

Multidisciplinary working

- The daily comms cells meetings provided a platform for staff from all areas to find out what was happening in the hospital and inform the rest of the team of any concerns regarding the operation of the hospital. This enabled all staff from the executive director to the bookings team contribute to the meeting. We observed positive interaction and respectful communication between professionals during the comms cell on the day of our inspection. It enabled the wider hospital population to understand the daily tasks and challenges.
- We observed effective multi-disciplinary working to support the patients. Staff told us they worked well as a team. This was evident on the ward area, operating theatres and the way that staff worked across the surgery and outpatient departments.
- The senior management team held regular meetings with local stakeholders including the clinical commissioning groups (CCGs) and the local NHS trust. Feedback from the CCG confirmed that the service was responsive and engaged fully to improve care for patients.

Seven-day services

- The surgery service generally operated Monday to Friday between 8am to 9pm. Occasional Saturday theatre lists were planned according to need.
- The service did not provide 24-hour consultant cover however patients did have access to a 24-hour BMI advice line.

Good

Surgery

Access to information

- There were comprehensive patient pathway records available to staff that contained all the information staff needed to deliver effective care and treatment.
- Staff sent discharge letters to the patient's GP on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided. This allowed continuity of patient care in the community.
- Staff had access to patient bookings and policy information electronically although this could sometimes be an issue as there were limited computer terminals located throughout the department.
- The service had a secure electronic portal for transferring patient information between the local NHS trust and the hospital.

Health promotion

- The service's website offered advice on a range of health promotion information and posters were seen promoting good heart health and keeping fit.
- Staff provided a range of information to patients on various eye and skin conditions. This enabled patients to learn about their condition and make informed decisions regarding care and treatment options.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The inclusion/exclusion criteria for the service meant that patients who had complicated medical histories, or did not have capacity to consent were not eligible for treatment at the hospital.
- Staff understood the consent to care and best interest process. They told us of action they would take if someone lacked capacity.
- The service had a policy and procedure for consent which was aligned to the Mental Capacity Act 2005 (MCA) which staff had electronic access to.
- Consent was part of mandatory training for all staff involved in the consent taking process. Data provided after our inspection showed that 100% of eligible staff were compliant.
- The ten sets of medical records for surgical patients that we reviewed all had documented consent in place and consent was also part of the service regular records audit.
- Consent for surgical procedures was obtained in outpatient clinic prior to their procedure appointment. This was in line with guidance from the Royal College of Surgeons (RCS) Good Surgical Practice 2014, which states staff should "obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision".

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- We observed staff treating patients with compassion, kindness and respect. Staff introduced themselves to patients before initiating any care interventions and sought their consent.
- Patients told us they were treated with care and respect. They told us the staff were 'very caring and kind' and they received care and support that met their needs.
- Staff ensured patients' privacy and dignity was maintained. There were no private areas to ask patients any sensitive information but staff commented that they would take the patient to one of the consulting rooms if they needed to ask any questions of that nature. We observed the use of curtains around chair spaces and dignity was protected when patients transferred from the wheelchair used to transport patients to the operating table.
- Chaperones were available if required and there were posters advising how to request if desired.
- The service friends and family test (FFT) data was consistently positive during the reporting period of February 2018 to July 2018. Results showed that between 98% and 100% of patients would recommend the service to their friends or family. This data related to combined surgical and outpatient services at the hospital. Response rates ranged between 14% and 29%, and the service was considering how to ensure patients completed FFT forms post procedure, rather than requesting they be returned at future appointments.

Emotional support

- We saw staff speaking with patients in a kind and supportive manner throughout the course of our inspection.

Good

Surgery

- A patient who was nervous about surgery told us that they were reassured by staff and this helped to "make things a bit easier".
- A member of staff always sat beside patients during procedures in the operating theatre to hold their hand if appropriate and provide reassurance.

Understanding and involvement of patients and those close to them

- Surgical patients were supported and provided with written material to ensure they had the information they needed regarding their care.
- Patients we spoke with told us they felt well prepared as they had received support from staff at their pre-admission assessments and on admission.
- Staff involved patients and those close to them as appropriate in the decisions about their care and treatment. Patients we spoke with all confirmed that their treatment had been discussed with them and they felt able to make informed decisions about their care.
- For those patients who were self-funding, which included those with private health insurance, there was information on display about the cost of treatment and this was also discussed at consultation prior to agreeing surgical procedures.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- The premises and facilities were appropriate for the service that was delivered.
- The service provided elective surgery Monday to Friday each week from 8am to 9pm and occasionally on Saturdays dependent on demand.
- The hospital had streamlined its service to treat local anaesthetic mainly ophthalmic NHS patients through contracts with the local NHS trust and commissioners. This meant that local people received NHS-funded surgery at the hospital.
- During the reporting period August 2017 to July 2018 there were 2875 day case admissions of which 76% were NHS funded and 24% self-funded.
- There were effective admission processes including exclusion and inclusion criteria. Patients' suitability for surgery and any concerns from the pre-assessment were discussed with the consultant. This ensured that patients met their criteria for surgery.

Meeting people's individual needs

- The hospital was centrally located to local public transport links and offered free of charge parking for its patients including a disabled parking bay.
- The premises were well maintained and there was level access for people with limited mobility and wheelchair users.A passenger lift was available for access to floors above ground floor level.
- The service had access to telephone translation services to assist patients whose first language was not English.
- There was a hearing loop situated at main reception, and specific information available in larger font to aid ease of reading.
- Staff received training in dementia awareness as part of mandatory training. Information supplied by the service showed that 100% of staff had received this training and staff we spoke with confirmed that they understood what dementia was but that due to the inclusion/ exclusion criteria it was rare that a patient with dementia attended the surgical unit.
- A frailty tool was completed on all day case admissions to help identify where there were patient care needs not being met.

Access and flow

- The service offered access to treatment both for NHS and self-funding patients. GPs referred patients to the hospital via the "choose and book" system, or the local NHS Trust referred patients directly to the hospital. The choose and book system enabled patients to pick an appointment time that suited their needs. In addition, the hospital facilitated appointment changes when required.
- The service performed a daily review of the 18-week referral to treatment (RTT) waiting times and investigated patient's pathways above 14 weeks. Patients waiting over 16 weeks were escalated to clinical leads to increase theatre activity to help reduce waiting times. We were not assured that this was effective as information supplied following our inspection showed the RTT admitted percentage had consistently failed to meet the 90% target since February 2018.

Good

Surgery

- During the period July 2017 to August 2018, data provided by the service showed that they failed to meet the target of 90% for patients admitted within 18 weeks of referral for seven out of the 14 months. The lowest percentage being 64.4% in April 2018. They achieved an overall 84.6% for the 14-month period which was lower than the national average of 88.3% for the same period. There were several reasons provided; namely, poor weather and staffing issues including a consultant long term illness resulting in the cancellation of theatre schedules.
- The service monitored RTT waiting times, did not attend (DNA) rates and cancelled procedures internally using patient administration software. These were also reviewed and discussed at quarterly meetings with the local clinical commissioning groups (CCGs) where any trends were highlighted. Information from the CCG post inspection revealed no concerns regarding the RTT data.
- There was a new data manager and a pre-assessment process in place which aimed to identify patients with the potential to breech and action as necessary to comply with the RTT pathway.
- During the same reporting period (August 2017 to July 2018) there were 729 patients cancelled with March 2018 having the highest number at 116. The reason given for this was severe weather and a power failure. Staff confirmed that the theatre cancellations were a mixture of patients cancelling, moving patient's procedure dates, and low staffing levels with minimal on the day cancellations. The total number of cancelled procedures for a non-clinical reason during the same period was 10.
- Of the above cancelled procedures, the percentage of patients offered another appointment within 28 days of the cancelled appointment was 90%. This meant that the impact and potential harm to patients was minimal.
- During the same period, 93 patients did not attend (DNA) for their procedure. Patients who DNA were contacted to find out why they failed to attend and, were offered a further surgery date. If patients failed to attend a second agreed date they were discharged.

Learning from complaints and concerns

- Complaints about the service were low and during the reporting period August 2017 to July 2018 the service reported nine formal complaints which equates to 0.3 complaints per 100-day case admissions. None of the complaints related to surgery.
- The senior management team meetings and the clinical governance committee (CGC) meetings both had complaints as agenda items and we saw that discussion took place within meeting minutes regarding the complaints about consultant attitude. Actions were put in place to discuss with medical staff, with a plan to monitor moving forward.
- The senior management team provided an update during the inspection regarding the trend in complaints. Following feedback to staff, no further similar complaints had been received in the two months prior to our inspection.
- Information was readily available to patients on how to raise a concern or complaint. This included details on how to escalate to external adjudication services including the Parliamentary and Health Service Ombudsman (PHSO, for NHS patients) and the Independent Health Sector Complaints Adjudication Service (IHSCAS).
- The service followed a three-stage process in dealing with complaints, with clear timeframes set out in the within review date complaints policy. The responsibility for all complaints rested with the executive director, supported by the compliance co-ordinator, acting quality and risk manager and director of clinical services manager.
- Complaints were recorded on the risk management system and acknowledged within 48 hours. The director of clinical services with the support of the quality and risk manager reviewed each complaint on receipt.
- At the time of our inspection there were no open complaints.

Are surgery services well-led?

Good

We rated well led as **good.**

Leadership

- The leadership structure within the service was relatively new but clearly defined and consisted of the executive director and the director of clinical services who were responsible for the day to day management of the service. The executive director, who was also the registered manager was appointed to a substantive position in January 2018 after a period of being the

interim executive director. The director of clinical services was appointed to a substantive post in April 2018 following 12 months in an interim position and there was also a newly appointed (August 2018) theatre manager who reported to the senior management at hospital.

- All senior staff had the skills, experience and knowledge for their roles. They were keen to develop the capacity for the service and the theatre manager was in the process of investigating the development of Local Safety Standards for Invasive Procedures (LocSSIPs) that would be compliant with the National Safety Standards for Invasive Procedures (NatSSIPs).
- The leadership team understood the challenges to quality and sustainability, and had clearly identified the actions needed to address them. For instance; the move towards employing substantive staff rather than reliance on bank staff and the withdrawal of general anaesthetics and cosmetic surgery which had happened during the previous 12 months.
- The senior management team encouraged learning and a culture of openness and transparency. They operated an 'open door policy' and encouraged staff to raise concerns directly with them. We saw senior managers visiting the ward and theatres during our inspection and staff told us this was a normal daily occurrence.
- The leaders were visible and approachable and staff confirmed they were also 'hands on' helping out when needed with clinical tasks. For example; the theatre manager assisted in theatre on a daily basis for theatres and the director of clinical services and the executive director also worked in the theatres on a regular basis.

Vision and strategy

- The service shared the BMI Healthcare vision. This was to provide the best outcomes, the best patient experience, and the most cost-effective care. All staff we spoke with were aware of the vision, goals and values of the hospital and had some understanding of how the service set out to achieve them.
- There was a local focus to become a centre of excellence for the provision of ophthalmic surgery.
- There was a local mission statement; 'our aim is to deliver high quality, cost effective care to all patients'. All staff knew the mission statement which was displayed throughout the hospital.

Culture

- There was a very positive culture at the service with staff commenting that they all worked together as a family.
- Staff described the senior leadership team as supportive and approachable. They described an open-door policy and had faith that if they had an issue it would be dealt with sensitively.
- The theatre manager was new in post but staff described them as very responsive and enthusiastic.
- The service encouraged honesty and there was a strong emphasis in providing a service that was designed around patient need.
- Staff described a culture of learning and development identified at meaningful appraisals.
- We saw that staff worked across the surgery and outpatient services to ensure the smooth running of each area. This included senior management helping with clinical work when needed.
- A different non-managerial member of staff was invited to the monthly management meetings to enable them to develop knowledge of the process and to ensure a culture of openness and transparency.

Governance

- The service followed the BMI corporate governance structure. The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Senior Management Team (SMT), Clinical Effectiveness Meeting (CEM) and Health, Safety and Environment meeting.
- There was an effective governance framework to support the delivery of the strategy and good quality care with several committees including a clinical governance committee (CGC) and a risk committee which had clear lines of reporting.
- The monthly governance meeting agenda items included, key performance indicators, clinical audit plan, patient safety incidents, and the risk register.
- Staff were clear about their roles and understood what they were accountable for.
- The Clinical Governance Committee (CGC), met monthly. Items discussed, included but were not limited to; complaints and incidents, reports from other clinical committees and an update on the risk register. There was a standing agenda item to review external and national guidance and new legislation, such as Medicines and Healthcare Products Regulatory Agency

(MHRA) patient safety alerts. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored.
- The MAC met quarterly and we reviewed the minutes of the meetings which showed clinical governance areas such as complaint and incidents, review of practising privileges, and the upcoming CQC inspection were discussed. Meetings were well attended with representation from surgery staff.
- The executive director and the Medical Advisory Committee (MAC) had oversight of the practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.

Managing risks, issues and performance

- The senior management team (SMT) met weekly. Minutes of meetings we reviewed showed items discussed included complaints, incidents, patient feedback, and key departmental feedback.
- A 'comms cell' meeting took place every morning. This was a meeting of key members of staff from each department and allowed for communication of a number of key issues, regarding patients, procedures and operational issues.
- There was a systematic programme of clinical and internal audit, used to monitor quality, and systems to identify where action was taken.
- The management and monitoring of SLAs with third parties was discussed at the CGC and SMT meetings to ensure that there was oversight of the governance procedures.
- In September 2015, the National Safety Standards for Invasive Procedures (NatSSIPS) were published. The evidenced based standards are applicable to invasive procedures carried out within the surgery department at the hospital and aimed to reduce the number of patient safety incidents related to invasive procedures. There was a requirement for all organisation's providing NHS funded care to implement local safety standards for invasive procedures. The theatre manager confirmed that they were reviewing procedures locally to standardise practice, referred to as LocSSIPS.
- The service had recently introduced an electronic tool to document both incidents and risks. The risk register included 23 risks of which a number were standardised BMI risks, as well as local risks. We reviewed the risks and saw that they were reviewed regularly and updated. In addition, the top five risks were on the comms cell board which was available for all staff to see. This ensured that all staff were aware of the risks to the service and enabled effective oversight of risk. The top five risks included; well led aspect of governance, patient safety for IPC processes and action for deteriorating patient, facilities and infrastructure, and information management. There were actions plans developed to work through these risks.
- The local risks for surgery included items such as scalpels that were judged by consultants to be not fit for purpose. Actions to resolve included - faulty items being identified and replaced prior to any procedures starting and a new supplier was being sourced.
- BMI Dashboards were produced monthly which allowed the service to benchmark itself against similar sized hospitals within the organisation.
- The service had a local business continuity plan to safeguard the interests of patients, and staff in the event of an emergency or significant business disruption.

Managing information

- The service had a good understanding of performance monitoring, with information on quality, operations and finances used to measure improvement, not just assurance.
- There were clear and robust service performance measures, which were reported and monitored by the parent BMI organisation and the local commissioners.
- The service had employed a data manager to ensure that there were effective arrangements to monitor, manage and report on quality and performance.
- Quality and sustainability were standard agenda items in relevant senior management and governance meetings.
- Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre- and post -operative records.
- Following care and treatment letters were sent out to patients'' GPs detailing procedures undertaken and any follow ups they may require.
- There were a variety of leaflets and information available to patients which included post op care.

Good

Surgery

Engagement

- At the time of our inspection there was no local newsletter or written communication for staff but there was open and regular verbal communication with daily theatre huddles during which staff were encouraged to speak up.
- Staff of all levels were actively invited to participate in the planning and delivery of services and in shaping the culture.
- The service was in the process of implementing the 'you said, we did' scheme. This will provide the service with a method to feedback to senior managers.
- There was a BMI corporate newsletter which was used to inform staff of changes and performance within the organisation.

Learning, continuous improvement and innovation

- The service had undergone significant changes in leadership and culture during the 12 months leading up to our inspection. There was a very positive drive to improve and staff were encouraged to innovate and bring new ideas to develop the service further. We saw that newideas such as the morning theatre huddle were being rolled out across the service and staff had developed a patient information booklet specific to BMI Southend Hospital patients undergoing cataract surgery.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatient service consists of three ophthalmic consulting rooms, an ophthalmic visual testing room, and two other consulting rooms (one of which is a treatment room).

Summary of findings

See the surgery section for main findings.

We found one area of practice that required improvement in outpatient services:

Some medical records within the outpatient department lacked legibility.

Good

Outpatients

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Mandatory training

- For our detailed findings on mandatory training, please see the surgery section of this report.
- There were effective processes in place to plan, deliver and oversee compliance with mandatory training.
- The outpatient lead and senior managers oversaw mandatory training compliance within the hospital. Staff worked in both the outpatient and surgery services within the hospital and therefore we have reported detailed findings in the surgery section of this report.
- Mandatory training was delivered through variety of methods including e-Learning (electronic system named BMI Learn) and face to face.
- Mandatory training subjects included, but were not limited to; infection prevention and control, conflict resolution, safeguarding adults and children and information governance.

Safeguarding

- For our detailed findings on safeguarding, please see the surgery section of this report.
- There were effective systems and processes in place to safeguard vulnerable patients from abuse.
- The clinical service manager was the location lead for adult safeguarding. Despite not seeing or treating patients under the age of 18 years the clinical service manager was due to complete level three safeguarding training the week following our inspection. This had not been completed previously due to the member of staff being relatively new in role. In addition, staff had access to level three safeguarding trained staff through companywide BMI systems in place.
- Data provided prior to our inspection demonstrated that 100% of staff had received safeguarding children level one and two and 100% of staff had received safeguarding adults level one and 97.3% safeguarding adults level two training.
- Staff were clear in their responsibilities to identify and report any identified safeguarding concerns.
- Staff had access to clear guidance on the identification and subsequent reporting processes for safeguarding concerns.
- Outpatient areas displayed flow charts to guide staff in decision making. Local authority contact numbers and referral information was available to staff.
- Staff had access to a policy named safeguarding adults. The policy provided guidance on various forms of abuse including female genital mutilation, radicalisation and domestic abuse. The safeguarding children policy also contained further information regarding forms of abuse including neglect and child sexual exploitation. We reviewed the polices and noted they were both in date and subject to regular review.

Cleanliness, infection control and hygiene

- There were effective processes in place to prevent and control the spread of infection.
- Between August 2017 and July 2018, the hospital had no reported cases of Methicillin Resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Escherichia coli (E-Coli) or Clostridium difficile (C-diff).
- The hospital had an infection prevention and control lead in post.
- All areas within the outpatient department were visibly clean and free from dust. We saw cleaning taking place throughout the course of our unannounced inspection.
- All staff had arms bare below the elbow to prevent and control the spread of infection.
- Hand washing facilities, cleansing gel and gloves were regularly available throughout the department in addition to information for staff, patients and visitors on the 'five moments of hand hygiene'. The five moments of hand hygiene are guidelines to indicate when healthcare professionals should perform hand hygiene practices.
- Hand cleansing gel was available at regular intervals throughout the department with signage in place to remind staff, visitors and patients to make use of the gel. We saw that staff encouraged patients and visitors to use hand cleansing gel upon arrival to the hospital.
- All clinical and non-clinical areas were hard floored to enable effective cleaning. In addition, the department had recently replaced all patient chairs within waiting areas to ensure they were wipe clean to facilitate effective cleaning.

- All equipment (including consumable items) was stored above floor level to enable effective cleaning of areas within storage rooms.
- Training records demonstrated that 91% of eligible staff had received training in infection prevention and control. In addition, 85% of eligible staff had received training in infection prevention and control/care bundles and aseptic non-touch technique.
- The service carried out infection prevention and control and hand hygiene audits. Please see the surgery section of this report for more information.

Environment and equipment

- There were effective systems and processes in place to maintain equipment within the outpatient department.
- Outpatient areas were located off the main reception and on level one of the hospital. All patients and visitors booked in at the main reception prior to attending the relevant outpatient area.
- All areas within the outpatient department were clearly signed to allow for navigation between areas. Fire exit routes were clearly marked.
- The outpatient service consisted of two ophthalmic outpatient rooms, one visual field room, one outpatient treatment room and two further outpatient rooms (non-ophthalmic).
- The downstairs waiting area was not directly overseen by a staff member. However, this area had clear signage in place advising patients and visitors on how to summon help if required. An emergency buzzer was in place in the event of collapse or illness.
- Clinical areas were secured by restricted access to various areas including the laser treatment room. This prevented unauthorised access. Laser treatment areas had illuminated signage in place to indicate when lasers were in use.
- Equipment within the outpatient department was predominantly single use. Re-usable items were sent for sterilisation through an existing service level agreement in place.
- Clinical waste and sharps (needles) were stored correctly in colour coded bags and containers. Sharps boxes were within safe 'fill limits' to prevent and control the spread of infection and minimise the risk of a needlestick injury. All boxes were signed and dated to ensure they were replaced on a regular basis.
- However, we found one clinical bin half full of clinical waste within a treatment room that was not in use. The area had been used the previous day which meant that cleaning was not consistent. We raised this with the registered manager who advised they would arrange for the disposal of waste.
- The downstairs outpatient area used emergency equipment, located in the theatre area of the hospital. For more information relating to the checking and maintenance of this equipment, please see the surgery section of this report.
- Emergency equipment for the upstairs outpatient department was located in a central location to enable timely access to equipment in the event of an emergency. We checked the oxygen, automated external defibrillator (AED) and consumable equipment stored in this area. All equipment was in date, accessible and stored in a tagged bag. This ensured that staff could identify if equipment had been tampered with. All other emergency oxygen sources and oxygen masks were securely stored and within expiry dates.
- We reviewed check sheets for emergency equipment in the upstairs outpatient area. Equipment had been checked, as required, on a weekly basis since July 2018. In addition, the AED check had been completed once per calendar month from January 2018 as required.
- Fire extinguishers were available at regular intervals and had been serviced within the recommended timeframes.
- Equipment maintenance was overseen by a designated lead within the service.
- We reviewed equipment used within the outpatient setting including ophthalmic lasers, visual field testing equipment and consumable items. All equipment had been serviced within recommended timeframes and was well organised and free from clutter.
- Annual laser audits were carried out with the most recent inspection taking place in March 2018. The service passed the laser audit which was carried out by a Radiation Protection and Laser Protection Advisor.
- All equipment used was stored on site at the service. Visiting consultants did not use their own equipment during consultations.

Assessing and responding to patient risk

- There were systems and processes in place to identify and respond to patients at risk of clinical deterioration.
- Staff received training in adult basic life support (BLS) and adult immediate life support. Data provided by the

service prior to our inspection showed that 100% of clinical staff had completed BLS training and 100% of eligible staff had completed adult immediate life support training.
- Staff received training in conflict resolution. Data provided by the service prior to our inspection showed that 100% of staff had received this training.
- The hospital organised practical emergency scenario exercises to provide staff with the opportunity to practice lifesaving treatment and skills in the event of collapse or cardiac arrest.
- The most recent resuscitation simulation took place in August 2018 and was based in the operating theatre; however outpatient staff were involved in this exercise. Assessor feedback was mostly positive and recommended additional training in the use of one piece of equipment.
- At our inspection we spoke with staff about the simulation exercise feedback. Staff told us the sessions were useful to gain experience and highlight training needs. Staff had received additional training in the use of equipment, as highlighted by the assessor on the day of the scenario taking place.
- Prior to acceptance in the outpatient clinic, all patients were triaged. There was a strict inclusion and exclusion criteria in place. Excluded patients included those with incapacitating disease consistent with threat to life, unstable medical conditions, patients in receipt of psychiatric treatment, obesity (body mass index great than 40) and patients under 18 years of age.
- At the time of our inspection, there was a draft service level agreement awaiting final agreement for the transfer of deteriorating patients to a nearby NHS trust.
- We reviewed incident data relating to a patient who had become unwell whilst in the outpatient department. Staff had taken appropriate action, followed the deteriorating patient pathway and taken clinical observations including a national early warning score 2 (NEWS2, used to monitor and detect clinical deterioration).
- Laser Protection Advisor (LPA) support was provided by a local NHS trust as part of a service level agreement (SLA). We reviewed the SLA which was subject to regular review. Staff told us the trust were very responsive and accessible for help and advice. We saw that contact details of the LPA were visible in treatment areas of the service in addition to posters containing information around laser safety. The LPA was contactable through onsite visits, email and telephone.
- The outpatient department displayed a daily huddle information sheet. This document advised staff who the named lead was on each day for ward and theatre areas, the resuscitation team lead, fire officer and the resuscitation roster for the upcoming week. This meant staff knew who to contact in the event of assistance being required.
- The outpatient lead was in the process of planning the implementation of daily safety huddles to ensure that all information relating to the service and patient safety was effectively distributed amongst staff. This practice was already taking place within the theatre department and recognised as useful. Please see the surgery section of this report for more details.

Nurse staffing

- For our detailed findings on staffing, please see the surgery section of this report.
- There were sufficient numbers of nursing staff in place at the time of our inspection.
- Outpatient staff also worked in the surgery service within the hospital.
- The outpatient department employed 3.5 registered nurses and 0.5 healthcare assistants (full time equivalent).
- There had been no registered nursing or healthcare assistant staff turnover within the outpatient department from August 2017 to July 2018.
- The vacancy rate for registered nurses was 0% within the outpatient departments.
- From August 2017 to July 2018, there was no reported sickness for either registered nurses or healthcare assistants within the outpatient department.
- From January 2018 to July 2018, the rate of bank staff usage ranged from 25% to 33% in the outpatient department in relation to registered nurses. It is to note however, due to a limited number of staff at the service, this usage of bank staff pertained to one regular bank worker.
- From January 2018 to July 2018, the use of bank or agency healthcare assistants was 0%.
- Due to the size of service, no specific tool was used to ascertain staffing requirements. However, staffing was

planned four weeks in advance and allocated to a rota system. Staffing was then reviewed weekly and then at daily intervals to take in to account staff sickness for example.

Medical staffing

- For our detailed findings on medical staffing, please see the surgery section of this report.
- There were sufficient numbers of medical staff in place at the time of our inspection.
- The service provided care and treatment through 15 doctors under practising privileges. The majority of doctors held substantive posts with local NHS organisations.
- When consultants were off site, contact could be made through their secretaries, for example in the event that advice was required regarding a patient's condition. There was also an arrangement for consultants to cover for each other during periods of annual leave and staff confirmed this worked well.

Records

- There were effective processes in place to create, maintain and securely store medical records.
- The hospital had a dedicated medical records officer in post who was responsible for the filing, storing and maintenance of medical records.
- All medical records were paper based and created at the point of initial consultation. Once a treatment plan had been completed, medical records were electronically scanned and could be recalled in a timely manner if required for further appointments.
- Medical records were prepared and retrieved a day in advance of all outpatient appointments to ensure.
- Medical records were retrieved in advance of outpatient clinics to ensure that healthcare professionals had access to patient information.
- Medical records storage areas were well organised in a secure area. At all times during our inspection we saw that this storage area was locked, therefore preventing unauthorised access.
- We saw that medical records were secure whilst in the outpatient setting; no notes were left unattended during our inspection.
- Medical records contained a dedicated section for correspondence to and from GP's and other healthcare professionals. Letters were sent after consultation, if required.
- We reviewed ten sets of outpatient medical records on the day of our inspection. All records were well organised and contained patient identifiable information on each individual section to ensure records were correctly filed.
- However, three out of ten medical records contained illegible writing which had been documented during patient consultations. We raised our concerns to the registered manager and clinical services lead at the time of our inspection.
- The registered manager and clinical services lead gave assurances that this would be fed back to the consultants concerned, in the aim of highlighting the importance of legible medical records.
- Following our inspection, the service provided information on the actions taken to address non-legibility within outpatient medical records. This included the medical advisory committee chair writing to all consultants, emphasising the importance of legible medical records in line with BMI policy. In addition, medical records audits had been increased in frequency, from bi-monthly to monthly and the BMI group medical director had also written to staff highlighting the need for improved compliance in this area. Local medical records audits had been introduced in addition to monthly audits, specifically looking at legibility. At the time of report writing, initial compliance figures were not available due to the recent implementation of this audit.
- Prior to our inspection, bi-monthly medical records audits took place. We reviewed audit data which showed compliance at 97% for the months of June and September 2018. It is of note, however, that audit results pertained to both the outpatient and surgical departments at the service.

Medicines

- For our detailed findings on medicines please see the safe section in the surgery report
- Medicines used within the outpatient department were supplied under service level agreement with a local NHS Trust. Oversight and monitoring of the SLA was through the service's registered manager.
- The storage, preparation, availability and other aspects of medicines management was audited, with the most recent audit taking place in August 2018. Data showed compliance at 96%.

Good

Outpatients

- Refrigerated medicines were stored securely in a locked medication fridge. Medicines were well organised and all were within their expiry dates.
- Medicines within the medicines fridge were checked on a daily basis when the department was open. We reviewed previous check sheets and found the fridge had been checked on all relevant days from 1 September 2018, up until the date of our unannounced inspection. All temperatures readings were within the recommended range.
- Staff had access to a document named 'procedure for the management of medicines when temperatures are out of range'. Out of range temperatures (between 2 degrees Celsius and 8 degrees Celsius for refrigerated items), can threaten the integrity of medicines within this area.
- We noted that the document was due for review in May 2018, however, a review had not taken place. The outpatient lead advised that some procedures and policies were awaiting update at a BMI wide corporate level and that staff adhered to the most recent procedure in place. They also advised they would raise this with BMI staff to ensure they received an update.
- The outpatient service did not store controlled drugs as the use of these medicines was not required in the outpatient setting.
- Consultants used prescription pads to issue medicines to patients within the outpatient setting. Prescription pads were stored securely in a safe and were signed in and out prior to and after each clinic. Each prescription pad had an associated log for staff to sign out prescriptions demonstrating they had been issued to a patient.
- On review of prescription pad records, we saw that one prescription had been signed out to a patient, however the prescription page was still in the book. We raised our concerns with the outpatient lead who stated they would investigate why the prescription had not been issued to the patient. All other records were correct and accounted for.
- Medical gases were stored securely and all were within their expiry date. At the time of our inspection, 100% of eligible staff had received medical gases training.

Incidents

- For our detailed findings on incidents please see the surgery section of this report.
- There were effective processes in place to report, investigate and share learning from clinical and non-clinical incidents.
- Staff had access to a policy named incident management. The policy was in date and provided staff with clear guidance on incident reporting processes and clearly outlined responsibilities of staff, dependent on role.
- We spoke with one member of staff who could clearly articulate the meaning of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Clinical and non-clinical incidents were reviewed at clinical effectiveness committee meetings, governance meetings and at the daily comms cell briefing which took place at 10am each day.
- There had been no never events reported from August 2017 to July 2018 in relation to the outpatient department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no reported non-clinical incidents and 67 clinical incidents relating to the both the surgery and outpatient department from July 2017 to June 2018. Of which, 94% were declared as no harm and 6% were classed as low harm.
- Our review of incidents between October 2017 to September 2018 showed 74 reported incidents within this period. All six incidents relating to outpatients were declared as no harm. There were no themes or trends and the nature of incidents included but was not limited to; administration error, patient deterioration and information governance.
- We spoke with the outpatient lead nurse who described the incident reporting process in detail. All incidents were reported electronically, at designated computer terminals throughout the service. However, staff acknowledged that a lack of terminals enabled to facilitate online reporting was sometimes difficult and told us that in the future they were hopeful to gain a dedicated laptop for this purpose.

Good

Outpatients

Are outpatients and diagnostic imaging services effective?

We do not rate the effectiveness for outpatient services in acute independent hospitals.

Evidence-based care and treatment

- For our detailed findings on evidence-based care and treatment please see the surgery section of this report.
- The service provided care that was evidence based in accordance with best practice guidelines.
- The outpatient department participated in a number of local audits including but not limited to; medical records, infection prevention and control and hand hygiene.
- Compliance with local audit was monitored on a daily basis at comms cell meetings. Meetings took place at 10am and were attended by the outpatient lead to enable feedback to staff within the outpatient department.
- We reviewed a number of policies over the course of our inspection. All policies were found to be in date and subject to regular review. Policies were based on national guidance and guidelines with references including, but not limited to; the Department of Health, Resuscitation Council (UK), Royal College of Surgeons and the World Health Organisation.

Nutrition and hydration

- Due to the nature of services provided, the outpatient department did not provide nutrition to visiting patients. However, hot and cold drinks were available at regular intervals throughout the department.

Pain relief

- We reviewed ten sets of outpatient medical records and saw that pain relief had not been required in the outpatient setting. For our detailed findings on pain relief, please see the surgery section of this report.

Patient outcomes

- The service was in the process of implementing patient reported outcome measures (PROMs) for cataract patients. Please see the surgery section of this report for more details.
- The outpatient service did not participate in national audits due to the nature of services provided.

Competent staff

- For our detailed findings on competent staff, please see the surgery section of this report.
- There were systems and processes in place to ensure staff were competent within their role, developed and regularly appraised. The outpatient lead nurse, clinical services manager and executive director monitored compliance with training through use of a spreadsheet to ensure staff had the necessary skills and knowledge to safely carry out their role.
- The outpatient lead maintained visibility within the department and operated an 'open door' policy for staff to raise any identified learning needs.
- We reviewed the induction policy which provided guidance to ensure all staff were supported to obtain the necessary skills and knowledge to carry out their role. The policy was applicable to all new starters including permanent, agency and bank staff and outlined the responsibilities for managers to ensure adequate support was available for new staff.
- An induction workbook provided a range of information to staff including signposting to learning resources including BMILearn (online training).
- Staff received an annual appraisal which ran on a yearly basis, January to December. Data provided prior to our inspection showed that 100% of staff in the outpatient department had received an appraisal.
- One member of staff told us they felt developed in their role. BMI had provided the opportunity to fund and facilitate additional role-specific training in ophthalmology.
- The registered manager was keen to develop staff and described BMI as supportive in this process. Various opportunities existed for staff including the opportunity to develop from healthcare assistant, to associate practitioner and then registered nurse.
- Practising privileges were reviewed on a regular basis at medical advisory committee meetings. Nurse revalidation and disclosure and barring service checks (DBS) were monitored through the use of a tracker spreadsheet.
- Staff had access to online guidance to support with the revalidation process. Data showed all nurses were within their revalidation period at the time of our inspection. In addition, all staff had received a DBS check within the last three years.

Multidisciplinary working

Good

Outpatients

- Staff communicated with each other on a regular basis. Daily 'comms cell' meetings enabled staff from all areas of the hospital to converse about many topics including service delivery, patient care and risk.
- Throughout our inspection we saw effective communication taking place between the outpatient and surgery teams at the hospital. In addition, administrative staff, including reception and booking team staff were seen to interact with operational staff on a regular basis.
- Senior managers were in regular contact with both the local NHS trust and clinical commissioning groups (CCGs). CCG feedback advised that the service willingly engaged and worked together to improve care for patients.

Seven-day services

- The outpatient department was open Monday to Friday, with occasional Saturday clinics in place when there was an increased demand for appointments.
- Appointments were available between 9am to 5pm however, late evening clinics were also offered to ensure a range of appointment times to suit a patient's needs.

Access to information

- Data provided prior to our inspection showed that no patients were seen in the outpatient setting without access to all relevant medical records.
- After consultation, consultants dictated findings which were subsequently typed and shared with the patient's GP.
- Staff accessed policies electronically through computer terminals located throughout the outpatient department. We asked a member of staff to locate a number of polices including safeguarding. All policies were located in a timely manner.
- Histology results were accessible through a local NHS trust reporting system meaning results could be shared with other healthcare professionals if required. In the case of referral back to the NHS trust, medical records were shared as required.
- New and revised policies were placed in staff rest areas to ensure staff were aware of policy updates. Staff were required to sign and acknowledge reading policies.
- However, there was a limited number of computer terminal available to staff to look up policies or report incidents. This issue had been raised by staff, who were hopeful to gain a laptop to use in the future.

Health promotion

- The outpatient department provided a range of information to patients on various subjects including but not limited to; cataracts, various eye conditions and arthritis. This enabled patients to learn about their condition and make informed decisions regarding care and treatment options.
- The service's website contained a variety of information on general health such as heart conditions and getting fit.

Consent and Mental Capacity Act

- For our detailed findings on consent and the Mental Capacity Act, please see the surgery section of this report.
- Staff received training in consent which was mandatory for all healthcare professionals involved in the consent taking process. Data provided after our inspection showed that 100% of eligible staff had received this training.
- Staff accessed policy guidance electronically. The consent for examination or treatment policy was found to be in date, regularly reviewed and referenced national guidance and the Mental Capacity Act (2005).
- We reviewed 10 sets of medical records pertaining to outpatients. Our review showed that all had documented consent in place, where clinically appropriate.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- Friends and family test (FFT) data was consistently positive from February 2018 to July 2018 inclusive. Data showed that 98% to 100% of patients would recommend the service to their friends or family. However, please note this data pertained to both outpatient and surgical services at the hospital.
- We spoke with the outpatient lead who advised the service were identifying ways to improve the FFT response rate. From February 2018 to July 2018,

response rates ranged between 14% and 29%. The service was considering the completion of FFT forms whilst patients were onsite, rather than requesting they be returned at future appointments.

- Patient feedback was positive. Our review of feedback showed comments including but not limited to; 'prompt appointment, efficient service', 'a quiet and calm environment' and 'pleasant staff providing prompt and careful attention'.
- We saw a member of staff greet a patient and their relative in a friendly manner, offering refreshments upon their arrival.
- We spoke with one patient who described the service as efficient and also described how he had felt his dignity and privacy was respected during appointments.
- A policy named 'chaperones during examination, treatment and care' was available to staff and clearly outlined the role of chaperones; 'a person who is present as a safeguard for all parties (patient and healthcare professional) and as a witness to continuing consent to an examination or procedure'.
- Patient feedback was displayed on the comms cell board to enable staff to review information.
- Staff respected patient's privacy and dignity within outpatient areas. At all times during our inspection we saw consultations took place in the privacy of consultation rooms, with doors closed. Staff were seen to knock, prior to entering.

Emotional support

- Relatives and carers were welcomed to attend consultations with their loved ones. We spoke with one patient who described they had received adequate information about their appointment, condition and subsequent treatment plan.
- We saw staff speaking with patients in a kind and supportive manner throughout the course of our inspection.
- The outpatient service did not provide counselling services as these were not required in the outpatient setting due to the inclusion and exclusion criteria in place. Any complex cases were not accepted and referred back to an NHS hospital to ensure that the appropriate specialist support was in place.

Understanding and involvement of patients and those close to them

- Consultation costs were discussed at the point of initial assessment, with additional information available to patients either at the hospital or through the service's website.
- The outpatient lead was passionate about developing new ways of providing patients with information about their condition. A new 'frequently asked questions' leaflet had been developed within the previous four months to ensure patients had access to adequate information to understand their care and treatment.
- Staff worked frequently in the same areas at the service. This meant they got to know regular patients and therefore provide continuity of care for patients who used the service.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- The service offered flexibility of appointments to both self-funding and NHS funded patients.
- The service was designed in conjunction with local commissioners to meet the needs of local people.
- The premises and facilities were appropriate for the delivery of service.
- The outpatient department was centrally located to local public transport links and had dedicated car parking on-site.
- There was adequate seating, refreshments and sufficient access for patients with additional physical needs. Waiting areas were calm and quiet to minimise distress.
- Dependent on demand, clinic availability was extended to include Saturdays to ensure that patients were seen in a timely manner.
- The service provided a high proportion of NHS-funded care to support local NHS services. Data from August 2017 to July 2018 showed that 71% of patients had been referred from local NHS services for consultation and treatment.

Meeting people's individual needs

Good

Outpatients

- Staff received training in dementia awareness. Data provided by the service prior to our inspection showed that 100% of staff had received this training.
- We saw there was information on display for patients relating to the cost of treatment. In addition, costs were discussed at initial consultation prior to treatment taking place.
- The outpatient lead had implemented a range of patient information leaflets to ensure that patients had access to relevant information regarding their care and treatment. This included a list of 'frequently asked questions' to help guide and inform patients about their condition and treatment.
- Short notice outpatient appointments could be provided within 24 hours if required.
- Initial consultations had longer appointment times allocated to ensure patients and medical staff had adequate time to discuss conditions and ask /answer questions regarding required treatments.
- The outpatient reception desk was at varying heights to accommodate patients attending in wheelchairs. In addition, a hearing induction loop was present at the reception desk to assist patients and visitors who had a reduced range of hearing.
- The department had access to telephone translation services to assist patients whose first language was not English.
- The outpatient lead described a recent case where at pre-assessment, it was found a profoundly deaf patient was due to attend the service. In response to this, the service arranged a sign language interpreter to assist during consultation and surgical stages of treatment.
- The service had identified the need to offer patients more flexibility with regards to pre-assessment appointments. In response to this, an evening clinic was added to facilitate attendance of patients unable to attend daytime pre-assessment.
- There were parking spaces available for patients attending the outpatient department. All areas were wheelchair accessible with access to a lift, if required, for patient appointments on level one of the hospital.
- Eligible staff received chaperone training. At the time of our inspection, 75% of eligible staff had completed this training.
- Chaperones were available on request. Clear signage was in place advising how this could be requested, if required.

Access and flow

- The service offered access to the consultation and treatment in a timely manner for both NHS and self-funding patients.
- Referrals for consultation and treatment came through a variety of methods including from the local NHS trust (for NHS care), GP and local ophthalmologists.
- The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). NHS referrals constituted a high proportion of the hospital's attendances with 71% of patient referrals coming from the local NHS trust.
- Data showed that the service met and exceeded the 92% RTT target in the months of April 2018 (93.9%, May 2018 (96.4%), June 2018 (96.8%) and July 2018 (97.9%).
- During the reporting period of September 2017 to August 2018, 490 patients did not attend (DNA) for their appointment. Patients who failed to attend were contacted and depending on the reason, offered another date for consultation.
- During the same reporting period, 600 patients had cancelled appointments. This was due to a variety of reasons including patient cancellation or staffing levels for example.
- Rates of patients who did not attend DNA were monitored on a regular basis by the hospital's booking and senior management teams.
- Access to the service was reviewed on a daily basis at comms cell meetings. In addition, the booking and appointments team reviewed RTT data and any patient, waiting more than 14 weeks triggered an in-depth review as to why they had not received an appointment.
- Regular engagement took place between the service and local clinical commissioning group to ensure that patients were being assessed and treated in a timely manner.
- At the time of our inspection, RTT times were approximately 14 to 16 weeks and therefore within NHS constitution requirements of RTT within 18 weeks.
- NHS funded patients could book an appointment through the choose and book scheme. If required, amendments to appointments could be made by contacting the hospital directly.
- Short notice appointments could be facilitated for both NHS-funded and self-funding patients. A contact telephone number was provided for patients to call in the event of encountering any issues after treatment.

Good

Outpatients

- During our inspection we spoke with one patient who advised they had been seen in the outpatient department on a number of occasions. They told us that clinics ran on time and that they had always been seen within a timely manner.
- During our inspection, we saw that consultants and staff facilitated flow within the outpatient department, with clinics running on time to avoid patients waiting for prolonged periods.

Learning from complaints and concerns

- The hospital had a complaints policy in place. The document outlined clear lines of responsibility and a timeframe for acknowledging and responding to complaints. It had been recently reviewed in August 2018 with future review planned for 2021.
- Policy guidance included referral processes to external independent adjudication services including the Parliamentary and Health Service Ombudsman (PHSO, for NHS patients) and the Independent Healthcare Sector Complaints Adjudication Service (IHSCA, for self-funded patients).
- Complaints were a standing agenda item at senior management committee meetings. We reviewed minutes from July 2018 which demonstrated discussion had taken place around an upward trend in complaints relating to consultant attitude. Clear actions were put in place to feedback this information to staff with identified learning, and future monitoring planned.
- During our inspection we requested an update into the recently identified trend in complaints. Senior managers told us that after feedback to staff, no complaints of this nature had been received in the two months prior to our inspection. This was an example of how complaints had been fed back to staff and subsequently used to drive improvement within the department.
- From October 2017 to September 2018, the outpatient department had received five complaints. Of these, three related to an alleged poor consultant attitude, one was a billing query and one related to a delay in referral back to a local NHS trust due to faulty dictation machine equipment.
- We reviewed complaint responses and saw complaints had been acknowledged and responded to in a timely manner, in line with the BMI complaint policy.
- We saw there were numerous information points for patients within the outpatient department which signposted patients on how to make a complaint and provide feedback to the service.
- The service's website contained information on how to make a complaint, with further guidance to the PHSO and IHSCA if a complaint could not be resolved locally.

Are outpatients and diagnostic imaging services well-led?

Good

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

Leadership

- There was a clear leadership structure in place within the outpatient department.
- The outpatient department lead reported to the hospital's clinical services manager. The outpatient department lead provided line management and support for registered nurses and healthcare assistants working in both the outpatient and surgical areas.
- The outpatient manager had experience within their role and was in the process of completing extended training within ophthalmology at the time of our inspection.
- During our inspection, we saw the outpatient lead working effectively amongst staff in all clinical and non-clinical areas, assisting where required.

Vision and strategy

- For our detailed findings on the hospital's vision and strategy, please see the surgery section of this report.
- Staff were passionate about delivering efficient, effective and safe patient care. The vision of the service was to become a centre of excellence for the provision of eye care.
- The services mission statement was; 'our aim is to deliver high quality, cost effective care to all patients'. Staff we spoke with were aware of the mission statement which was also displayed at regular intervals throughout the hospital.
- The introduction of the pre-assessment service had placed increased demand on staff to facilitate this

service. The outpatient lead felt that additional registered nurses and healthcare assistants would enable the service to grow and improve in a safe and sustainable manner.

Culture

- A member of staff within the outpatient department described senior leaders at the service as 'approachable, supportive and responsive' to issues raised. They told us they felt empowered to carry out their role with the current leadership team in place.
- Senior management meetings took place on a monthly basis. The outpatient lead described how one member of non-managerial operational staff was encouraged to attend to ensure a culture of openness and transparency.
- The service placed focus on career development through regular and meaningful appraisals. Staff worked in dual roles within the hospital and told us development opportunities were available.

Governance

- For specific detail on governance processes at the hospital please see the surgery section of this report.
- Hospital wide governance positions had been subject to recent change. The registered manager had commenced in a substantive role in January 2018 after a period of being the interim executive director at the hospital. The clinical services lead was made substantive in April 2018.
- The outpatient lead described feeling part of the service wide governance through regular inclusion at medical advisory committee meetings and clinical governance meetings. An example of change through discussion at clinical governance meetings was the introduction of a telephone pre-assessment service within the outpatient department.

Managing risks, issues and performance

- For our detailed findings on managing risks, issues and performance, please see the surgery section of this report.
- The outpatient lead monitored risk within the outpatient service in conjunction with the theatre lead, clinical services and registered manager.
- Risks were reviewed at regular intervals through use of an electronic risk register.
- On a daily basis at 10am, comms cell meetings took place. The outpatient lead attended these meetings which featured a brief review of the top five risks the service faced. This ensured that all staff were aware of risks and which enabled effective oversight of risk within the service.
- The daily comms cell meetings covered a range of subjects including but not limited to; a review of recent incidents, a health and safety update, training compliance review, planned clinics and risk review. This enabled staff to gain a wider view of risk, issues and general performance within the hospital.
- The outpatient lead had previously identified that staff within the department had not been documenting that cleaning and fridge checking was taking place effectively. As a result, new processes were implemented to ensure compliance with infection prevention control, cleaning schedules and fridge checking. We saw these changes had been implemented on the day of our inspection.
- Both the registered manager and outpatient lead described an open and transparent culture of incident reporting, with the sharing of learning between the outpatient and surgery departments.
- Practising privileges were subject to regular review at medical advisory committee meetings. Consultant's appraisal took place at their substantive place of work (NHS trust). In addition, the clinical services lead met with the responsible officer at relevant NHS trusts to ensure staff were competent within their role.
- Disclosure and barring (DBS) checks were monitored through the use of a spreadsheet tracking system. At the time of our inspection, all registered healthcare professionals had received a DBS check within the last three years.

Managing information

- For our detailed findings on managing information please see the surgery section of this report.
- In the three months prior to our inspection, no patients within the outpatients department were seen without access to all relevant medical records. This meant that healthcare professionals had access to appropriate information to make informed decisions about a patient's care and treatment.
- Service performance data was routinely monitored, used to identify potential performance issues and reviewed on a daily basis at the comms cell meetings.

- Discussion took place around appointment waiting times, incidents and other various subjects including health and safety.

Engagement

- The service had recently implemented a scheme called 'you said, we did'. This provided staff with a method to feedback to senior managers, which was rated red, amber and green (RAG). Feedback was regularly reviewed, with clear lines of responsibility and had clear processes in place to ensure that staff feedback took place.
- The clinical services lead acknowledged that there were no regular staff newsletters in circulation. They told us this was something they were looking to introduce in the near future to improve regular communication with staff. However, we saw a multitude of issues were discussed at the daily comms cell meetings to enable the feedback of information to staff in a timely manner.

Learning, continuous improvement and innovation

- The outpatient department lead had developed an ophthalmic information leaflet after identifying a trend in frequently asked questions. This ensured patients had access to information about their condition and treatment.
- At the time of our inspection, the outpatient department was due to implement huddles to ensure staff had access to a range of relevant information regarding the service on a daily basis.
- For more details on learning, continuous improvement and innovation, please see the surgery section of this report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should continue to monitor and embed newly implemented processes to drive improvements with regards to the legibility of medical records within the outpatient department.
- The provider should ensure it follows its own policy on performing 48-hour telephone follow up calls.
- The provider should ensure it improves its referral to treatment pathway for admitted patients.
- The provider should continue to improve embedding governance processes.

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.

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.