BMI The Hampshire Clinic

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Hampshire Clinic is one of 62 hospitals and treatment centres provided by BMI Healthcare Ltd. It is located in Old Basing, Hampshire, and on-site facilities include 58 available beds, four theatres (two laminar flow), an endoscopy suite, and outpatient suite offering consulting and treatment rooms, and an imaging department offering X ray and ultrasound. The hospital also has a static MRI and CT run under a service contract with Alliance Medical: this service was not included during this inspection as it is a separate organisation.

The BMI Hampshire Clinic provides a range of medical, surgical and diagnostic services to patients who pay for themselves, are insured, or are NHS-funded patients. Services offered include general surgery, orthopaedics, highly-specialist gastro intestinal surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging.

Medical services can be thought of as those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. The medical service consists of two separate components; oncology chemotherapy treatment, and a diagnostic endoscopy service. Endoscopy or chemotherapy services undertaken as a day case are therefore included within medical care in this report.

The announced inspection took place on 21 and 22 March 2016, followed by a routine unannounced visit on 5 April 2016.

This was a comprehensive planned inspection of all core services provided at the hospital: medicine, surgery, outpatient and diagnostic imaging. There is a small critical care facility and this was inspected under surgical services. There are some surgical and outpatient services for patients under 16 years, and these are reported on within the surgical report by Specialist Advisers, but the majority of patients are adults

The Hampshire Clinic was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean people are protected from abuse and avoidable harm.

- Patients were protected from the risk of abuse and avoidable harm acrossall inspected services.
- Staff reported incidents and openness about safety was encouraged.
- Incidents were monitored and reviewed in most services and staff clearly demonstrated examples of learning from these.
- Clinical areas were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections. Where necessary, action was taken to address any identified learning.
- Staff received appropriate training for their role, were supported to keep their skills up-to-date and were further supported in their role through a corporate performance review process. BMI set a target of 90% compliance with mandatory training. Records provided by the hospital showed that the compliance rate for OPD staff was 100% and 100 % for diagnostic imaging staff
- Staff followed national and local guidance when providing care and treatment.

Summary of findings

- Equipment was maintained and tested, in line with manufacturer's guidance. There were appropriate checks and maintenance on the hospital building and plant.
- Medicines were stored securely and chemotherapy was prepared safely. Nursing staff were trained to administer chemotherapy.
- There was regular monitoring of patient records for accuracy and completeness. They were securely stored and available when needed.
- Staffing levels and skills mix were planned, implemented and reviewed to keep patient's safe at all times.
- Plans were in place to respond to emergencies and major situations.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation.
- The medical advisory committee (MAC) reviewed patient outcomes and the renewal of practising privileges of individual consultants. It also reviewed policies and guidance and advised on effective care. The Medical Advisory Committee (MAC) also monitored outcomes of individual consultants and fed back any concerns that were not within normal ranges.
- Regular communication between BMI Hampshire Clinic Hospital Medical Advisory Committee (MAC) Chair and the various trust medical directors was maintained to ensure a coordinated approach to consultant engagement. Consultant concerns were discussed by the hospital management team with the MAC Chair, and if considered serious enough, with the BMI Group Medical Director. Concerns that related to standards of practice, quality or patient safety were also shared with the consultant's responsible officer.
- Oncology patient outcomes were monitored at cancer multi-disciplinary meetings and doctors monitored them in their follow up clinics.
- Patients' pain needs were met appropriately during a procedure or investigation. Pain relief was managed effectively using a patient scoring tool,
- The consent process for patients was well structured and, although rarely used in practice, staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Completed consent forms were seen in the oncology unit's patient records. These were clear and concise and showed consent had been obtained from the patient for planned treatment.
- Quarterly consent audits were completed as part of the hospital audit programme. Results of audits for 2015 showed 75% compliance with standards. Actions for improvement included ensuring the consultant's full name as well as signature was recorded on the form.
- The endoscopy service did not have Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. Preliminary work by the corporate endoscopy team to assess the status of the endoscopy service had led to a proposal to redesign the service at BMI Hampshire Clinic which was about to commence at the time of our inspection
- Patient outcome data was reported for comparative analysis for surgical services, but the endoscopy service was not auditing their performance or collecting data on patient outcomes.

Summary of findings

- Patient satisfaction regarding food quality had declined recently since outsourcing the contract. The hospital management were closely monitoring and addressing these issues to ensure improvements were made. A dietician was onsite every Thursday and oncology patients were referred as needed.
- Staff were competent, skilled and knowledgeable, and were supported to further enhance their clinical and counselling skills.

Are services caring at this hospital?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- There were substantial observations and comments about the emotional care afforded to patients undergoing highly -specialist and complex surgery. The responsible surgeons made themselves available and accessible to patients, ward staff and the RMO, beyond expectation.
- Staff responded compassionately when patients needed help and supported them to meet their personal needs as and when required. Some patients described “exceptional care” delivered by highly-motivated and caring staff. These staff were noted to be not just nursing staff, but across a wide range of professional and non professional staff bodies.
- Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.
- Patients commented that they had been well supported by staff, particularly if they have received upsetting or difficult news at their outpatient appointment.
- Patients were treated courteously and respectfully, and their privacy and dignity was maintained.
- Staff described how all children were involved in the discussions and decision making processes about their treatment and care, in a way which supported their understanding.
- Patients and relatives commented positively about the care provided and said they were involved in decision making.
- The hospital took part in the Friends and Family Test (FFT). For the reporting period April 2015 to September 2015, 99% of patients said they would recommend the hospital to their friends and families. Between 20% to 38% of patients responded to the FFT.

Are services responsive at this hospital?

By responsive, we mean that services are organised so they meet people’s needs.

- Services were planned and delivered in way which met the needs of the local population. Patients told us that there was good access to appointments and at times which suited their needs.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services being delivered.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the National Health Service (NHS) in England: this allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- There was openness and transparency in how complaints were dealt with, and staff could demonstrate where learning and actions had taken place. Patient’s comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the BMI Hampshire website. However, we did not see any guidance, posters or leaflets instructing patients on how to make a complaint.

Summary of findings

- A complaints database enabled the executive director and the director of nursing to track progress and close complaints when the complainant was satisfied.
- For the reporting period January 2015 to December 2015, the hospital consistently met the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral.
- Patients were able to access services when needed and we found services responsive to meeting individual needs. They were satisfied with the appointments system. Most patients told us it was easy to get an appointment when they needed it.
- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. However, staff noted there were rarely patients who had complex or additional needs.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 78% for dementia which was slightly lower than the England average of 81%.

Are services well led at this hospital?

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promotes an open and fair culture.

- There was a clear statement of vision and values, which was driven by quality and safety. This aligned with the corporate purpose and vision of providing high-quality and convenient patient care
- Staff knew and understood the vision, values and strategic goals.
- Quality of care was regularly discussed in board meetings, and in other relevant meetings below the board level.
- There was an effective and comprehensive process in place to identify, understand and monitor and address current and future risks. Staff attended governance meetings and committees such as infection prevention and control meetings. Staff received feedback from hospital-wide meetings in emails and we saw team meeting minutes that were available to all staff.
- There were effective governance structures, and a hospital- wide risk register which was updated regularly. Departmental risk registers also identified specific risks in that area which may affect staff, patients and visitors. The risk registers reflected actions to be taken to mitigate any risks. However, the Hospital's risk register captured high level, hospital wide risks, but this was not fully mature at theatre level.
- The Medical Advisory Committee (MAC) met monthly. The MAC had standing agenda items, which included regulatory compliance, practicing privileges, incidents and complaints, quality assurance and proposed new clinical services and techniques. There was representation at this meeting from anaesthetics, and different surgical disciplines.
- The departments provided the senior management team (SMT) with a weekly report, which effectively updated them with operational information from that week. This included any risk issues.
- There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on the intranet and signed a declaration to confirm they had read and understood the policy relevant to their area of work.
- Staff reported an open and transparent culture. They were positive about the leadership at management level. They told us the leadership team were visible, accessible and approachable. They felt concerns were listened to and where possible acted upon.

Summary of findings

- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test.
- Results of the latest patient survey (February 2016) showed high levels of satisfaction with 99.6% recommendation.The hospital was 32nd place (out of 59 BMI hospitals) across the BMI group for patient satisfaction scores.

However, there were also areas of less good practice where the provider needs to make improvements.

Importantly, the provider must ensure:

- accessible guidance on how to make a complaint is available to all patients
- the plan to upgrade the endoscopy unit to meet Joint Advisory Group on gastrointestinal endoscopy (JAG) standards is progressed.
- data on patient outcomes is collated to monitor performance.
- staff are aware of and engaged with risks relating to their department.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	Overall, this service was rated as good and specifically good for each of the key questions of safe, effective, caring, responsive and well-led. Staff demonstrated an awareness of how to report incidents and learning from incidents was shared at departmental level. Staff undertook appropriate mandatory training for their role. Patients were protected from the risk of abuse. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections. Staffing levels and the skill mix of staff was appropriate for both the endoscopy and oncology services. Agency staff were not used, regular bank staff were occasionally employed to provide cover. Nursing staff received training to ensure they could respond appropriately if a patient's condition deteriorated and in an emergency situation. Staff followed national and local guidance when providing care and treatment. Staff were supported in their role through a corporate performance review process. Staff were encouraged to participate in training and development. Patients' pain needs were met appropriately during a procedure or investigation. The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. During the inspection we observed care was provided compassionately by caring staff. Patients' feedback through interviews and comments cards was positive; they commended the professionalism and kindness of staff. Patients were treated with dignity and respect. They felt they were fully involved in planning their care and treatment. Staff took time to ensure they listened to and responded to patients' questions appropriately. This included the provision of emotional support. Services were planned and delivered in a way which met the needs of patients. Access to appointments was timely and depended on patients' preferences. Interpretation services were available, however, staff could not recall the need to access this service for the

Summary of findings

patients they cared for. Patients were aware of how to provide feedback and complain about the service if needed. Complaints were investigated and changes made if necessary.
Effective governance systems were in place. The risk management framework was under review. Since January 2016 the executive team was beginning to share the risk register with heads of departments. Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture. Patients were given opportunities to provide feedback about their experiences and this was used to improve the service. However, the endoscopy unit did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. Staff were generally well informed about issues relating to their department. However, endoscopy staff had not been formally engaged with regarding the plans for redeveloping the unit and service to meet JAG accreditation. Although a first meeting was planned during the week of the inspection.

Surgery

Good 

Overall we rated this service as good because:
Staff monitored patient safety; they investigated incidents and shared learning to improve care.
All the areas we viewed were visibly clean and well maintained; however, the corridors in the area around the operating theatres were a little cluttered.
Equipment was available and staff completed regular safety checks on equipment and the environment.
Consultants gained consent from patients during the initial consultation and again on the day of surgery.
Patient records were well structured and staff completed all the relevant sections with few exceptions.
Staffing levels were sufficient to meet the needs of the patients. The service had competent staff who worked well as a team to care for patients. They told us training was available and managers gave them time to attend.
Staff were up to date with their mandatory training and understood the safeguarding policies and procedures for adults and children. Doctors were

Summary of findings

available to provide care for patients 24 hours a day. The hospital gave discharge information to patients when they went home and sent it to their GPs within 48 hours of discharge.
The service had policies and guidance to ensure staff provided care and treatment that took account of evidence based standards and procedures. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals within the BMI group Staff supported and treated patients with dignity and respect, and the patients were involved in decisions about their care plan. There were substantial observations and comments about the emotional care afforded to patients undergoing highly -specialist and complex surgery. The responsible surgeons made themselves available and accessible to patients, ward staff and the RMO, beyond expectation.
Patients told us they received enough information and were satisfied with the care and treatment they received. Information leaflets were available about the hospital services, including child and young adult friendly versions, the staff had access to translation services for patients whose first language was not English.
There were clear governance structures in place with committees for clinical governance, health and safety, infection control, medicines management, resuscitation, transfusion and radiation protection.

Outpatients and diagnostic imaging

Good

Overall, this service was rated as good. We found outpatients and diagnostic imaging (OPD) was good for the key questions of safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to rate this.
There were appropriate systems in place to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse. Staff received up-to-date training in all safety systems.
Patients' care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews

Summary of findings

of services. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice. Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect. Feedback from people who use the service and those close to them was positive about the way staff treated them. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs. Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole.
Staff managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities. Services were planned and delivered in way which met the needs of the local population. Waiting times, delays, and cancellations were minimal and managed appropriately. There was openness and transparency in how complaints were dealt with.
There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals. There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Summary of findings

Contents

Good

BMI The Hampshire Clinic

Services we looked at
Medical care; Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to BMI The Hampshire Clinic

The Hampshire Clinic is one of 62 hospitals and treatment centres provided by BMI Healthcare Ltd. It is located in Old Basing, Hampshire, and on-site facilities include 58 available beds, four theatres (two laminar flow), an endoscopy suite, and outpatient suite offering consulting and treatment rooms, and an imaging department offering X ray and ultrasound. The hospital also has a static MRI and CT run under a service contract with Alliance Medical: this service was not included during this inspection as it is a separate organisation.

The BMI Hampshire Clinic provides a range of medical, surgical and diagnostic services to patients who pay for themselves, are insured, or are NHS patients.

This was a comprehensive planned inspection of all core services provided at the hospital: medicine, surgery, outpatient and diagnostic imaging. There is a small critical care facility and this was inspected under surgical services. There are some surgical and outpatient services for patients under 16 years, and these are reported on within the surgical report by Specialist advisers, but the majority of patients are adults.

The following services are outsourced:

• Agency Clinical Staff - Team 24

• Blood Transfusion Service - Hampshire Hospitals NHS Foundation Trust

• Catering - Compass

• Microbiology - Dr Nicki Hutchinson

• Pathology Service - Hampshire Hospitals NHS Foundation Trust

• Radiation and Laser Protection support and advice - Royal Surrey County Hospital, Guildford

• Resident Medical Officer - Cape Medical.

We carried out a comprehensive announced inspection of BMI The Hampshire clinic on 21 and 22 March 2016, and an unannounced inspection on 5 April 2016.

We inspected the following three core services:

• medicine (endoscopy)

• surgery

• outpatients and diagnostic imaging.

The registered manager, Bruce Robinson, registered on 17 July 2013.

Our inspection team

Our inspection team was led by:

Inspection Lead: Moira Black, Care Quality Commission, Inspection Manager.

The team of nine included CQC inspectors and a variety of specialists: The team included CQC inspectors and four specialist advisers, including a consultant surgeon, a consultant nurse, a radiographer and a governance specialist.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• **Is it safe?**

• **Is it effective?**

• **Is it caring?**

• **Is it responsive to people's needs?**

• **Is it well led?**

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical

Summary of this inspection

commissioning group. We carried out a comprehensive announced inspection of BMI The Hampshire clinic on 21 and 22 March 2016, and an unannounced inspection on 5 April 2016.

As part of the inspection process, we spoke with members of the executive management team and individual staff of all grades. We met with staff working within the surgical, endoscopy and outpatient areas. We spoke with patients and people attending the outpatient clinics. We looked at comments made by patients when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital. We observed care and treatment, talked with patients, and reviewed patients' records of care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at BMI The Hampshire Clinic.

Information about BMI The Hampshire Clinic

Key facts and figures

The accountable officer for controlled drugs is Bruce Robinson, registered manager.

Hospital activity during the year to October 2014-September 2015:

6,035 day-case inpatients;

1,979 overnight inpatients;

8,890 visits to theatre;

15,332 outpatients (first attendees).

Safety

In the reporting period (October 2014-September 2015):

- One "Never Event", reported in September 2015.
- No statutory notifications of deaths.
- No cases of C. difficile; MSSA or MRSA.
- No safeguarding concerns
- VTE screening target of 95% met (100% achieved)
- Five cases of hospital acquired VTE
- 323 clinical incidents. The rate of clinical incidents (per 100 inpatient discharges) has fallen within the reporting period
- One serious incident.

Staffing:

For inpatient departments at the hospital:

- A ratio of nurse team leader to nurse other of approximately 1 to 9.6
- A ratio of nurse/ other to care assistant of approximately 1 to 0.4.
- Occasional (less than 20%) to no use of agency staff for inpatient staff groups

Effective

- Nine cases of unplanned returns to theatre in the reporting period (October 2014-September 2015). The rate of unplanned transfers (per 100 inpatient discharges) has fallen in the same reporting period.
- 16 cases of unplanned readmission within 29 days of discharge in the reporting period (Oct 14 to Sep 15). A consistent low rate of unplanned readmissions (per 100 inpatient discharges) in the same reporting period.
- High levels of staff appraisal rates (equal to or greater than 75%) in the reporting period (Oct 14 to Sep 15) for:
- Care Assistants working in inpatient departments
- Nurses working in inpatient departments
- Other Support Workers (hospital-wide).
- Moderate levels of staff appraisal rates (between 50% and 74%) in the same reporting period for:
- Administrative and Clerical staff (hospital-wide)
- Allied Health Professionals (hospital-wide).

Caring

- High (equal to or greater than 85%) FFT scores in the period Apr 15 to Sep 15.

Summary of this inspection

- Low (less than 30%) response rates in the same reporting period with the exception of Aug 15 when the response rate was moderate (between 30% and 60%).
- BMI The Hampshire Clinic has received four items of rated feedback on the NHS Choices website in the reporting period (Oct 14 to Sep 15): three extremely likely to recommend, one unlikely to recommend.

Responsive

- The provider and clinical commissioning groups determined the range of surgical services provided. Surgery was available to NHS funded, self-pay and insured patients and all received the same level of care including children and young people.
- Staff planned and delivered services to meet the needs of the local population. They met daily to ensure patients' admission and discharge was timely, and with the right level of care and support. The hospital was meeting their referral to treatment targets for patient admissions.
- Patients occupied the level three intensive care beds for 93 of the 365 (25%) available bed days during the reporting period (October 2014 to September 2015) and patients occupied level two critical care beds for 251 of 365 available bed days (69%).
- Delays and cancellations were minimal and there were no breaches of the national waiting time targets for referral to treatment. (RTT) The hospital achieved 100% in 10 months and 99% in two months between October 2014 and September 2015; and consistently exceeded the 90% target.
- For the reporting period January 2015 to December 2015, the hospital consistently met the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral.
- The hospital received 37 complaints in 2014 compared to 27 complaints in 2013
- CQC have directly received one complaint in the reporting period.

Well Led

- Moderate levels of vacancy (between 10% and 19%) for: Allied Health Professionals (hospital-wide).
- Low levels of vacancy (less than 10%) for: Nurses and Care Assistants working in inpatient departments.
- No vacancies for: Administrative and Clerical staff (hospital-wide)
- Other Support Workers (hospital-wide).
- Mainly low rates of sickness (less than 10%) for in the reporting period (Oct 14 to Sep 15) for: Administrative and Clerical staff (hospital-wide) Allied Health Professionals (hospital-wide) Nurses working in inpatient departments: Other Support Workers (hospital-wide).
- Moderate rates of sickness (between 10% and 19%) for inpatient Care Assistants in Nov 14 - Feb 15 and Apr 15.
- High levels of staff stability (equal to or greater than 80%) for all inpatient and hospital-wide staff groups in the reporting period (Oct 14 to Sep 15).
- Low levels of staff turnover (less than 20%) for all inpatient and hospital-wide staff groups in the reporting period (Oct 14 to Sep 15).
- 100% completion rate of validation of registration for Doctors and Dentists working under practicing privileges, Allied Health Professionals (hospital-wide) and inpatient Nurses.

No whistleblowing concerns have been reported to CQC in the last 12 months.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We are will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Good

Medical care

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

Information about the service

The BMI Hampshire Clinic provides medical services to patients who pay for themselves, are insured, or are NHS patients. Medical services can be thought of as those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Endoscopy or chemotherapy services undertaken as a day case are also included within medical care.

The BMI Hampshire Clinic medical service consists of two separate components; oncology chemotherapy treatment, and a diagnostic endoscopy service. Oncology patients were cared for on Enbourne ward which was open between 7am and 7pm, Monday to Friday. Four rooms were allocated for oncology patients and they were seen on Tuesday to Thursday and occasionally Saturdays if needed.

The endoscopy service operated between 7am and 7pm, Monday to Friday. Endoscopy procedures were carried out under local anaesthetic or sedation. Procedures under general anaesthesia were carried out in theatres. The endoscopy unit was located between the ward and theatres department. The unit consisted of a reception area, toilet, treatment room and a small decontamination room.

Between March 2015 and February 2016, 492 patients received oncology treatment and 889 patients visited the endoscopy unit as day cases. The most common procedure was diagnostic colonoscopy (this is a diagnostic test performed under light or no sedation.)

During the inspection, we spoke with eight nursing staff, one consultant and administrative staff. We also spoke with three patients and two relatives. We reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment being used. We reviewed 13 patient care records and we observed interactions between staff and patients.

Good

Medical care

Summary of findings

Overall, this service was rated as good and specifically good for each of the key questions of safe, effective, caring, responsive and well-led.

- Staff demonstrated an awareness of how to report incidents and learning from incidents was shared at departmental level. Staff undertook appropriate mandatory training for their role. Patients were protected from the risk of abuse.
- Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Staffing levels and the skill mix of staff was appropriate for both the endoscopy and oncology services. Agency staff were not used, regular bank staff were occasionally employed to provide cover. Nursing staff received training to ensure they could respond appropriately if a patient's condition deteriorated and in an emergency situation.
- Staff followed national and local guidance when providing care and treatment. Staff were supported in their role through a corporate performance review process. Staff were encouraged to participate in training and development. Patients' pain needs were met appropriately during a procedure or investigation. The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- During the inspection we observed care was provided compassionately by caring staff. Patients' feedback through interviews and comments cards was positive; they commended the professionalism and kindness of staff. Patients were treated with dignity and respect. They felt they were fully involved in planning their care and treatment. Staff took time to ensure they listened to and responded to patients' questions appropriately. This included the provision of emotional support.
- Services were planned and delivered in a way which met the needs of patients. Access to appointments was timely and depended on patients' preferences. Interpretation services were available, however, staff could not recall the need to access this service for the patients they cared for. Patients were aware of how to provide feedback and complain about the service if needed. Complaints were investigated and changes made if necessary.
- Effective governance systems were in place.
- Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture. Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

However

- The endoscopy unit did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. Staff were generally well informed about issues relating to their department. However, endoscopy staff had not been formally engaged with regarding the plans for redeveloping the unit and service to meet JAG accreditation. Although a first meeting was planned during the week of the inspection.

Good

Medical care

Are medical care services safe?

Good

By safe, we mean people are protected from abuse and avoidable harm.

We rated medical care as good for safe because:

- There was identification, analysis and learning from incidents when things go wrong or 'near misses'. Staff received appropriate training for their role and were supported to keep their skills up-to-date. Patients in the oncology and endoscopy services were protected from the risk of abuse.
- Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Staffing levels and the skill mix of staff were appropriate for the services. Agency staff were not used, regular bank staff were occasionally employed to provide cover. Nursing staff received training to ensure they could respond appropriately if a patient's condition deteriorated and in an emergency situation.
- There was sufficient medical cover provided by resident medical officers (RMOs) who covered the hospital 24 hours a day for all specialities. Consultants were also available daily and would provide support and advice out of hours if necessary.
- Patient records were clear and well organised. Medicines were stored securely and chemotherapy was prepared safely. Nursing staff were trained to administer chemotherapy.

However

- Endoscopy decontamination was performed in a small room with equipment that was due for updating. BMI was considering future options for decontamination in line with its aim to achieve Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation.

Incidents

- In the reporting period March 2015 to February 2016, there were 428 clinical incidents reported across the hospital, nine of which had been reported by oncology and endoscopy staff. Six related to endoscopy, four of which involved administrative or communication issues and two related to equipment issues. Three related to the oncology service.
- Incidents were investigated for trends. For example, the number of day case patients who had to be admitted overnight as they returned from theatre later than expected. Following investigation it was agreed that day case patients would be scheduled on the theatre list earlier in the day to reduce the risk of an overnight stay.
- All staff we spoke with were aware of their responsibility to report incidents. Staff reported incidents on a paper incident report form which was submitted to the hospital risk manager for entry onto the corporate electronic reporting system.
- The endoscopy lead nurse described a recent incident that had occurred in the department due to a problem with a cable and the actions that were taken in response to this.. Learning from incidents from endoscopy units through an endoscopy network group of staff from independent hospitals and NHS hospitals, was also shared. For example, an incident of the use of diathermy (electric current) for flexible sigmoidoscopy. The endoscopy lead received safety alerts and acted upon them as needed.
- All incidents were reviewed by the director of nursing and executive director within one week. Investigations took place if needed to identify underlying causes and learning was shared at monthly clinical governance meetings.
- Staff discussed incidents reported in the previous 24 hours at the daily communication or 'huddle' meetings. These were attended by a representative of each department, and led by the director of nursing.
- The director of nursing received and disseminated medical and health regulatory (MHRA) safety alerts to relevant departments. These were noted in the minutes of the clinical governance meetings.
- Incidents were collated into a weekly incident report which was discussed at ward meetings and heads of department meetings. Individual incidents and learning were discussed at bimonthly clinical governance meetings and quarterly medical advisory committee (MAC) meetings.

Duty of Candour

- The duty of candour (DoC) 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.' Staff were aware of the principles of duty of candour although no staff recalled any incidents where DoC had been triggered. The electronic reporting system included a specific prompt relating to DoC.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The 'NHS safety thermometer' is a local improvement tool for measuring, monitoring, and analysing patient harms and 'harm free care' on one day each month.
- Safety thermometer data was not collected for Enbourne ward as it was not an inpatient unit, but nurses did monitor the completion of risk assessments. All patients had venous thromboembolism (VTE) assessments completed on admission. Staff also tested patients for Meticillin Resistant Staphyloccocus Aureus (MRSA) infection and risk assessments for pressure ulcers.

Cleanliness, infection control and hygiene

- All ward areas we visited and the endoscopy unit were visibly clean and tidy. A cleaning schedules folder included housekeeping/ nursing and contractor responsibilities. For example, patient medical equipment was cleaned by nursing staff between patients and the medicines fridge cleaned monthly. Cleaning schedules were signed as checked on a weekly basis by the domestic supervisor.
- Hand sanitizer points were available to encourage good hand hygiene practice. Notices outside every patient room prompted staff and visitors to observe good hand hygiene. We observed staff adhered to the national 'bare below the elbow' guidance which enabled thorough hand washing, and reduced the risk of spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff outside bedrooms, to ensure their safety when performing procedures. We saw staff used them appropriately.
- Clean equipment was labelled to indicate it was ready for use, for example, blood pressure monitors.
- The hospital infection control lead nurse provided support, advice and training to staff. They also undertook departmental audits. The monthly infection prevention and control scorecard for endoscopy unit showed 100% compliance with hand hygiene practices and 100% for sharps, cleaning and decontamination consistently for six months between October 2015 and February 2016. The results for Enbourne were also 100% for hand hygiene except for February 2016 when the result was 60%.
- Biannual detailed infection prevention and control audits were undertaken. The most recent audit (December 2015) for the inpatient wards including Enbourne ward highlighted some areas for improvement including standards of cleanliness and the need for a suitable hand wash basin in the sluice area. Some actions had been addressed immediately and others such as those to be completed as part of the refurbishment, including the provision of the hand wash basin were identified on the hospital risk register.
- Endoscopy decontamination was performed in a small room with equipment that required updating. BMI was considering future options for decontamination in line with its aim to achieve Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation for the BMI Hampshire Clinic.
- An environmental infection control audit for the endoscopy unit and decontamination room was carried out in October 2015 and highlighted the decontamination area was not compliant with national Department of Health guidance on endoscopy units, for example the room did not allow for dirty and clean segregation. Other issues related to improved cleaning and improved storage of equipment were actioned in November 2015. Although the area did not comply with current decontamination Department of Health guidance on endoscopy units, the service had put measures in place to mitigate infection control risks through adequate staffing, for example a dedicated decontamination technician and strict adherence to procedures. No incidents had been reported due to decontamination issues.
- In line with current best practise Enbourne ward had a 0% rate of Meticillin Resistant Staphylococcus Aureus (MRSA), Meticillin Sensitive Staphylococcus Aureus

(MSSA), or Clostridium Difficile (C. Difficile) in the reporting period December 2014 to December 2015. All patients underwent MRSA screening before admission to the hospital.

- A rolling programme of replacing carpets with washable floors in patient rooms was underway. This issue was on the risk register (January 2016). On Enbourne ward four rooms had washable floors and plans to replace carpet in a further four rooms was scheduled for the next month.

Environment and equipment

- During the inspection, we observed equipment was labelled as serviced and electrical appliance tested. Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment
- Nursing and housekeeping staff safely managed clinical waste and non-clinical waste to ensure segregation and safe disposal.
- Resuscitation equipment was maintained, in order and ready for use in an emergency. Trolleys were checked daily and records kept to demonstrate that checks had been completed. Expiry dates of items were recorded to easily identify items which were due for re-ordering. The trolleys were secured with tamper evident seals.
- The ward areas were well signposted and corridors were free from clutter.
- An annual health and safety audit was undertaken by the hospital quality and risk manager. The 2014 report and 2015 plan for Hampshire Clinic showed all actions had been achieved or partly achieved for 2014 and an improvement on the previous year's results.
- The hospital fire officer carried out weekly fire alarm tests and fire drills three times a year.
- There was a system to remind heads of department when servicing of equipment was due and to check when it was done. The materials manager kept this on a spreadsheet. The service level agreement with the local acute hospital covered planned preventative maintenance for the environment and plant.
- An equipment log was held for calibration of endoscopy equipment. A nurse was responsible for notifying theatre staff when items were due to be serviced and checking services had been completed.
- BMI Healthcare's electro-biomedical engineering (EBME) department managed the contracts for BMI healthcare that dealt with engineer contracts and the scheduling of servicing for the endoscopy equipment.

Medicines

- Chemotherapy treatment was supplied as pre-filled syringes and made up in the ward treatment room. The nursing staff said they had a very effective working relationship with the pharmacy staff. The pharmacist visited the ward daily to provide advice and arrange restocking of medicines.
- Regular pharmacy audits were scheduled in the hospital audit calendar. Controlled drugs and medicines management audits of all ward areas and endoscopy were undertaken. The recent audits (December 2015) showed a small number of areas for improvement but overall compliance with medicines management standards.
- All medicines requiring cold storage were held in the medicines fridge. The maximum and minimum temperatures were recorded daily to ensure medicines were maintained at a safe temperature.
- Local cancer network protocols were used in the prescribing of cancer treatments and chemotherapy.
- In the oncology unit, emergency medicines, including extravasation kits were available for use. An extravasation kit is equipment used to remove an intravenous drug or fluid that has leaked from a vein into the surrounding tissue. An anaphylaxis kit, for treating anaphylactic shock, was present on the unit with its content clearly labelled.
- Medicines and prescription pads were stored securely. Cupboards that contained oral and intravenous drugs were kept locked on Enbourne ward. Drugs were in date and accounted for.
- Intravenous sedation was used for endoscopic procedures and these sedatives were kept locked and secured in theatres.

Records

- We saw a comprehensive chemotherapy booklet that patients brought with them at each treatment session. This kept a record of the treatment received, along with other important information which benefitted both nurse and patient.
- Patient records were locked in a filing cabinet, to which only appropriate staff had access.

- Thirteen sets of patient notes were reviewed: eight for endoscopy patients and five for oncology patients. We found good documentation in clear and concise records.
- Medical records and personal identifiable information was stored securely and only accessible by authorised staff.
- Patients' records were held securely on site in the department and archived in the on site medical records department.
- Monthly records audits were undertaken as part of the annual audit plan. Summary results of the audits for January 2015 to December 2015 showed compliance with record keeping standards varied between 75% to 94% over the year. The main area of performance which was identified for improvement was the filing of consultant's daily progress notes in the patients' notes.

Safeguarding

- Safeguarding training for vulnerable adults was mandatory for all staff. All the staff we spoke with, were aware when to raise a concern and the process they should follow, but staff we spoke with could not recall raising any safeguarding concerns. Between October 2014 and September 2015 no safeguarding referrals had been raised by the hospital. Compliance with safeguarding training was 100% in Enbourne ward and endoscopy service.
- All staff were required to complete the level of safeguarding training appropriate to their role. For example, clinical staff were trained to level 2 safeguarding children and safeguarding vulnerable adults, all other staff were trained to level 1 safeguarding children and safeguarding vulnerable adults. In addition, in accordance with BMI policy and the director of nursing and children's lead nurse were trained to level 3.
- Staff were aware of who the hospital safeguarding lead was and how to respond if they witnessed or suspected abuse. A trained safeguarding lead was always on site when children were being cared for.
- Safeguarding information and contact numbers were displayed as a reminder and easy access for staff in the departments.

Mandatory training

- Staff and managers at BMI Hampshire Clinic followed the BMI healthcare mandatory training matrix requirements. All staff, dependent on their role, had a role specific mandatory training. For example, information security, fire safety and moving and handling was applicable to all staff whereas blood transfusion and intravenous administration training was only for staff who required the necessary skills in these areas, for example, oncology staff. Most training was done by e-learning, in some cases followed by workshops and assessments. Staff completed their training during their work time and all staff we spoke with said they were up to date with their training requirements.
- Individual staff could access and monitor their progress with mandatory training. Managers could access and monitor their team's achievement. Overall hospital achievement was monitored by the director of nursing at the clinical governance meetings. In January 2016 the hospital achievement for mandatory training was 92% which was above the BMI target of 90%. Staff in oncology and endoscopy had achieved over 90% of completion of mandatory training.
- In addition to e-learning, face-to-face mandatory training was provided in house for example, infection control, moving and handling, safeguarding and fire safety.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but assurance of mandatory training was checked by the medical advisory committee.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The resident medical officers (RMOs) received advanced life support (ALS) and paediatric advanced life support training via the RMO agency. Unannounced emergency ALS scenarios, were practised at least six times a year. Reports on the performance of the RMO and staff were provided to the hospital resuscitation committee and reviewed at monthly clinical governance committees.

Assessing and responding to patient risk

- Patients treated in the endoscopy suite were cared for by a team of staff led by a consultant. Following the procedure patients were transferred to the recovery area in theatres and cared for by recovery staff until they were safe to be transferred to the ward.

- Before oncology patients attended the day unit for chemotherapy, they attended a pre-assessment appointment where staff assessed risks relating to patient treatment. This clinical assessment included physical measurements and blood tests.
- Nursing staff used a triage log sheet based on the United Kingdom Oncology Nursing Society for all calls. If a patient's condition deteriorated. For example, if they complained of temperature, vomiting or pain, nursing staff contacted the patient's consultant for advice.
- Staff were aware of how to how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. Staff received training in 'acute illness management' and online assessment as a mandatory course for registered nurses and health care assistants.
- All staff had received training in immediate life support, with all other staff trained in basic life support.
- Staff completed scenario based training, including resuscitation simulation, every quarter. Staff received feedback during the session about how the team responded to the situation, with learning points and actions to take away.
- A RMO was on duty, who was trained in advanced life support to assist if a patient became unwell. Patients who became medically unwell could be transferred to the local acute NHS Trust by ambulance if required.
- It was a requirement of BMI Healthcare's practising privileges (PP) policy, that consultants remain available or arrange appropriate alternative named cover at all times when they had inpatients in the hospital. PP is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital.

Nursing staffing

- Enbourne staff used the BMI Healthcare nursing staffing planner tool to determine staffing levels, this factored in patient numbers, dependency of patients, skill mix and staff training. For example, a patient undergoing general anaesthesia was allocated three hours of nursing time and a patient undergoing sedation was allocated two hours. The tool allowed for plus or minus five hours nursing time. A normal staff to patient ratio of 1:6 was in operation. The ward sister prepared the staff roster two weeks in advance and it was reviewed on a daily basis. All staff we spoke with said there was sufficient staff and the ward sister felt the tool was sensitive and reliable enough to ensure there was always sufficient staff to meet patients' needs.
- Endoscopy staff reported they had sufficient numbers of staff to meet the workflow and patients' needs in a safe manner.
- There were no vacancies in the oncology team and endoscopy unit and no use of agency staff between October 2014 and September 2015. However, when needed regular bank nurses were employed who were familiar with the service and local procedures.
- There were two trained oncology nurses and one nurse in training. There were no healthcare assistants, although healthcare assistants were employed on Enbourne ward and provided support to nursing staff when needed.
- There was a consistent team of ward nursing staff. There were relatively low rates of nursing staffing sickness and vacancy (less than 10%, approximately six staff) from October 2014 to September 2015. Nursing staff turnover for the hospital was also low at 1% from October 2014 to September 2015.

Medical staffing

- Two oncology consultants at the BMI Hampshire Clinic also practised at the local NHS trust hospital. Patients were initially seen at the NHS trust and treatment provided at the Hampshire Clinic.
- Nursing staff said the consultants were always available, either on site or contactable by phone when needed.
- RMOs provided 24 hour medical cover to the ward for all specialities, on a two-week rotation system. The RMOs worked at the hospital regularly and knew the hospital and its routine well. RMOs were advised of cover arrangements for any consultant on leave.
- The endoscopy service was a consultant led service. Nursing staff said consultants were available when needed.

Major incident awareness and training

- Business continuity plans were in place, and gave details of the actions needed and who to call in emergencies. These were kept in folders on reception, the ward and plant room.
- A generator was available for use in case of power failure, and tested monthly.

Good

Medical care

- Fire evacuation drills were held three times a year, during the day, night and at the weekend. Recommendations from the January 2016 fire inspection were highlighted in the notes of the March 2016 health and safety meetings, which were attended by heads of departments.
- There was a member of the senior management team on duty each day who was responsible operationally for any major incident affecting the hospital. Out of hours there was an on call rota and staff were aware of whom to contact in case of a major incident.
- Business continuity plans in the form of brief action cards were in place for all aspects of the loss of service. For example, loss of premises, loss of IT system and adverse weather conditions. Key contact personnel and actions to be taken were recorded.

Are medical care services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated medical care as good for effective because:

- Staff followed national and local guidance when providing care and treatment. Medical services followed evidence based guidance and best practice. The endoscopy service was working towards achieving Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
- Oncology patient outcomes were monitored at cancer multi-disciplinary meetings and doctors monitored them in their follow up clinics.
- Staff were encouraged to participate in training and development to enable them to deliver good quality care. Staff were supported in their role through a performance review process and they all had regular appraisals.
- Patients' pain needs were met appropriately during a procedure or investigation.
- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Although rarely had to use it in practice.

Evidence-based care and treatment

- Endoscopy staff followed National Institute for Health and Care Excellence (NICE) guidance but did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited. A project led by the corporate team was about to commence to relocate and upgrade the endoscopy unit to meet JAG accreditation.
- The oncology unit followed best practice guidance in the care of their patients using NICE sources, and up to date clinical aspects were discussed at oncology steering groups. This was attended by the oncology lead nurse and ensured collaborative working within oncology teams in the wider NHS. The information was then disseminated across the team.
- All patients scheduled for an endoscopy procedure were offered a telephone or face to face pre-assessment appointment.
- Comprehensive patient assessment was documented in an endoscopy pathway and corroborated by our review of eight records. All the records we reviewed were full completed including relevant risk assessments such as venous thromboembolism and pressure ulcer. Ward staff called patients 24 to 48 hours after discharge to check on patients' recovery and obtain feedback.
- The most common procedures carried out in the last year were cystoscopy, sigmoidoscopy, colonoscopy and oesophageal duodenoscopy. Patients were cared for in the adjacent recovery area by dedicated recovery staff before transfer back to the ward.
- The oncology consultants were on site at the start of a patient's treatment and once a week on Thursday to review progress.

Pain relief

- On the ward, staff used a pain score on a scale of 0-3. Staff we spoke with were positive about the new pain score, which had been introduced in 2015 following patient feedback.

- Medicines, including controlled drugs were available to relieve pain if patients required them. Oncology patients usually brought their own medicines when attending treatment, but the pharmacy was able to provide drugs if prescribed.
- The oncology staff also sought advice from the palliative care nurse specialists at the local acute trust, or the local hospices. The RMO and consultant could also be contacted to discuss the need for prescribed medication.
- Patients undergoing endoscopy were offered local anaesthetic or sedation depending on the procedure. Patients were monitored throughout the procedure using the care pathway. However, no audit of comfort scores or patient feedback was undertaken in line with JAG standards.

Nutrition and hydration

- Patient satisfaction regarding food quality had declined recently since outsourcing the contract. The hospital management were closely monitoring and addressing these issues to ensure improvements were made.
- The chefs catered for all diets and were willing to prepare any specific foods to meet patients' preferences and needs, such as lactose intolerant, and coeliac disease as well as religious diets.
- A dietician was onsite every Thursday and oncology patients were referred as needed.

Patient outcomes

- The hospital participated in the regional cancer networks. The consultants discussed the care of their BMI Hampshire Clinic patients and monitored the outcomes of their treatment at the appropriate multidisciplinary meetings at the NHS acute trust. Regular treatment review meetings with patients also took place.
- The Medical Advisory Committee (MAC) monitored outcomes of individual consultants and fed back any concerns that were not within normal ranges.
- The endoscopy service did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. However work was underway to upgrade the endoscopy service to meet JAG accreditation.
- There was an audit schedule in progress across the services we inspected which included record keeping and consent audits.

Competent staff

- Staff had access to training and development opportunities to advance their professional skills and experience and develop their service. The hospital had a developed a close relationship with a local college to develop an apprenticeship programme for healthcare assistants; six healthcare assistants were enrolled in the programme, which trained them to develop competencies in for example, taking blood.
- There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date.
- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. All staff, who were required to have their registration validated, had this undertaken.
- Few staff underwent an induction programme and a performance review meeting at six weeks after commencement in employment. Staff we spoke with two new staff who said their induction process was thorough and they were undergoing on- the- job competency training. They were supported by their buddy and hospital trainer. Staff were supernumerary for an agreed period during their induction phase.
- A process was followed by the MAC to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake the treatment they were performing at the hospital. The competencies and skills were reviewed biennially. At the time of the inspection the hospital had 93 medical staff working under rules or practising privileges and all of practitioners had carried out episodes of care between October 2014 and September 2015.
- The nurses working in the oncology unit were all appropriately trained and had completed competencies in the administration of intravenous chemotherapy, through a nationally recognised course. Nursing staff attended an annual BMI update.
- The endoscopy lead nurse had additional training in endoscopy.
- Appraisal rates for theatre nurses (including endoscopy) at Hampshire Clinic from October 2014 to September 2015 were 60% and 100% for inpatient nursing staff. However, for endoscopy staff it was over 90%.
- Clinical supervision was completed annually for oncology nurses, which included assessment of clinical competencies.

- The oncology clinical lead nurse attended regular oncology conferences and internal corporate meetings within BMI healthcare and disseminated the information to her team.

Multidisciplinary working

- We observed, there was effective team working, between all staff groups. This was facilitated by a daily morning 'huddle' meeting, where a representative of each department was present. We observed one meeting which enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.
- Formal heads of departments meetings took place monthly, where department issues and priorities were raised. Such as audit progress and health and safety matters.
- There was close working with the local NHS trust and community healthcare practitioners. For example, oncology nurses did not provide end of life care and referred patients to palliative care nurses to meet patients' needs.
- The resident medical officer (RMO) attended the ward staff handover each evening, and there was a handover every two weeks where any changes in policies and practice were also discussed.

Seven-day services

- Patients were booked in to the endoscopy and oncology service in advance.
- The endoscopy unit was open Monday to Friday 7am to 7pm.
- Enbourne ward was open 7am to 7pm Monday to Friday. Oncology patients were seen on Tuesday, Wednesday and Friday and occasionally Saturdays if needed. Oncology nurses were available seven days a week out of hours to respond to patient calls. Staff said they normally received two to three calls per week out of hours, normally to provide reassurance to patients.

Access to information

- Oncology patients were given a folder that contained a chemotherapy record booklet at their pre-assessment appointment. This served as a record of their entire treatment plan, including clinical advice on potential side effects and out of hours contact details. Patients were asked to keep this booklet in a safe place and bring it with them at each chemotherapy appointment or session.
- Oncology nurses communicated with other healthcare professionals involved in patients' care. They sent letters to GPs confirming pre-assessment information for the patients about to start chemotherapy courses. This helped to forewarn them that their patient was about to undergo the treatment and might require their support.
- The endoscopy service did not use an electronic record system, all notes were recorded manually in the patients' healthcare record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Completed consent forms were seen in the oncology unit's patient records. These were clear and concise and showed consent had been obtained from the patient for planned treatment. Quarterly consent audits were completed as part of the hospital audit programme. Results of audits for 2015 showed 75% compliance with standards. Actions for improvement included ensuring the consultant's full name as well as signature was recorded on the form.
- Patients attending the endoscopy unit were admitted to Enbourne ward; where the consultant would attend to ensure the patient was formally consented for the procedure.
- Staff training for consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was an e-learning module. DoLS provides for the lawful deprivation of liberty of patients who lack the capacity to consent to their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their own best interests, to protect them from harm.
- Children were not treated in the oncology or endoscopy services.

Are medical care services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness dignity and respect.

We rated medical care as good for caring because:

Good

Medical care

- Patients were treated with dignity, respect and kindness.
- Patients were involved and encouraged to be partners in their care and in making decisions.
- Patients and staff work worked together to plan care and there was shared decision-making about care and treatment
- Staff responded compassionately when patients needed help and support them to meet their basic personal needs as and when required.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

Compassionate care

- Staff treated patients with dignity and respect. We observed patients' privacy was maintained.
- During our conversations with staff it was clear they were passionate about caring for patients and clearly put the patient's needs first.
- Patients we spoke with were very positive about their experience of the care from BMI Hampshire Clinic. We received the following comments: 'Very happy', 'I have been here before and recommended family.'
- We reviewed two comments cards from patients who had used the medical service. They were positive. Comments included: 'Kind, caring and attentive', 'Impressed with dedication of all staff.'
- We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- Throughout the inspection, we witnessed numerous caring interactions between staff and patients. All the patients we spoke with told us that staff were friendly, helpful and caring. Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients.
- The hospital took part in the Friends and Family Test. For the reporting period April 2015 to September 2015 the hospital reported consistently high results. Between 99% and 100% of patients would recommend the hospital to their friends and families. The proportion of patients who responded to the test was comparatively low and variable between 20% and 38%. Staff considered this was due to the length of the form which patients were required to complete, which was under review to improve completion rates.
- We observed staff supporting oncology patients in a caring and compassionate manner. There was evidence of a good rapport between patients and their nurses and staff demonstrated professionalism and knowledge that provided reassurance and support to their patients during their treatment.

Understanding and involvement of patients and those close to them

- Patient undergoing endoscopy procedures had been provided with relevant information, both verbal and written, to make an informed decision about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- Patients in the oncology unit stated they were kept informed about their care, involved in any decision-making, and were listened to at all times.
- Patients on the oncology unit had access to a range of literature such as local breast cancer support group and information on types of cancer including bowel and bladder. Nursing staff also made an information pack specific for the patient depending on their condition and personal circumstances, for example, advice on how to talk about cancer to young children. The oncology unit had access to interpreters, but said they rarely treated patients where an interpreter was required.
- Oncology nurses provided patients with information on discharge, should they have any concerns when not attending for treatment. They gave them information about the signs and symptoms to look out for following chemotherapy, and what they could do to relieve them. They also gave them in and out of hours contact details in case of advice or concerns.

Emotional support

- Patients commented that they had been well supported emotionally by staff. For example, in relation to side effects of chemotherapy. Patients were referred to counselling services and specialist nurses at the NHS trust if needed or requested.

Are medical care services responsive?

Good

By responsive, we mean that services are organised so they meet people's needs.

Good

Medical care

We rated medical care as good for responsive because:

- Services were planned and delivered to meet the needs patients.
- Care and treatment was coordinated with other services.
- Facilities and premises were appropriate.
- Patients were able to access the right care at the right time.
- The appointments system was easy to use and supported patients to make appointments. Waiting times, delays and cancellations were minimal and managed appropriately.
- Services run on time and people were kept informed of any disruption.
- Patients found it easy to complain or raise a concern and were treated compassionately.
- Complaints and concerns were responded to and improvements made.

Service planning and delivery to meet the needs of local people

- The oncology service was located in Enbourne ward. Four patient rooms which had washable floors, were prioritised for oncology patients, to ensure high standards of hygiene for patients who may be immunocompromised.
- The endoscopy unit did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. BMI Healthcare were aware of the inadequacies of the service, for example, the limited decontamination area posed infection control risks in handling the scopes. A project led by the BMI corporate team was underway to relocate and upgrade the endoscopy unit to meet JAG accreditation. In the meantime, staff ensured their work practices and patient pathways mitigated the risks and safely met patients' needs.

Access and flow

- Enbourne ward admitted and discharged 30-40 patients per day for day case procedures, approximately six patients each day for oncology on three days and approximately five patients each day for endoscopy procedures.
- Endoscopy staff worked efficiently according to the patient pathway to ensure patients did not have to wait unnecessarily for their procedure. Patients were transferred to the adjacent theatre recovery area following endoscopy and when ready were transferred back to the ward.
- If patients were due back from theatre later than expected and discharge was likely to be after 8.30pm, arrangements were made for the patient to stay overnight on one of the inpatient wards. Staff said this situation occurred infrequently, approximately once a month.

Meeting people's individual needs

- Staff had access to an interpreting service however, they said it was very rarely needed as the patients they treated were able to communicate in English.
- Staff ensured appropriate adjustments were made for patients with a learning disability or dementia. For example, they ensure patients were booked in at a time to suit them or were able to visit the unit before the procedure to reduce anxiety levels.

Learning from complaints and concerns

- Patients were actively encouraged to leave comments and feedback via the BMI patient satisfaction survey, 'Tell us how we did'.
- If a patient wanted to make a complaint, staff told us that they would ask their immediate line manager/ service manager to speak to the patient. Most complaints were resolved locally.
- During February 2015 to January 2016, the hospital received 34 formal complaints. One complaint related to the endoscopy service, which was investigated and responded to. No complaints were received regarding the oncology service.
- All complaints were monitored by the hospital director and responded to in line with the hospitals policy. Complaints were investigated by the relevant head of department with involvement from consultants and nurses if needed. Complaints and compliments were shared at the heads of department meeting. Any trends or themes were reviewed at the Medical Advisory Committee.
- Changes were made as a result of complaints or patient feedback. For example, the introduction of silent clocks in patient rooms in response to patient concerns about noisy ticking clocks and more regular cleaning of the new waiting room on Enbourne ward in response to patient concerns about the state of the room.

- Staff we spoke with knew about the complaints procedure and how to respond to patient concerns. All staff received information about the complaints procedure as part of their induction.
- Complaints received in the previous 24 hours were discussed at the daily communication meeting to ensure all staff were aware and learning, if appropriate, was quickly shared.

Are medical care services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promote an open and fair culture.

We rated medical care as good for well-led because:

- Effective governance systems were in place through meetings and performance management.
- The risk register framework had recently been revised and was to be discussed monthly at heads of departments meetings and clinical governance.
- Staff had opportunities to raise ideas and concerns when needed, which they were confident would be addressed by their managers.
- Managers were committed to provide high quality care and improve services and facilities for patients. Staff felt supported and were able to develop to improve their practice.
- Staff in all areas stated they were well supported by their immediate line managers. All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital. There was an open and supportive learning culture.
- Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

However:

- The endoscopy unit did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. Staff were generally well informed about issues relating to their department. However, endoscopy staff had not been formally engaged with regarding the plans for redeveloping the unit and service to meet JAG accreditation, although a first meeting was planned during the week of the inspection.

Vision, strategy innovation and sustainability for this core service

- The Hampshire Clinic vision was in line with the BMI corporate vision of 'We aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare.'
- Endoscopy staff were aware of the corporate strategy for the department to improve facilities for patients and achieve JAG accreditation.
- Staff spoke of incorporating the '6 Cs' (care, compassion, competence, communication, courage and commitment) into their daily interactions with patients. The 6 C's was included in the NHS England's Chief Nursing Officer's strategy, Compassion in practice, 2012.
- The BMI strategic plans were shared with staff through heads of department and senior nurse meetings.

Governance, risk management and quality measurement for this core service

- The hospital had developed a high-level risk register that the executive director, the director of nursing, and the lead for quality and risk reviewed monthly. However, we did not see evidence that this document was developed at department level to monitor more local risks. Since January 2016 the risk register had become part of the agenda for the heads of departments and clinical governance meetings to review and progress actions. The risk register for January 2016 contained 10 risks mainly related to environment and equipment, for example, replacement of carpets.
- The issues regarding the decontamination room in the endoscopy unit was not on the risk register. However, staff in the endoscopy service had not been constructively engaged with regarding the plans for the new unit. Although a meeting was planned the same week of the inspection.
- There was a clear governance and reporting structure at BMI Hampshire Clinic, in line with the corporate governance framework. All meetings were structured around agenda headings of safe, effective, caring, responsive and well-led.

- Ward and theatre managers participated in monthly heads of department meetings where matters such as operational issues, patient satisfaction, audits and training were discussed. The minutes of the December 2015 meeting identified staff were struggling to complete the audits and there was a plan to improve the situation.
- There was a clinical governance committee, which met monthly to discuss matters such as incidents, complaints, audits and new policies. For example, the January 2016 minutes recorded the introduction of new resuscitation guidelines and themes from complaints such as communication and catering which were being addressed. The clinical governance forum also received reports from subcommittees and provider visit reports by the corporate governance team.
- Many of the senior staff attended both heads of department meetings and clinical governance meetings. Information was communicated to all staff at team meetings and by newsletters/email. A daily 'huddle' took place each morning attended by the heads of department where they reviewed what was happening that day and any issues identified.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on the BMI intranet. Staff signed a declaration to confirm they had read and understood the policy relevant to their area of work.
- The medical advisory committee (MAC) had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant was required to complete biennial reviews with the MAC chair, where data on their clinical performance was discussed. The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals.

Leadership/culture of service

- Front line staff were very positive about the leadership at departmental and senior management level. The leadership team was visible and approachable. For example, the director of nursing conducted daily walkabouts to speak to patients and staff first hand and respond to concerns.
- The Enbourne ward held monthly meetings with a standard agenda which covered business and staff issues. Such as complaints, incidents, new policies and staff training.
- The oncology lead nurse was also the manager of all the inpatient wards and highly regarded by her staff.
- The theatre manager oversaw the endoscopy service and worked with the endoscopy lead nurse.
- Staff felt supported and worked in collaborative teams. All staff said they felt their role was valued.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. Patient feedback cards were available in the bedrooms and a notice board displayed the recent survey results for patients. Improvements made as a result of the 2014 survey included the introduction of silent clocks in patient rooms.
- Results of the monthly patient surveys between April 2015 and September 2015 showed 99% to 100% of patients would recommend the service, although response rates were relatively low, below 30%. Staff considered this was due to the length of the form which patients were required to complete. This was under review with an aim to shorten the form to improve response rates.
- There was no local endoscopy user group for staff to raise issues, although the endoscopy lead nurse participated in a BMI endoscopy network group.
- BMI carried out a biennial staff survey. At the time of the inspection the staff survey had been completed however, results were not yet available. The 2014 staff survey results showed 97.7% staff were committed to doing 'Their best for BMI Healthcare' and 84.1% staff said 'I am clear about my objectives and what is expected of me.' Least positive results included 'I know what is happening and what is planned in my hospital function' (47.5%) and 'Communication is good between different part of hospital and corporate site' (43.4%). Actions following the staff survey included improving communication at team meetings and weekly heads of departments meetings and an open door policy with the hospital executive director.

Good

Medical care

- Staff felt performance and loyalty was recognised, for example, staff had been successful in internal promotions.
- BMI rewarded staff in their corporate 'Above and Beyond' nominations. We spoke with staff who had received the award and were proud their contribution had been commended by the organisation.

Innovation, improvement and sustainability

- Roll out of electronic prescribing was planned in 2016.

Good

Surgery

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

Information about the service

BMI The Hampshire Clinic provides elective surgery to patients who pay for themselves, are insured, or are NHS funded patients.

Between October 2014 and September 2015 there were 6189 day case visits to theatre and there were 2132 in patient stays; of which 15% were NHS patients, 74% were insured and 11% of patients paid for themselves. Surgical specialities include general surgery, orthopaedic surgery, and cataracts.

The hospital carries out surgical treatments for children and young people over the age of three years, mostly for ear, nose and throat, orthopaedic procedures and general surgery. In the period October 2014 to September 2015 there were 35 inpatient and 117 day case treatments for children and young people.

There are four operating theatres; two have laminar airflow ventilation systems (a system of circulating filtered air to reduce the risk of airborne contamination). The laminar flow theatres were used for orthopaedic and plastic surgery procedures. The non-laminar flow theatres were used for general and urological surgery, open and laparoscopic procedures, and ear nose and throat operations.

The surgical operations most commonly performed between October 2014 and September 2015 were orthopaedic, dental and eye surgery.

The Hospital had one day-case ward, Enbourne with 16 beds, and two in-patient wards: Loddon with 13 orthopaedic beds and Lyde with 25 general surgery beds including two dedicated paediatric rooms. All rooms have en-suite facilities and there were an additional 3 intensive therapy unit (ITU) beds available. This is where patients who require very close observation are admitted following complex surgery

During our inspection, we visited the pre-assessment clinic, the surgical wards, anaesthetic rooms, theatres, recovery area, and the intensive care unit. We spoke with 20 members of staff, including senior managers, medical staff, registered nurses, health care assistants, operating department assistants, and administrative staff. We also spoke with 3 patients and reviewed 17 patient records and six medication charts.

We looked at the patient environment and observed patient care in all areas. Before, during and after our inspection we reviewed the hospital's performance and quality information.

Good

Surgery

Summary of findings

Overall we rated this service as good because:

- Staff supported and treated patients with dignity and respect, and the patients were involved in decisions about their care plan. There were substantial observations and comments about the emotional care afforded to patients undergoing highly -specialist and complex surgery. The responsible surgeons made themselves available and accessible to patients, ward staff and the RMO, beyond expectation.
- Some patients described “exceptional care” delivered by highly-motivated and caring staff. These staff were noted to be not just nursing staff, but across a wide range of professional and non professional staff bodies.
- Staff responded compassionately when patients needed help and supported them to meet their personal needs as and when required.
- Staff monitored patient safety; they investigated incidents and shared learning to improve care.
- All the areas we viewed were visibly clean and well maintained; however, the corridors in the area around the operating theatres were a little cluttered. Equipment was available and staff completed regular safety checks on equipment and the environment.
- Consultants gained consent from patients during the initial consultation and again on the day of surgery. Patient records were well structured and staff completed all the relevant sections with few exceptions.
- Staffing levels were sufficient to meet the needs of the patients. The service had competent staff who worked well as a team to care for patients. They told us training was available and managers gave them time to attend. Staff were up to date with their mandatory training and understood the safeguarding policies and procedures for adults and children. Doctors were available to provide care for patients 24 hours a day. The hospital gave discharge information to patients when they went home and sent it to their GPs within 48 hours of discharge.
- The service had policies and guidance to ensure staff provided care and treatment that took account of evidence based standards and procedures. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals within the BMI group
- Patients told us they received enough information and were satisfied with the care and treatment they received. Information leaflets were available about the hospital services, including child and young adult friendly versions, the staff had access to translation services for patients whose first language was not English.

There were clear governance structures in place with committees for clinical governance, health and safety, infection control, medicines management, resuscitation, transfusion and radiation protection

Good

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- Staff at all levels within the organisation monitored patient safety and shared learning to improve care.
- There were systems for monitoring safety, including checks of the environment, equipment, cleanliness, and hygienic practices.
- There were safe arrangements for managing medicines and for responding to suspected or actual incidents of abuse.
- Staff fully completed the pre-printed care pathway records for patients consistently and we observed good handover practice on the wards.
- Staff were up to date with their mandatory training and staffing levels were managed to meet the needs of the patients, and to respond to emergencies.

Incidents

- There was a never event (a serious, preventable patient safety incident which should not occur if the available preventative measures are implemented) reported in September 2015. The event involved an incision made on the wrong side, which the surgeon immediately rectified immediately and carried out the duty of candour. The theatre manager described the event, and we saw the investigation report and the evidence of practice changes to prevent further occurrence.
- The hospital had reported 323 clinical incidents during the reporting period (October 2014 – September 2015 and the overall rate of incidents reported had fallen slightly from 4.9 to 3.8 per 100 inpatient discharges. There was no breakdown of these figures to detail how many related to surgical services.
- Staff said there was an open culture for reporting incidents, and they knew how to report them on the electronic reporting system. Senior staff used a simple risk-scoring matrix and undertook a root cause analysis (RCA) of serious incidents. Staff discussed trends and serious incidents at monthly clinical governance meetings and at the medical advisory committee (MAC). Senior managers shared learning via the Heads of Department meetings; we were able to review samples of the minutes and found them to be robust.
- When we spoke to staff, they were able to outline learning and changes in practice from recent incidents; however, we did not see any local action plans. We saw evidence of minutes from these meetings to support this.

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. Staff could describe the principles of the Duty of Candour, and gave examples of when they had put it into practice.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The NHS Safety Thermometer is a monthly snapshot audit for measuring, monitoring, and analysing patient harms and 'harm free' care. All patients had venous thromboembolism (VTE) assessments completed on admission. Staff also tested patients for Methicillin Resistant Staphylococcus Aureus (MRSA) infection and risk assessments for pressure ulcers. The ward manager updated the safety thermometer data for NHS patients.
- Additional audits took place on inpatient wards for example catheter care, PICC line, and cannulae. The infection control lead nurse monitored the results of these and arranged training sessions in areas where there were results that were not up to the expected standard.

Cleanliness, infection control and hygiene

- There were no incidents of (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), or Clostridium Difficile (C. Difficile) in the reporting period October 2014 to September 2015. All patients underwent MRSA screening before admission to the hospital.
- Throughout our inspection, we observed staff adhered to the hospitals infection control policies and procedures. Staff washed their hands in between patients and were bare below the elbows to minimise the risk of spread of infection.
- Personal protective equipment was available, staff were seen changing gloves, and aprons in between patients to prevent the risk of cross infection.

- Hand sanitizer gel was available at the entrance to the ward and theatres, along corridors, and in each of the patient's rooms.
- The ward area was visibly clean and well maintained. Domestic staff were seen cleaning the ward. They used a colour-coded system to minimise the risk of cross infection
- Theatres were visibly clean. Each theatre and the recovery area had cleaning checklists, which staff completed daily. Senior staff told us they monitored the completion of the checklists to ensure all areas were clean.
- BMI Hampshire Clinic appointed a new infection prevention and control lead nurse in September 2015. The lead monitored audits, provided guidance at senior nurse meetings, and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital.
- Infection control audits for each department took place twice a year. There were also monthly mini environmental audits for each department, which included a hand hygiene audit and bare below the elbow.
- The hospital appointed an infection prevention lead nurse in the autumn of 2015. She made improvements to training and audit and monitored results. For example training compliance in the reporting period for aseptic technique training improved from 46% compliance in the previous year to 81%. In addition, hand hygiene training had increased from 75% compliant to 78%. The infection prevention and control nurse also introduced care bundles including high impact interventions, which were not part of the training programme previously.
- In January 2016, the infection prevention nurse carried out a mattress audit and she identified 22 mattresses with some damage. The hospital management went on to replace the mattresses to ensure that they did not cause an infection risk.

Environment and equipment

- The 2015 Patient-Led Assessments of the Care Environment (PLACE) score results showed that the BMI Hampshire Clinic scored 100% for cleanliness and 89.9% for condition, appearance, and maintenance.
- The ward and theatres had a portable resuscitation trolley which contained equipment that was for use in the event of a cardiac arrest. We saw a daily check sheet which documented all trolleys had been checked to ensure equipment was available and in date.
- Equipment was visibly clean and clearly labelled with the last service or maintenance check within the previous year.
- A service engineer on site maintained equipment and undertook safety testing of non-medical equipment. Engineers managed planned preventative maintenance for the environment including water supply and temperature to minimise the risk of Legionella bacteria colonisation.
- The hospital used an external contractor to sterilise reusable surgical equipment. They had enough equipment in store, staffed ordered any extra equipment or specialist equipment in advance.
- Single use equipment such as syringes, needles, oxygen masks were readily available on the ward and in the operating theatre department. Staff were positive about being able to access the equipment they needed and said they had sufficient equipment to care for patients.
- The hospital had four operating theatres in the theatre suite. All theatres had an adjoining anaesthetic room where staff prepared patients for their operation.
- There was a six-bedded recovery ward, equipped with appropriate facilities to care for patients in the immediate post-operative period before they returned to the ward.
- Staff checked anaesthetic and resuscitation equipment on days when the theatre was operating. Records showed that staff checked all the equipment daily in line with professional guidance. Equipment for pacing heart rhythms was available, accessible and checked.
- The corridors in the area around the operating theatres were a little cluttered, but remained safe and fully accessible.

Medicines

- The hospital had an on-site pharmacy open Monday to Friday 08.30 – 16.30. There was a pharmacy manager, two other pharmacists and a pharmacy technician.
- An out of hours service was available for emergencies from a national supply chain; the on-call manager

accessed this via the pharmacy manager. There was no pharmacy arrangement with the local NHS hospital but nearby BMI sister hospitals were open at the weekends and able to provide medicines.

- When the pharmacy closed, there was a standard operational procedure (SOP) in place, which allowed the Resident Medical Officer, in exceptional circumstances, to dispense discharge medication from dispensary stock, which he accessed with a senior manager.
- To take out (TTO) packs were available to aid discharge.
- On the ward and in theatres, prescription pads and medicines, including controlled drugs were stored securely. Access to the pharmacy was via a keypad with a secure code system.
- Staff stored medicines at recommended temperatures, monitored refrigerator and room temperatures, and took appropriate actions when temperatures were outside the recommended ranges.
- Emergency medicines, including oxygen, were available for use and expiry dates checked weekly to ensure they were safe to use.
- The emergency trolleys were stocked with the correct medicines and staff checked on a daily basis to ensure it was safe for use.
- BMI medication policies were in place along with local standard operating policies (SOPs) and work instructions. These were all current or under review.
- Staff recorded any allergies on the medicines record to ensure that no medicines were prescribed inappropriately.
- Nursing staff could access guidance, such as the hospital's medicines policy and current British National Formularies.
- We reviewed six medication charts; staff had fully completed all these medication charts.
- Action plans were developed to address pharmacy noncompliance with regular audit; we saw evidence that the pharmacy team monitored these.
- Processes were in place to manage medical gases including a permit to work scheme and quality assurance of the locally prepared medical air.
- Discharge medication was labelled and stored in a cupboard in the pharmacy department.

Records

- We reviewed seven adult patient records and 10 children, and young peoples' records. The records contained pre-operative assessments, records from the surgical procedure, recovery observations, nursing notes, and discharge information. The entries were legible and had been signed and dated by the members of staff.
- The hospital used printed booklets for recording patient care for different care pathways. These standard care pathways included prompts to record key information about patients, including their past medical history and medication, as well as details of their pre-operative risk assessments.
- All of the care records included risk assessments appropriate to the type of operation and length of stay in hospital. For example, all care records contained risk assessments for venous thromboembolism (VTE) assessments. Patients who needed to stay overnight or for longer periods also had manual handling, pressure ulcer risk, and nutritional assessments.
- The booklets for surgery included the World Health Organisation (WHO) five steps to safer surgery checklist.
- Staff stored patient records behind the nurses' station, to maintain confidentiality.

Safeguarding

- There was a safeguarding children's policy and a policy for safeguarding vulnerable adults. There were also referral flowcharts with contact numbers for vulnerable adults and for safeguarding children.
- The director of nursing was the safeguarding lead in the hospital for adults and children. The practice development nurse (adults) and the lead paediatric nurse (children) supported her in this role; all three were level three trained, which meant they were able to investigate safeguarding issues in a management capacity.
- There were no safeguarding concerns reported in the last year. However, staff were clear about their roles and responsibilities if they witnessed or suspected abuse.
- Staff compliance with the mandatory training for Safeguarding Children awareness was 97%, and for safeguarding vulnerable adults was 100 %.).

Mandatory training

- The hospitals target for compliance with mandatory training was stated as 90%. This figure included new staff.

- Most staff completed their training on-line through BMI Learn, but some attended face-to-face training in, for example: manual handling, antiseptic non-touch technique (ANTT)
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs.
- Agency staff used were well known to the hospital and the induction for them covered the layout of the department, emergency procedures and where to find essential information. The induction covered all the key statutory and mandatory training.
- Heads of departments received an electronic reminder when their team members' training was due.
- Consultants and clinicians with practising privileges did not complete training via the hospital system but the medical advisory committee (MAC) checked assurance of mandatory training undertaken by clinicians in their NHS roles. Managers told us that if doctors were not up to date with mandatory training and did not provide current and valid practice certificates they were suspended.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The RMO confirmed they had to complete induction training before they began work at the hospital, and the records confirmed this.

Assessing and responding to patient risk

- Staff carried out risk assessments on patients before admission for surgery, to identify patients at risk of falls, acquiring pressure ulcers, and screening for venous thromboembolism (VTE).
- The hospital had a Commissioning for Quality and Innovation (CQUIN) for VTE and achieved 100% compliance during the reporting period. However, five patients acquired pulmonary embolism during the period; we saw minutes from the MAC committee, which showed investigations had taken place into the occurrences of pulmonary embolism.
- The MAC discussed this in depth and actions to prevent future occurrence shared with colleagues via the meeting minutes.
- Patients completed a comprehensive preadmission questionnaire to assess if there were any health risks, which may be a contraindication to their surgery or require further investigations. When staff identified patients at risk, they informed the anaesthetist responsible for the patient.
- Staff monitored patients at risk at surgical pre-assessment and checked again before treatment. These included risks about mobility, cognitive understanding, medical history, skin damage, and venous thromboembolism (VTE).
- We observed that staff undertook thorough pre-assessments, for example, links with patient's GP by phone or letter regarding medication; and patient specific information, such as allergies were considered.
- Anaesthetists assessed all patients who required surgery under the American Society of Anaesthesiologists (ASA) grading system for preoperative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled anaesthetists to plan specific post-operative care for patients.
- In theatre, staff used the "Five Steps to Safer Surgery" checklist. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the start of each theatre list and the World Health Organisation (WHO) surgical safety checklist. (A tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications). We observed two sessions in theatre. Theatre staff completed The Five Steps to Safer Surgery checklist in full, with all staff engaged for each stage, the sign in, time out and sign out. Swab and instruments counts were audible and there was a silent focus from all staff during the count to ensure all staff were listening.
- Staff audited completion of the WHO checklist monthly. Results for October 2015 to January 2016 showed 100% compliance. However, the audit undertaken in February 2016 achieved 82.5%; the theatre manager had produced an action plan to improve compliance.
- There was access to the minimum requirement of two units of O Rhesus negative emergency blood. We saw from records that staff checked the blood fridge temperature and stock daily. Information provided by the hospital showed that the attendance at blood transfusion training for nurses and healthcare assistants was 88% compliant against a target of 90%.

- Staff in recovery and on the ward completed national early warning scores (NEWS). This system allowed staff to record observations and gave protocols to follow if the patient's condition deteriorated.
- The hospital reported nine cases of an inpatient transfer to another hospital in the reporting period (Oct 2014 – September 2015). There was a service level agreement (SLA) with a local NHS trust if over three HDU beds were required. Senior nursing staff were able to organise this when required.
- We saw robust processes and policies, in place for dealing with complex patients who required intra-peritoneal chemotherapy, and for dealing with the residual chemotherapy drugs and devices exposed to the drugs.
- Staff took part in simulation exercises to review the team response to an emergency. The trainer gave verbal and written feedback to staff and any necessary improvements made.

Nursing staffing

- Senior nursing staff used the BMI nursing dependency and skill mix tool that calculated staffing levels. Staffing levels were planned for five days in advance.
- The hospital monitored daily staffing levels on the ward. Staff displayed the required and the actual numbers on the ward notice board.
- At the time of our inspection, the staff on duty matched the number required.
- There was one remaining vacancy for the night shift on Loddon ward.
- The Hospital had three ITU beds; when these were occupied one to one nursing care was required. We reviewed six months of data which showed that the level of nursing care was consistently above the minimum requirement
- Senior nurses from each area met at 11.00 each day to assess where bank or agency may be needed. Registered nurses and healthcare assistants were available when required to meet demand. Use of agency was less than 20% during the reporting period; regular bank staff usually provided any extra numbers required.
- A senior nurse was available at the hospital as a point of contact to accept out of hours admissions and help resolve patient queries.
- Student nurses worked on the ward in a supernumerary role, as part of a student nursing rotation.
- Three paediatric trained nurses looked after any children and young people who are admitted
- Ward nurses met for a handover at the start of each shift, to discuss the needs of each patient. We observed thorough and patient-centred handovers and staff handed over changes in patient's conditions, which ensured that they took actions to minimise any potential risk to patients.
- Theatre staffing ratios met the guidelines from the Association for Perioperative Practice (AfPP). Hampshire clinic also had two nursing staff, who were trained surgical assistants

Surgical staffing

- Consultants and anaesthetists worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector The Hospital medical advisory committee (MAC) ensured that consultants were granted practising privileges if deemed competent and safe to practice. This was renewable every two years. Robust systems were in place that ensured consultants only completed operations they were skilled and competent to perform.
- Consultants took responsibility for the care and treatment of their patients at all times; they were accessible by telephone 24 hours a day and there were on call rotas for anaesthetists, physicians, and radiographers. However, if interventional diagnostic radiology was required staff transferred patients to the local NHS Trust.
- Consultants were required, as part of the practising privileges hospital policy, to remain available (both by phone and in person) or arrange appropriate alternative named cover if unavailable when they had inpatients in the hospital.
- The resident medical officer (RMO) was on site at all times and was the doctor responsible for the care of the patients when the consultant was off site. The RMO was trained in advanced life support and held a bleep for any queries, which included cardiac arrest in the hospital.
- Nursing staff spoke highly of the consultant anaesthetists and surgeons.
- A member of the senior nursing staff told us that medical cover was good and consultants were always

obtainable. They said they would return to see their patients and always provided cover arrangements when not accessible. There was an on call anaesthetist and the resident medical officer to provide support.

- There was a resident medical officer (RMO) on-site 24 hours a day. The RMO conducted a ward round every 12 hours with the senior nurse, to review all inpatients that stayed overnight. If there were concerns, they spoke with the consultant responsible for the patient. The RMO told us they were always able to contact a consultant if required.
- Handovers between staff were effective; the RMOs attended the handover to night shift and the morning team meeting.
- The consultant and anaesthetist saw patients prior to each surgical procedure.
- Anaesthetists remained at the hospital until the patient had recovered from their surgery and provided a 24 hour on-call service.
- Consultants visited their patients in ITU twice a day to assess progress.

Major incident awareness and training

The hospital had local and corporate business continuity plans with supporting action cards for use in a major incident. Staff undertook regular reviews of the plans to ensure their effectiveness. Staff kept the plans in a folder behind main reception containing, for example: key people contact list, key codes, and emergency cascade list with contact numbers.

Are surgery services effective?

Good

We rated effective as good because:

- The service had policies and guidance that ensured staff provided care and treatment that took account of evidence based guidance and current legislation. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals within the BMI group.
- BMI Healthcare was working with Private Healthcare Information Network(PHIN) to look at the better reporting of patient outcomes across the independent healthcare sector, particularly in a way which is comparable with the data available from NHS providers to assist with information transparency and, in turn, patient choice.
- Specialist nurses provided an enhanced level of care to patients throughout the care pathway.
- Staff managed pain relief using a pain-scoring tool patients showed us the pain scorecards available in each room for describing their pain.
- The hospital offered a choice of meals and drinks and the chef catered for patients requiring special diets.
- Staff worked effectively within their team and with other teams and provided co-ordinated care to patients, who focused on their needs; Discharge planning began during the pre-assessment process, which ensured when patients were discharged, they had the support they needed, and at the right time.
- The service had competent staff who worked well as a team to care for patients. Staff told us training was available, and managers gave them time to attend and complete training. Appraisal rates on the wards were high; however, this was not the case amongst the theatre staff.
- Information was available for patients about the care and treatment given. Consultants gained consent from patients during the initial consultation and again on the day of surgery. The hospital gave discharge information to patients when they went home and sent it to their GPs within 48 hours of discharge.

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE)
- Staff assessed patients for the risk venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines [CG92].
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines [CG74]. Following discharge, the hospital had implemented a 48-hour follow up call for all hip and knee patients as part of the 30-day SSI audits
- There was a local hospital program of audits undertaken, this included records, consent, WHO

checklists, IPC, VTE assessment and resuscitation. Staff discussed results at clinical governance meetings, sub-committees and senior nurse group meetings at a BMI corporate level. We saw results from audits in the minutes of clinical governance meetings for example; record keeping was 81% compliant across all standards in December 2015.

- The Royal Colleges of Anaesthetists, surgeons and GPs advised the use of enhanced recovery programmes (ERP) for hip and knee surgery. ERPs were in place within the care pathways used on the wards for knee and hip replacement.

Pain relief

- Staff managed pain relief for patients using a pain-scoring tool; patients showed us the pain scorecards available in each room for describing their pain.
- Patients received an information booklet about pain control as part of their information pack. This included advice on how to describe pain to staff, and guidance about asking for help.
- Staff told us anaesthetists prescribed regular and 'as required' pain relief medication for use post operatively and we saw evidence of this in patient medication charts. There were pain-scoring forms in the patient record and staff had completed these.
- Patients had a variety of pain medication available to them.

Nutrition and hydration

- Staff advised patients about fasting times at the pre-assessment appointment, and gave patients a guidance leaflet, which included what and when to eat and drink before and after surgery.
- Patient records showed that staff monitored fluid intake and output and recorded the outcome on the fluid balance charts. This was to ensure patients were sufficiently hydrated after their operation
- Inpatients had a choice of meals for breakfast, lunch, and dinner and staff offered additional snacks in the mornings and afternoons. Patients could ask for meals at other times, from a more limited range of options, and change their orders if they preferred.
- Catering staff informed us that if a patient had a special dietary requirement the chef visited the patient on the ward menu options were available for patients who needed special diets for religious or cultural reasons.
- A dietitian was on site every Thursday to provide advice and support to patients.
- In the Patient-Led Assessments of the Care Environment (PLACE) for 2015, (March) the hospital scored 95.8% for ward food, which was above the England average of 94%.

Patient outcomes

- BMI Healthcare was working with the Private Healthcare Information Network (PHIN) to look at better reporting of patient outcomes across the independent healthcare sector and to compare results reported by NHS organisations.
- Staff audited patient outcomes through participation in national audit programmes. For example, The National Joint Register (NJR) - The purpose of the NJR is to collect high quality and relevant data about joint replacement surgery to provide an early warning of issues relating to patient safety. The theatre manager made the National Joint Registry report available for surgeons and staff. The hospital completed 98 hip replacements and 81 knee replacements in the year April 2014 to March 2015 and was compliant with all the quality measures relating to the data submission.
- Hampshire Clinic also participated in Patient Reported Outcome Measures (PROMs) for three clinical procedures; hip replacements, knee replacements and groin hernia. For hip procedures 25/25, patients reported an improvement in health. For knee procedures 20/22 reported an improvement in health, and for groin hernia 12/16 reported an improvement in health
- There had been no patient deaths at the hospital during the reporting period, (October 2014 – September 2015) but staff told that an unexpected death had occurred the previous week, which was being investigated.
- For the reporting period October 2014 to September 2015, there were nine cases of unplanned transfer of an inpatient to another hospital.
- There were four cases of unplanned readmission to theatre within 29 days of discharge in the reporting period (October 2014 to September 2015); there were none between April and September 2015. This was equivalent to 0.1% per 100 visits to the operating theatre.

- The hospital benchmarked its performance against other hospitals in the BMI group and managers reported patient outcomes on a monthly basis to the Heads of Department meeting and to every Clinical Governance Forum and Medical Advisory Committee.

Competent staff

- The medical advisory committee (MAC) granted and reviewed practising privileges for medical staff. New consultants had to provide evidence of qualifications, training, and registration.
- The hospital maintained a list of consultants, which included information about their indemnity insurance and review dates, and all had submitted appraisals as required. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.
- Registered nurses mentored newly qualified nurses through a BMI preceptorship programme and supported supernumerary nursing students during placements.
- All staff undertook a formal induction process, which included working supernumerary for two weeks. Senior, staff assessed competencies at the end of the process before staff worked independently. We spoke with staff who confirmed this process.
- All the staff we spoke to told us they had time to complete their mandatory training, and that BMI management offered them many opportunities to attend further training and courses.
- The senior managers told us all RMOs had Advanced Life Support (ALS) and Paediatric Advanced Life Support (PALS).
- At the time of our visit, of the nurses assigned to do ALS, 80% had completed it. This ensured that there was a high level of skill available to support the RMO when ITU beds were occupied.
- Appraisal rates for theatre staff were low, the rates for all non-medical staff were 55% for the reporting period (between October 2014 and September 2015 The theatre manager told us that this was improving due to recent recruitment enabling her to take the time away from clinical duties to carry out the staff appraisals.
- There were two surgical care practitioners supported by the hospital to complete a recognised external competency based qualification for their role, in line with guidance from the Perioperative Care Collaboration (PCC). They had support from a mentor and consultant whilst completing this training.
- There were two accredited surgical co-practitioners, one for gynaecology, and one for orthopaedic practice.
- The specialist nurses in urology, colorectal, spinal, and paediatrics provided enhanced care for patients. Their specialist training improved nursing and counselling skills; and they trained ward nurses to undertake specialist care when they were away, for example, all the registered nurses and healthcare assistants are now able to do portable ultra sound scanning which the urology specialist introduced to help patients with retention post-surgery post removal of catheter.

Multidisciplinary working (in relation to this core service only)

- Throughout the inspection, we observed good multidisciplinary working between the different teams involved in a patient's care and treatment. There was clear communication between staff from different teams, such as the anaesthetist and anaesthetic nurse and theatre staff to ward staff.
- Staff described the multidisciplinary team as being supportive of each other and they felt that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- Patient records included multi-professional clinical notes, which included those from physiotherapists, to support safe care and treatment.
- Pre-assessment, ward, and theatre staff worked together co-ordinate and deliver patient care effectively.
- Nursing and medical staff maintained good links with the local NHS trust; for example, the hospital had agreements in place with the critical care unit and a private transport service.
- The colorectal nurses were seconded to work at a local trust and has a specialist competency set. They attend a weekly MDT at the trust as well as best practice meetings.

Seven-day services

- There was nursing care seven days a week 24 hours a day. The theatres were available for elective surgery between 8.30am and 8pm Monday to Friday, with occasional lists on a Saturday morning.

- Consultants provided 24-hour telephone on-call cover for their patients. If a consultant was unable to provide on call cover they ensured another consultant from the hospital provided cover. Consultants conducted daily ward rounds.
- A resident medical officer (RMO) was on site 24 hours a day, seven days a week.
- There were on-call rotas for anaesthetists, physicians, radiology, and senior managers, which were available to staff when needed.
- Pharmacy services were available during normal working hours, (Monday to Friday 8.30 -16.30) Outside of these hours one nurse and the resident medical officer (RMO) each had a key to the pharmacy to ensure medication was available at all times. The on-call manager could access an out of hours service for emergencies from a national supply chain, when necessary.

Access to information

- Staff confirmed records were accessible to all staff involved in patient care, including physiotherapists and pharmacists.
- There were resource folders in the ward and theatre offices for reference. These included guidance documents and policies, audit reports and minutes of meetings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants gained consent from patients during the initial consultation and again on the day of surgery. Patient records documented that staff obtained verbal or written consent for care and treatment. We reviewed records for adults and children that confirmed consent forms were completed, signed, and dated by the consultant and the patient or parent.
- The paediatric nurses were always available to attend pre-assessment clinics with children and young people. They kept child appropriate materials to help children understand any procedures they were about to undergo and supported them to consent to treatment and care.
- Staff told us they confirmed consent from children and their parents or carers before starting care or treatment.
- Young people aged 16 or 17 were able to consent for treatment themselves.
- Staff told us they had access to translation services when necessary for patients whose first language was not English and informed consent was needed. All patients we spoke to felt staff had given them sufficient information about their procedure and could discuss it with their consultant and nursing staff.
- We saw from records 90% of staff had completed training on Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs) and understood the legal requirements of both. They told us the majority of patients they admitted had the capacity to make their own decisions.

Are surgery services caring?

Outstanding ☆

We found that surgical services were outstanding for caring because:

- There were substantial observations and comments about the emotional care afforded to patients undergoing highly -specialist and complex surgery. The responsible surgeons made themselves available and accessible to patients, ward staff and the RMO, beyond expectation.
- Some patients described “exceptional care” delivered by highly-motivated and caring staff. These staff were noted to be not just nursing staff, but across a wide range of professional and non professional staff bodies.
- Staff responded compassionately when patients needed help and supported them to meet their personal needs as and when required.
- Staff supported and treated patients with dignity and respect, and the patients were involved in decisions about their care plan
- Staff were caring and compassionate to patient’s needs, and treated patients with dignity and respect. Patients told us that staff treated them in a caring way, and were flexible in their support, to enable patients to access services. We observed this to be the case on our inspection visit
- Patients were informed of any associated costs where applicable prior to treatment. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- There were appropriate arrangements to support and meet patient and staffs’ emotional needs.

Good

Surgery

Compassionate care

- All patients we spoke with were very pleased with the quality of care they had received. They told us they felt at ease, comfortable, and relaxed prior to having surgery. They told us staff had spoken to them in a kind manner and treated them with dignity and respect. One patient assured us that he would be completing the friends and family (FFT) questionnaire, and that he would recommend this hospital to others
- We observed staff provided kind, polite and compassionate care at all times. They referred to patients in a caring way, and demonstrated a keen interest in ensuring they had a pleasant and comfortable experience.
- The hospital participated in the 'friends and family test' (FFT). During the reporting period October 2014 to September 2015, the hospital reported consistently high levels of satisfaction and 95% of patients would recommend the hospital to their friends and families.
- In the Patient Led Assessments of the Care Environment (PLACE) in April 2015 privacy, dignity, and wellbeing scored 89.5% compared to an England average of 87.7%.

Understanding and involvement of patients and those close to them

- Staff gave patients information about their procedure at their pre-assessment appointment. This included procedure specific information leaflets and a patient information booklet about their stay. Patients confirmed this
- We observed staff as they discussed care in detail with patients, and explained what to expect post- operatively including length of stay, and involved patients in their plans for discharge. Ward staff gave patients a discharge pack with specific post-operative instructions and a copy of the discharge letter sent to their GP and district nurse.
- Patients told us that they received enough information about their procedure and were happy with the opportunities the staff gave them to ask any questions.
- We observed staff in the anaesthetic and recovery rooms explained care and treatment to patients and asking about their wellbeing.
- BMI Healthcare published results of patient satisfaction surveys each year. Recent results for Hampshire Clinic (March 2015) showed that 254 patients responded and the satisfaction level for the six categories ranged from 94.6% satisfied (accommodation) to 100% satisfied (quality of care)

Emotional support

- Sufficient time was allocated for the pre assessment appointment to allow patients time to discuss any fears or anxieties.
- Ward staff demonstrated sensitivity towards the emotional needs of patients and their relatives. At staff meetings we observed discussions included consideration of patients' anxieties and how best to provide support. Senior nursing staff also described how they took account of patients' wider family support when planning their discharge and overall care needs.
- Staff gave all patients a ward contact card at discharge and encouraged patients to call if they had any concerns after their operation.
- The specialist nurses were able to spend time with all patients in their care to give them any support they needed.

Are surgery services responsive?

Good

We rated responsive as good because:

- The provider and clinical commissioning groups determined the range of surgical services provided. Surgery was available to NHS funded, self-pay and insured patients and all received the same level of care including children and young people.
- Staff planned and delivered services to meet the needs of the local population. They met daily to ensure patients' admission and discharge was timely, and with the right level of care and support. The hospital was meeting their referral to treatment targets for patient admissions.
- The hospital had access to a translation service for patients whose first language was not English. Information leaflets about the services, including child-friendly or easy-to-read information leaflets were available throughout the hospital.

- Staff ensured they made appropriate adjustments for patients with a learning disability or dementia. For example, they ensure patients were booked in at a time to suit them or were able to visit the unit before the procedure to reduce anxiety levels.
- There was a complaints system in place; the hospital investigated and responded to complaints within the designated timescales, and there was evidence that the hospital used learning from complaints to improve the quality of care.
- However, there was no specific screening for patients living with dementia, but staff alerted the surgeons if they were concerned about a patient's mental capacity.

Service planning and delivery to meet the needs of local people

- The hospital had developed NHS services through liaison with the Clinical Commissioning Group (CCG), for example to set up ophthalmology and orthopaedic surgical services.
- The theatre manager and booking team planned the lists for elective surgery. This meant they checked all aspects of patients' requirements before booking them onto the list, and ensured that operating lists were utilised effectively.
- Surgical teams had access to intensive care and critical care beds, which helped them, plan operating lists appropriately.
- The charge nurse on the orthopaedic ward told us that approximately 40% of the patients were NHS- funded.

Access and flow

- All admissions were pre-planned so staff were able to assess patients' needs prior to treatment. This enabled staff to plan patient's care to meet their specific requirements, particularly those relating to any cultural or linguistic, needs; and those with dementia or learning difficulties.
- Delays and cancellations were minimal and there were no breaches of the national waiting time targets for referral to treatment. (RTT) The hospital achieved 100% in 10 months and 99% in two months between October 2014 and September 2015; and consistently exceeded the 90% target
- The operating department was open from 8am to 8.30pm Monday to Friday, and there was a theatre for minor operations open for 2 afternoons per week. This meant there was a planned programme of activity.
- Surgeons discussed dates for surgery with patients at their initial outpatient's appointment. NHS patients were booked in the same way as self-funded patients and patients told us that they had a choice of dates.
- Staff undertook some patient pre-assessments on the telephone, which meant that the patients did not have to make an extra appointment.
- Staff discussed bed capacity at daily communication meetings; they identified any risks to flow and addressed them.
- Patients occupied the level three intensive care beds for 93 of the 365 (25%) available bed days during the reporting period (October 2014 to September 2015) and patients occupied level two critical care beds for 251 of 365 available bed days (69%).
- Discharges were authorised by the admitting consultant. The registered medical officer (RMO) occasionally discharged patients following guidance from the consultant. This meant patients were discharged in a timely way.
- Staff gave discharge packs to patients to take home, with information on how to access services if they had any worries. Staff prepared discharge summaries for GPs within 48 hours. For children, discharge summaries went to their GP and if the child was, less than five years old a copy was sent to the health visitor. Staff also informed the social worker of the child's attendance at the hospitals in some circumstances.
- Patients participated in the enhanced recovery pathway following hip or knee replacements. This enabled the multi-professional team to support early mobilisation and independence, and reduce hospital stay.

Meeting people's individual needs

- Patients' discharge planning began during the pre-admission process where staff gained an understanding of home circumstances and likely care needs. Staff could refer patients directly to a community service for home visits and for additional support following discharge.
- For patients whose first language was not English telephone translation facilities were available. All clinical areas were accessible to patients and relatives who had reduced mobility
- The specialist nurses were available to provide enhanced care, for example stoma care for patients who had colorectal surgery.

Good

Surgery

- Staff identified patients' special needs such as specific dietary requirements at pre admission.
- Information leaflets about the services were available in all areas we visited including child-friendly leaflets and information written for young people.
- Parents were able to stay with children at all times and this was encouraged by the staff to reduce any anxiety.
- There were no tools for screening patients living with dementia and no specific systems in place to support patients with dementia or those with a learning disability. Staff told us that they could make adjustments for patients but they rarely saw patients who required extra support.

Learning from complaints and concerns

- The hospital published information about how to complain on its' website and followed the BMI complaints policy. There were also 'please tell us' leaflets available around the hospital which outlined the complaints procedure.
- Between 1st April 2014 and 31st March 2015, the hospital received 27 complaints. No themes had emerged but actions were taken as a result of complaints for example improved car park lighting, a pain score card put in all patient rooms to help with pain management, and improved menu choices including the introduction of a "chef's special" option.
- We saw evidence in the minutes of the clinical governance meetings and the MAC meetings of discussions and actions arising from complaints. The executive director and the director of nursing took responsibility for dealing with complaints.
- A complaints database enabled the executive director and the director of nursing to track progress and close complaints when the complainant was satisfied.

Are surgery services well-led?

Good

We rated well led as good because:

- There was a vision for the services provided at the hospital. There were clear governance structures in place with committees for clinical governance, health and safety, infection control, medication, resuscitation, transfusion and radiation protection. Staff were positive about the culture and the support they received from managers.
- There were daily communication meetings to discuss what was happening in the hospital and patients were encouraged to complete patient surveys.
- Staff in all areas said that their manager was visible and approachable and they spoke highly of their managers. They continually told us that they felt well supported and valued. Staff told us that they enjoyed working for the hospital due to the strong team support from colleagues.
- There were high levels of staff stability and low levels of staff turnover.
- Staff completed internal audits relating to safety and infection control. The service also submitted outcome data to national databases.
- The hospital measured patient satisfaction via a number of routes and the most recent annual results showed that 100% of patients were satisfied with their care. Feedback included the views of children and young people.

However

- Although the Hospital had developed a risk register that captured high level and hospital wide risks, this did not yet operate at theatre and ward level.

Vision and strategy for this this core service

- The Hampshire Clinic vision was 'Our Vision is to be part of a Group that creates a world of consumer led care, where individuals choose our extensive health and well-being services throughout their lives, to help improve the health of the nation.'
- The hospital business plan stated that the aim for the surgical department was to maximise utilization through robust schedule management.
- Priorities for surgical services also included: developing a peritoneal malignancy centre of excellence; developing urology prostate mapping and diagnostic and focal therapy services; developing liver resection capability, and develop cervical spine proposition.

Governance, risk management and quality measurement for this core service

- There was a clinical governance committee, which met monthly to discuss governance issues such as complaints, incidents, and risks.
- The Medical Advisory Committee (MAC) met monthly. The MAC had standing agenda items, which included regulatory compliance, practicing privileges, incidents and complaints, quality assurance and proposed new clinical services and techniques. There was representation at this meeting from anaesthetics, and different surgical disciplines.
- Senior theatre and ward staff attended governance meetings and committees such as infection prevention and control meetings. Staff received feedback from hospital wide meetings in emails and we saw team meeting minutes that were available to all staff.
- We saw a range of standard operating procedures (SOPs) kept within a folder in the operating department. These were a comprehensive and well-written reference for staff. And at the time of our visit were up to date
- The service had a yearly audit plan which included the WHO checklist, VTE, infection control and care bundles. The manager shared audit results with staff at team meetings, but told us that in recent months it was difficult to gather the team together due to staffing and capacity issues. This had started to improve as new recruits took up posts. Results were available to staff unable to attend meetings in the form of minutes.
- The hospital had developed a high-level risk register that the executive director, the director of nursing, and the lead for quality and risk reviewed monthly. Local risks were also reviewed at governance and MAC meetings. However, we did not see evidence that this document was developed at department level to monitor more local risks.

Leadership / culture of service related to this core service

- Ward and theatre staff told us they felt managers and consultants were approachable. The theatre manager told us that the chief executive was supportive.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- Many staff had worked at the hospital for a long time and said it was a good place to work. They described it as 'a lovely place to work' where 'everyone is supportive and helps each other.'
- One senior nurse said 'I wouldn't work anywhere else'
- No whistle blowing concerns were reported to the CQC in the year to September 2015

Public and staff engagement

- There were examples of patients being involved in service development. The hospital had introduced the friends and family feedback form to gain feedback from patients about the treatment they had received. When we were there this feedback showed that 96% of patients would recommend this hospital.
- Managers kept staff regularly updated about any changes through team meetings and access to minutes from meetings if they were unable to attend.

Innovation, improvement and sustainability

- BMI Hampshire clinic provides a surgical treatment for pseudomyxoma peritonei in collaboration with the local NHS Foundation Trust - one of only two centres in the country where this rare cancer is treated.
- The urology service offers minimal access surgery by one of the United Kingdom's leading surgeons and recently he provided a masterclass for GPs.
- Members of the surgical team are developing a business case for robotic arm surgery for urology/gynaecology procedures.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Outpatient services at BMI The Hampshire Clinic cover a wide range of specialities. These include dermatology, endocrinology, neurology, oncology, neurophysiology, pain management and rheumatology.

Diagnostic imaging facilities provided by BMI The Hampshire Clinic include x-rays and ultrasound. Magnetic resonance imaging (MRI) scans, CT scans, and outpatient physiotherapy services are available on site, but run by another provider and therefore not included in this inspection process. Between October 2014 and September 2015, the outpatient department at the BMI Hampshire Clinic provided 10,355 new patient appointments and 32,059 follow up appointments.

The outpatient department operates between 8am and 8pm Monday to Friday, and on Saturdays between 8am and 1pm. The operating times within diagnostic imaging services is between 8am and 8pm Monday to Friday, with on-call services between 8pm to 8am.

There are eighteen general consulting rooms and two clinical treatment rooms. Minor operations are carried out within the outpatient department and there is a dedicated room allocated for these procedures

During the inspection we visited the outpatient department and diagnostic imaging services. We spoke with 15 patients and 14 members of staff including, nurses, consultants, radiographers, health care assistants, radiography department assistants, administrators and managers.

Throughout our inspection we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at 10 computerised records and patient care records. We looked at the environment and at equipment being used. With the patient's permission, we observed care being provided.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall, this service was rated as good. We found outpatients and diagnostic imaging (OPD) was good for the key questions of safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to rate this.

There were appropriate systems in place to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse. Staff received up-to-date training in all safety systems.

Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice. Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.

Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole. We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect. Feedback from people who use the service and those close to them was positive about the way staff treated them. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Staff managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities. Services were planned and delivered in way which met the needs of the local population. Waiting times, delays, and cancellations were minimal and managed appropriately. There was openness and transparency in how complaints were dealt with.

There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals. There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated 'safe as good.

By safe we mean that people are protected from abuse and avoidable harm.

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

When something went wrong, there was an appropriate thorough review that involved all relevant staff and people who used the services.

There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse.

Lessons were learnt and communicated widely to support improvement in other areas as well as services that were directly affected.

Improvements to safety were made and the resulting changes were monitored. Staff received up-to-date training in all safety systems.

Staffing levels and skills mix were planned, implemented and reviewed to keep patient's safe at all times.

Plans were in place to respond to emergencies and major situations.

Incidents

- In all outpatient areas, staff were aware of their responsibility to report incidents. Staff reported incidents either via an electronic system or to their manager who logged the incident on the reporting system. Staff we spoke with were confident to report incidents and challenge poor behaviour by staff at any level, if they were concerned about poor practice that could harm a person.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- In the reporting period October 2014 to September 2015, there were 323 clinical incidents reported across the hospital. There was no breakdown of incidents by each department on the report so it was not clear what the track record for incidents was in the outpatient services.
- We reviewed clinical incident report documentation held in the Outpatient Department (OPD). During the period of 1 March 2015 to 29 February 2016, the department had 33 clinical incidents and 4 non-clinical incidents.

We saw evidence that all incidents had been investigated and appropriate action taken.

- The hospital reported there were no serious incidents requiring investigation in outpatients during period October 2014 to September 2015. In same period, there were no deaths.
- The duty of candour (DoC) 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.
- Senior staff told us they had received information and training on the duty of candour.
- We saw evidence DoC was discussed in team meetings.
- Staff we spoke with were able to describe the principles of Duty of Candour and would contact a patient and provide truthful information if errors had been made.

Cleanliness, infection control and hygiene

- All outpatient areas, both waiting rooms and clinical rooms were visibly clean and well maintained. The environment in both waiting areas was light, airy and calm.
- Hand sanitisers points were available for patients, staff and visitors to use. This encouraged good hand hygiene practice. There were also posters in waiting areas and at the main reception encouraging patients to clean hands, to minimise the spread of infection.
- The housekeeping team managed the cleanliness. Each area of the hospital had a checklist, which the housekeeping member was required to complete. The checklist was then reviewed by the housekeeping lead and actions were documented and discussed with the staff member.
- The housekeeping team carried out regular audits and spot checks. Results were presented at the quality assurance meetings and learning was shared with staff.

Good

Outpatients and diagnostic imaging

- The 2016 patient satisfaction questionnaire showed the hospital scored highly in housekeeping.
- The housekeeping team told us they received very positive feedback on cleanliness.
- During the inspection we observed to be adhering to 'bare below the elbow' guidance to enable thorough hand washing and prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We observed staff using them appropriately.
- We checked PPE equipment including lead coats during the inspection: they were clean and in good condition.
- There were 'sharps' in in all consultation rooms and we noted that none of these bins were more than half full, which reduced the risk of needle-stick injury.
- In line with current best practise the BMI Hampshire Clinic had a 0% MRSA rate (October 2014- September 2015), which was achieved through an effective MRSA screening programme.
- Infection control practices were monitored by the infection control co-ordinator. Regular infection control audits were conducted and a recent hand hygiene audit showed 100% compliance. Staff we spoke with were aware of the outcomes from audits and changes needed to practice, through information sharing at meetings.

Environment and equipment

- Equipment was visibly clean. We saw labels on the equipment with the last service date and review date. They also had an asset number to enable easy tracking of the item, if it required servicing or maintenance.
- Portable appliance testing undertaken annually. Staff we spoke with were clear on the procedure to follow if faulty or broken equipment was found.
- Staff did not report any concerns regarding availability or access to equipment. Staff told us senior management was supportive to requests for new equipment.
- Bi-monthly cleaning audits were carried out by housekeeping leads, and six monthly audits were carried out by an external organisation. Results and learning was disseminated to all staff.
- There was a clear process for clinical and non-clinical cleaning, and the relevant staff members aware of their responsibilities.
- The housekeeping team managed waste disposal. There was clear labelling of clinical waste bins and sharps boxes checked in clinical rooms contained the start date.
- Resuscitation equipment was clean, well maintained and ready for use in an emergency. Trolleys were checked daily, logs were checked and confirmed daily review. A checklist was used and disposable items due to expire were disposed of and replaced.
- The outpatient's areas were accessible to all patients, including those with limited mobility as the OPD was on the ground floor.
- During the inspection, we observed that specialised personal protective equipment was available for use within radiation areas. We saw staff wore personal radiation dose monitors.

Medicines

- Medicines were stored safely in outpatients. We saw locked medicines cupboards and the keys were held by the lead nurse on duty. Staff we spoke with knew who held the keys.
- No controlled medicines were kept within OPD and radiology.
- The OPD did not use Patient Group Directions (PGDs). **PGDs** provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients.
- Hand written prescriptions were stored securely onsite.
- Prescription tracking systems were in place in accordance with national guidance and appropriate actions had been taken when discrepancies were identified.
- A limited range of To Take Out (TTO) packs were available for a specific clinic.
- Fridges were locked and temperatures checked daily and logged, to ensure medicines were stored at the correct temperature.
- One patient commented on given a clear explanation of their treatment plan and any necessary medications they needed to take.

Records

Good

Outpatients and diagnostic imaging

- At the time of inspection we saw patient personal information and medical records were managed safely and securely. During clinics, all clinical notes were kept in a locked office and transferred to the consultant when the patient arrived. Staff told us that they had no difficulty in retrieving patient notes for clinic appointments.
- Patient records were held securely on site in the medical records room. There was an archive facility for patient notes.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.
- Image transfers to other hospitals was managed electronically.

Safeguarding

- There were safeguarding children's and vulnerable adult's policies.
- Staff confirmed in conversations that safeguarding vulnerable adults was included in their mandatory training. Hospital training records confirmed this. Specify levels of safeguarding training requirements
- Staff that we spoke with demonstrated a good understanding about safeguarding processes. They knew what actions they needed to take if they suspected a patient or a visitor to the hospital had been subject to abuse.
- Processes were in place and followed to ensure the right patient received the correct radiological scan at the right time. A senior radiographer reviewed all x-ray requests before x-ray. Consultant radiologists reviewed all GP referrals before x-ray.
- There was a cross checking system in outpatients to ensure the correct patient identity. Reception staff checked patient details on arrival. The consultant or nurse, when calling through the patient, carried out a further check. The clinical staff rechecked the patient details once in the consultation room, to ensure the patient and their notes and any electronic records related to the same patient.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction and updated them in line with current policy. This included, display screen equipment, infection control, basic life support, Control of Substances Hazardous to Health (COSHH), fire warden, equality and diversity and children and adult safeguarding. The imaging and diagnostic team had a comprehensive induction checklist, and we saw evidence that competencies were checked.
- Training was delivered through the BMI online learning package (BMiLearn) followed by face-to-face teaching and practical sessions. Staff reported they completed online learning and booked dates for the practical/ face-to-face teaching sessions.
- Each staff member was linked to a role-profile in the BMiLearn system so they were automatically assigned to a relevant mandatory training plan.
- BMI set a target of 90% compliance with mandatory training. Records provided by the hospital showed that the compliance rate for OPD staff was 100% and 100 % for diagnostic imaging staff.
- There was a lead in each area for mandatory training, who took responsibility for maintaining their team staff training matrix and reminded staff to update training as needed.
- No staff we spoke with reported any issues finding time to complete their mandatory training.

Assessing and responding to patient risk

- Staff in outpatients were aware how to respond to patients who became unwell and how to obtain additional help from colleagues, to help them care for the patient.
- The outpatient's team had their own risk register. We saw that potential hazards, people affected, and assessment of risk, and controls that had been put in place to reduce the level of risk. For example, some of the treatment rooms were recorded as a potential risk to patients, as they were old and needed replacing. Staff had reviewed where all procedures were carried out and ensured these were allocated in appropriate clinical rooms. This ensured care and treatment provided was safe for patients. An action plan was in place for new treatment rooms and refurbishment.
- Staff had training in basic life support, with clinical staff trained in immediate life support.
- "Staff complete annual scenario-based training for major haemorrhage and this is provided by the local NHS trust. In addition staff complete unannounced

resuscitation simulation scenarios at least 6 times per year. Staff received feedback during the session about how the team responded to the situation, with learning points and actions to take away.
- Call bells were provided in all clinical rooms. Once a week in outpatients, the call bell system was checked in a clinical room to ensure it was working and the outcome logged and reported if necessary.
- The hospital always had access to a registered medical officer (RMO), provided by external provider, on duty, who was trained in advanced life support and European paediatric advanced life support (EPALS). They provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the inpatient ward or to the local acute NHS Trust in line with the emergency transfer policy. Staff reported that this rarely happened.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation.

Nursing staffing

- The hospital used the 'BMI Healthcare Nursing Dependency and Skill Mix Planning Tool 2015', to ensure the right members of staff were on duty at the right time, and with the right skills.
- There were no set guidelines on safe staffing levels for OPD. Outpatient and diagnostic imaging departments reported they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner.
- All outpatient areas, reported that they did not use any agency staff for the period October 2014 to September 2015. In the same period, there were no vacancies for nurses and care assistants in OPD.
- Staff teams had daily meetings to share important updates, such as changes to planned clinics or staffing for the day.
- Staff were willing to be flexible when needed and told us they liked the work and patient safety was a priority.

Medical staffing

- The hospital at the time of the inspection employed 93 medical staff working under rules or practising privileges. The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and Medical Advisory Committee (MAC) chair liaised appropriately with the GMC and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- There was a registered medical officer RMO on duty 24 hours a day to provide medical support to the outpatient and imaging departments.
- All agency staff worked with an experienced BMI Hampshire Clinic staff member.

Major incident awareness and training

- Staff were aware of their roles and responsibilities during a major incident.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as internet or electricity failure. The business continuity plans were available in folders at reception and electronically.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective as we do not currently collate sufficient evidence to rate this.

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.

There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice.

Good

Outpatients and diagnostic imaging

Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

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Evidence-based care and treatment

- Staff in in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- Radiation Exposure/diagnostic reference levels (DRL) were audited regularly and evidence of these were seen during inspection.
- Clinical audits were undertaken in diagnostic imaging. An audit plan and the results of these were observed during inspection. For example, an audit had been carried out on records of patients who had received intravenous injections. As a result of this audit, the hospital had made changes to the way injections and procedures were documented. We saw evidence the learning had been disseminated with appropriate staff.
- IR(ME)R audits were undertaken in line with regulatory responsibility, copies of these audits, outcomes, actions and results were seen during our inspection. IR(ME)R incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR(ME)R incidents.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure.
- All radiology reports were checked and verified by the radiologist, before the report was sent to the referrer.

Pain relief

- Staff discussed options for pain relief with patients prior to any procedure being performed. Many procedures were undertaken with the use of local anaesthetic, which enabled patients to go home the same day.
- Patients were given written advice on any pain relief medications they may need to use at home, during their recovery from their outpatient procedure.
- Patients' records demonstrated pain relief was discussed and local anaesthesia was used for minor procedures.

Patient outcomes

- The Medical Advisory Committee (MAC) monitored outcome data for individual consultants as part of the biennial review of consultant's practising privileges. This included readmission rates, development of venous thromboembolism (VTE) and hospital acquired infection. In the period of October 2014 to September the hospital had achieved 100% VTE screening rates.
- All radiology reports were audited for compliance with the reporting times. A designated staff member oversaw this process, and discussed the audit results with the radiologists. This ensured that a system was in place to prevent unverified reports causing delays to patient care.

Competent staff

- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- In the period October 2014 to September 2015, 75% of outpatient nursing staff had received an appraisal. In the same period, 100% healthcare assistants had received an appraisal. All radiographers and radiography department assistants had received an appraisal.
- Practicing privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection.
- Diagnostic imaging bank staff, who did not routinely work at the hospital, always worked with an experienced BMI Hampshire Clinic staff member.

Multidisciplinary working (related to this core service)

- From the care we observed, there was effective team working, with strong working relationships between all staff groups**.**
- There was a service level agreement between the hospital and a mobile magnetic resonance imaging (MRI) provider (which was part of another organisation and not subject to this inspection process). The mobile MRI visited the hospital twice a week.

Good

Outpatients and diagnostic imaging

- Departments worked closely to ensure patients did not have to make unnecessary visits. For example patients were offered the x-ray same day as their OPD appointment. Results were available electronically for consultants to view in the clinic.
- Patients with wound injuries were prioritised, and were managed by liaising with other departments to ensure patient was seen on same day.
- There were service level agreements with the local acute NHS Trust, for support services to the hospital. This included processing and reporting on radiology, radiology monitoring, and support with life support training including the provision of emergency scenarios.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday, with clinics running from 7.30am to 8.30pm Monday to Fridays. Clinics were also held on Saturdays between 9am and 12pm. Patients we spoke to reported good access to appointments and at times which suited their needs.
- In diagnostic imaging, scans, x-rays and ultrasounds were available between 8. am and 8. pm Monday to Friday. During the weekend and overnight, radiographers were on call.

Access to information

- Staff we spoke with reported timely access to blood test results and diagnostic imaging. Results were available for the next appointment or for certain clinics, during that visit, which enabled prompt discussion with the patient on the findings and treatment plan.
- During the inspection, we observed there was an osteoporosis and bone density information board, situated in one of the corridors of the rooms. This provided patients with comprehensive and wide ranging information on what osteoporosis is; how this condition is diagnosed and treated. There was also information on prevention measures for the condition, which included a list of foods rich in calcium and vitamin D.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated in conversations a good understanding about their role with regard to the Mental Capacity Act.
- The consent process for patients was well-structured, with written information provided before consent being given.
- Verbal consent was given for most general x-ray procedures and OPD procedures and carried out. The consultants sought written consent for some of the procedures.

Are outpatients and diagnostic imaging services caring?

Good

We rated 'caring' as good.

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

Feedback from patients and those close to them was positive. Patients told us they were treated with dignity, respect and kindness.

Patient's privacy and confidentiality was respected. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Compassionate care

- All the patients we spoke with, were positive about the care and treatment they had received. We received comments such as; "The staff here are brilliant", "I would not go anywhere else", "Staff are friendly and caring" and "I am always treated in a caring manner". There were no negative comments from any patients within outpatients and diagnostic imaging.
- Throughout the inspection, we saw staff speaking in a calm, friendly and relaxed way to patients. Patients told us staff were helpful and supportive.
- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.
- The hospital took part in the Friends and Family Test (FFT). There was no breakdown of the figures therefore it was not possible to identify the significance of these figures with regards to outpatients. For the reporting

Good

Outpatients and diagnostic imaging

period April 2015 to September 2015 the hospital 99% of patients said they would recommend the hospital to their friends and families. Between 20% to 38% of patients responded to the FFT.

- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 89% for privacy, dignity and wellbeing which was higher than the England average of 87%.

Understanding and involvement of patients and those close to them

- Patients told us they had been provided with the relevant information, both verbal and written, to make informed decisions about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- During our inspection, we saw there was a wide range of health promotion literature in waiting areas. This included leaflets on; breast health, orthopaedics, osteoporosis and joint injections. Similarly staff told us patients were provided with written after care information leaflet. For example, we saw the 'Arthrography/Joint Injection' aftercare leaflet included information on; infection, managing pain and how to maintain the wound site.
- The lead nurse described that all children were involved in the discussions and decision making processes about their treatment and care.

Emotional support

- Patients commented that they had been well supported emotionally by staff, particularly if they have received upsetting or difficult news at their appointment.
- During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first.

Are outpatients and diagnostic imaging services responsive?

Good

We rated 'responsive' as good.

By responsive, we mean that services are organised so that they meet people's needs.

Services were planned and delivered in way which met the needs of the local population. Patients told us that there was good access to appointments and at times which suited their needs.

Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services being delivered.

There was openness and transparency in how complaints were dealt with.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality. Clinics were held Monday to Friday until 7.30pm in the evening and on Saturdays to accommodate patients with commitments during the working week. If consulting space was available, consultants could arrange unscheduled appointments to meet patients' needs.
- Patients were sent appropriate information prior to their first attendance, this contained information such as the consultant or clinic they were to see, length of time for the appointment and written information on any procedures which may be performed at the first appointment, including the cost of the appointment and subsequent procedures (for self-funding patients). One patient told us they had received very detailed information about the procedure and costs, and felt they came to the first appointment well prepared.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the National Health Service (NHS) in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- The hospital provided a bone densitometry service (also known as DEXA), however it had been recognised that the service had not been fully utilised. To ensure this service reached to more people, the radiology department liaised directly with the local GP practices.

Access and flow

- Patient's appointments were arranged through the consultant's individual secretaries and with the outpatient reception team.

Good

Outpatients and diagnostic imaging

- NHS patients who used Choose & Book, and were subject to NHS waiting time criteria, were managed by the hospital's own administration team.
- For the reporting period January 2015 to December 2015, the hospital consistently met the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral.
- Patients we spoke with were satisfied with the appointments system. Most patients told us it was very easy to get an appointment when they needed.
- The clinics we observed mostly ran to schedule, but patients could wait up to 20 minutes to see their consultant. Staff told us if there were delays, they would speak to patients and keep them informed. During our inspection we observed staff updating patients when delays occurred.
- The OPD reception team carried out regular audits on how long each patient had to wait in the waiting area before they were seen for their consultation, for each clinic. During the inspection we reviewed the last three audits, and saw that the waiting times did not exceed 30 minutes. The audits results were shared with staff and concerns were analysed and discussed, and action plans were put in place.
- The hospital had very low 'Did not attend' (DNA) rates. All patients who missed their appointment were followed up and audited. Subsequently, the referrer was notified of the non-attendance.

Meeting people's individual needs

- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. However, staff noted there were rarely patients who had complex or additional needs.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 78% for dementia which was slightly lower than the England average of 81%.
- All written information, including pre-appointment information and signs were in English. These were not available in other formats such as other languages, pictorial or braille. Staff described there were rarely patients whose first language was not English. There were BMI policies for accessing interpreting services; however staff rarely had to access these.
- A loop system was installed in the reception area for the hard of hearing.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by BMI Healthcare.
- In diagnostic imaging, a range of leaflets were available and provided to patients about diagnostic imaging procedures.

Learning from complaints and concerns

- Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the BMI Hampshire website. However, we did not see any guidance, posters or leaflets instructing patients on how to make a complaint.
- All staff received information about the complaints procedure as part of their induction. The staff we spoke with were clear on the process and procedure.
- Staff told us complaints were openly discussed to ensure all staff were able to learn and contribute to any improvement action that might be required.
- Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint.
- We reviewed 10 (of which one complaint related to the outpatient area) complaints received in the last two years and found BMI Hampshire Clinic had kept record of all written complaints received, investigated and responded to, where possible, to the patient's satisfaction with an apology.

Are outpatients and diagnostic imaging services well-led?

Good

We rated 'well-led' as good.

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals.

Good

Outpatients and diagnostic imaging

Quality of care was regularly discussed in board meeting, and in other relevant meetings below the board level.

There was an effective and comprehensive process in place to identify, understand and monitor and address current and future risks.

There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Vision and strategy for this this core service

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The registered manager used this as the basis of the hospital wide strategy and vision.
- Staff had a clear vision for the service and were aware of the overall vision for the hospital. The vision was to provide high quality care in a timely and effective way.
- Staff told us they were all committed to constantly strive for and deliver the best care to patients, by staying abreast of all latest professional guidance and by embracing new initiatives.
- Managers in outpatients and diagnostic imaging knew about the executive team plans for developing their respective services. The plans included new treatment rooms for imaging and diagnostic department.

Governance, risk management and quality measurement for this core service

- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on intranet and signed a declaration to confirm they had read and understood the policy relevant to their area of work.
- Policies for radiological examination were written up as standard operating procedures.
- Local guidance was on display in every x-ray room.
- Team meetings included discussions about complaints, incidents, and risks.
- There was a hospital wide risk register which was updated regularly. The outpatient and diagnostic imaging departments held their own departmental risk register which identified specific risks in that area which may affect staff, patients and visitors. The risk register also reflected what action was to be taken to mitigate these risks. The departments provided the senior management team (SMT) with a weekly report, which effectively updated them with operational information from that week. This included any risk issues.
- We saw minutes of the Medical Advisory Committee (MAC) meeting which covered areas of good practice and risk and included outpatients. Minutes from the MAC meeting were circulated to all the consultants for information.

Leadership / culture of service

- Staff were positive about the leadership at management level. They told us the leadership team were visible and approachable. They felt concerns were listened to and where possible acted upon.
- Staff told us their immediate managers had appropriate skills, qualifications and experience to be able to lead and run departments, and were supportive.
- Unit leads told us were able to identify constraints to their services and suggest changes which could be made, to maintain the standard of care provided to patients. They felt that the senior management team were very focussed on patient care as their main priority and could be relied upon to action, wherever possible, any issues that improved the patient experience. They were given regular feedback from the senior management team on how well the service was performing.
- Staff reported an open and transparent culture.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test.
- Results of the latest patient survey (February 2016) showed high levels of satisfaction with 99.6% recommendation. The hospital was 32nd place (out of 59 BMI hospitals) across the BMI group for patient satisfaction scores.
- During our visit we saw there were a number of collection boxes for patients to return their completed questionnaires or they could be returned by post. Survey results were completed by an independent third party, and results communicated back to the hospital on a monthly basis for action and learning. Staff we spoke with told us they frequently discussed patient survey results and learning was shared.

Good

Outpatients and diagnostic imaging

- Staff told us that the organisation increasingly engaged through innovation awards. There was an 'Above and Beyond' award scheme in place, whereby patients could nominate a staff member or staff could nominate colleagues for an award. Winners were awarded in categories such as; outstanding care, innovative thinking, amazing support, true inspiration, brilliant leadership. Monthly winners received a plaque certificate and a mention in team meetings, celebrating their achievement. We saw evidence that staff in the OPD were recipients of this award.

Innovation, improvement and sustainability

- Most staff reported the hospital supported innovation with the executive team responsive to requests and suggestions for improvement.
- A number of innovations and improvements were made in outpatient's area. For example, a new and state of the art mammography unit, with the colour changing ambient lighting on the unit, had been built. A new quality assurance system had been introduced for the radiology department equipment. Staff reported the new system provided a more accurate reading and enabled regular audits.
- The Imaging Services Accreditation Scheme (SAS) was being introduced across the BMI hospitals. ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. The BMI Hampshire clinic was one of the hospitals which would receive this accreditation in the pilot scheme.
- The non- clinical team had also made improvements and changes. For example, the staff had introduced the feedback mechanism in the reception area, to ensure regular patient feedback was received. The booking form had been streamlined, to ensure effective usage of booking patients in.
- The hospital encouraged innovation by offering awards for innovation for staff. The management team recognised staff whose ideas were collated and subsequently implemented some of the ideas.

Outstanding practice and areas for improvement

Outstanding practice

- There were substantial observations and comments about the emotional care afforded to patients undergoing highly -specialist and complex surgery.The responsible surgeons made themselves available and accessible to patients, ward staff and the RMO, beyond expectation
- Some patients described “exceptional care” delivered by highly-motivated and caring staff. These staff were noted to be not just nursing staff, but across a wide range of professional and non professional staff bodies.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the plan to upgrade the endoscopy unit to meet Joint Advisory Group on gastrointestinal endoscopy (JAG) standards is progressed.
- The provider should ensure data on patient outcomes is collated to monitor performance.
- The provider should ensure staff are aware of and engaged with risks relating to their department.
- The provider should ensure patients are able to access information about making complaints in a variety of formats including non English language, where appropriate.