BMI Healthcare Limited

BMI The Hampshire Clinic

Quality Report

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Date of inspection visit: 23 January 2019
Date of publication: 28/03/2019

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Hampshire Clinic is operated by BMI Healthcare Ltd. The hospital has 62 beds. Facilities include four operating theatres, a three-bed level three care unit, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We focused our inspection in two areas, namely surgery and medical care.

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

We carried out an unannounced focussed inspection on 23 January 2019, to assess compliance against three warning notices which were issued to the provider on 06 July 2018.

Our inspection targeted the key concerns identified in the warning notice.

At our inspection we found the provider had made considerable progress on all issues identified in the warning notice. For example, we found the following:

- There was evidence of audit being carried out to confirm the effectiveness of infection control procedures and practices. All audits were dated and each had a separate action plan to address issues highlighted.
- The hospital ensured staff followed the pathway and guidance for assessing deteriorating patients.
- To support staff in the safe delivery of care, policies and procedures were reviewed regularly.
- The service undertook observational audits of the World Health Organisation surgery checklists.
- Staff were aware of the sepsis policy for sepsis management and the provider's sepsis care pathway. The sepsis screening tool made reference to the 2017 NICE guidance.
- There was an overall corporate risk register and specialty level risk register. The specialty level risk register accurately reflected current risks at the service. The senior leadership team were aware of the five top risks the hospital faced.
- There were effective processes developed for incidents that affected the health and safety of people using the service.
- In the endoscopy unit, there were arrangements in place for the management and control of spread of infection.
- Venous thromboembolism assessments (VTA) were fully completed. There was evidence these assessments were always reviewed when patients' risks were identified.

The hospital was compliant to the warning notice.

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals (South and South West)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care		The service was safe because the infection control monitoring procedures, processes and practices were monitored and strengthened. The service had ensured the resuscitation equipment was safe for use and managed safely at all times. Staff recognised and managed the deteriorating patient safely and effectively. Staff delivered care based on current NICE guidance. The oncology service was safe and the leadership improved existing quality systems since the previous inspection. Risk registers were regularly updated and reviewed. Departments discussed their local concerns at governance meetings where decisions made and outcomes achieved were recorded.
Surgery		The hospital used the latest NICE 2017 and NHS England guidance on sepsis. All relevant staff had been trained on this policy. Consultants reviewed assessments undertaken as part of the patient's treatment plan. The hospital had one standard process for the World Health Organisation surgical and endoscopy safety checklist. Staff undertook regular two hourly review of all patients during their stay. The hospital had a new incident management policy in place since November 2018. Staff training records were correctly filed in the relevant staff's file. The service improved the availability of face to face translation service and language line to staff and patients. The senior leadership team introduced new processes that enabled better governance.

BMI The Hampshire Clinic

Detailed findings

Services we looked at
Medical care and Surgery

Detailed findings

Contents

Background to BMI The Hampshire Clinic

BMI The Hampshire Clinic is operated by BMI Healthcare Limited. The hospital opened in 1984. It is a private hospital in Old Basing, Basingstoke, Hampshire. The BMI Hampshire Clinic provides a range of medical, surgical and diagnostic services to patients who pay for themselves, are insured, or, for some specific surgical procedures, are funded by the NHS.

The hospital has a registered manager who has been in post since 17 July 2013. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

On 24 and 25 April 2018, we carried out a responsive inspection to follow up on concerns relating to several recent incidents at the hospital. We also undertook an announced visit to the hospital on 16 May 2018 as part of our well led inspection.

We found significant concerns and on 06 July 2018 we took enforcement actions against the hospital. We issued the hospital with three warning notices under our legal powers. The warning notices outlined how the hospital failed to comply with Regulation 12, Safe care and treatment and Regulation 17, Good governance and Regulation 18, Staffing.

We also set out why the hospital was not compliant to the regulations and asked them to provide us with a timescale for improvement. We asked the hospital to send us a report on what actions they had taken to meet the legal requirements. This inspection was conducted to assess whether those actions had been taken.

We visited the service on 23 January 2019 to assess the actions the hospital had taken to make the necessary improvement. The hospital met the requirements outlined in the warning notice in full.

Our inspection team

The team comprised of two CQC inspectors and one specialist advisors with expertise in surgery, medicine (including endoscopy) and intensive care. The inspection team was overseen by Amanda Williams, Acting head of Hospital Inspection.

Facts and data about BMI The Hampshire Clinic

The hospital has three wards and is registered to provide the following regulated activities:

- Surgical procedures.

Detailed findings

- Treatment of disease, disorder and injury.
- Family planning.
- Diagnostic and screening procedures.

During the inspection, we visited two wards. We spoke with 10 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with two patients and their relatives. During our inspection, we inspected nine sets of patients' records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in 2018, which found the hospital was rated as requires improvement.

Activity

In the reporting period April 2018 to December 2018, there were 1,025 inpatient and 5,101 day- case episodes of care recorded at the hospital.

Track record on safety between April 2018 and December 2018.

- There were no never events declared by the service.
- The hospital declared 162 clinical incidents. Of these, 0 resulted in death, 99 were no harm, 5 moderate harm and 58 incidents low harm. The service did not report any incidents resulting in severe harm.
- The hospital reported three incidents according to statutory guidelines. No serious harm came from these events.
- There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA). Clostridium difficile (C.diff) or E-Coli.
- The hospital had received 27 complaints, of these 10 were upheld. The most common reasons people complained related to communications and billing payment process.

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal
- Grounds Maintenance
- Maintenance of medical equipment
- Pathology and histology

Medical care

Safe	
Effective	
Well-led	
Overall	

Information about the service

Medical was a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section. The service was safe, effective and well-led.

Summary of findings

The service was safe because the infection control monitoring procedures, processes and practices were monitored and strengthened. The service had ensured the resuscitation equipment was safe for use and managed safely at all times. Staff recognised and managed the deteriorating patient safely and effectively. Staff delivered care based on current NICE guidance. The oncology service was safe and the leadership improved existing quality systems since the previous inspection. Risk registers were regularly updated and reviewed. Departments discussed their local concerns at governance meetings where decisions made and outcomes achieved were recorded.

Medical care

Are medical care services safe?

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

During our previous inspection we found there were inadequate arrangements in place for the management and control of spread of infection in the endoscopy unit. We found clean linen was not stored appropriately and was kept in the cleaning cupboard. This area was also used to store the cleaner's bucket, cleaning chemicals and contained a large sink which created a risk of contamination. This issue was addressed immediately and on this visit, was no longer a concern, and clean laundry was stored appropriately.

During our previous inspection, we found there was limited evidence of audit carried out to confirm the effectiveness of infection control procedures and practices. The audits we saw were undated and there was no action plan to address the issues identified.

On this inspection we saw many improvements:

- The department was visibly clean tidy and clutter-free.
- Cleaning schedules were completed daily and were displayed in the treatment room and patient bays.
- Hand gel and personal protective equipment was readily available and used appropriately by the staff at the time of our visit. We saw staff were bare below the elbows and cleaned their hands between patient contacts.
- The clean and dirty flow for the scopes followed the process outlined in the national guidance and scopes were tracked using a barcode system.

The service provided infection prevention and control (IPC) audit data for patient equipment for November 2018. This was a 16-point check and achieved 100% compliance. A 'standard precautions' audit document was also provided and this also achieved 100% compliance in November 2018. This audit included the following:

Is liquid soap and water used for washing soiled hands?

Are nitrile gloves worn when in contact with or anticipated contact with body fluids or potentially contaminated items?

Is a single use apron worn when in contact with or anticipated contact with body fluids, potentially contaminated items or significant physical patient contact?

Are spillages of bodily fluids removed and the area decontaminated appropriately?

Is PPE stored correctly and away from sources of potential contamination (i.e. not in-patient bathroom or next to macerator)

Is Personal Protective Equipment (PPE)selected based on risk assessment and donned correctly? Is all PPE correctly removed and disposed of at point of use into the correct waste stream? Is hand hygiene performed immediately following removal of PPE? Are sharps disposed of safely and at point of use? Are sharps safety devices used correctly? Are all syringes and needles disposed of as a single unit?

The hand hygiene audits focussed on the following:

Was the healthcare worker's hands' skin intact and in good condition?

Was 'Bare Below the Elbows' observed?

Were hands decontaminated at point of care?

Was the correct six step technique used correctly?

The hospital provided three months of audit data which showed that the endoscopy service achieved 100% compliance for hand hygiene and environment audits.

The service had made improvements to their infection control monitoring procedures since our previous visit to ensure processes were monitored and effective IPC practices were strengthened.

We concluded the provider had ensured that infection control policies and procedures were in place and had assurance that staff followed them.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Medical care

During our previous inspection resuscitation equipment was available in the endoscopy suite. However, the equipment had not been tamper-proof evident and therefore there was risk equipment might not be available when needed in an emergency. There was no list detailing the individual items that needed to be held in the resuscitation trolley. Staff did not have information about what equipment was needed to be kept on the trolley, to assist them when carrying out their checks. Staff said as soon as an item was used it was replaced.

At this inspection, the hospital had made progress. We saw there was a tamper proof grab bag of airway equipment available in the endoscopy unit. There was a list of the content of the bag and expiry dates for items in it. We saw that staff checked the contents and completed daily checks to ensure dates were not missed. The bags were opened when dates of items expired and at the end of each year, or when items were needed for use. There was a fully stocked resuscitation trolley available in the corridor outside the theatre suite.

We saw the "Patient emergency in the endoscopy unit" standard operating procedure which detailed the staff roles and responses required. The procedure included an easy to follow flow chart which helped staff in their decision making.

Staff told us that they had received resuscitation scenario training in October 2018 and this had been added to the annual training programme.

We could see that concerns around the unsuitable flooring and fabric chairs in the department were resolved as the chairs and carpets had been replaced with easy to clean materials.

We concluded the provider had ensured that the resuscitation equipment was safe for such use and managed safely at all times.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records.

During our previous inspection of the endoscopy service, staff were not fully completing patients' observations, such as temperature checks, during procedures, or following procedures detailed in the pathway. Therefore, there was a risk staff would not identify early signs of patient deterioration.

On the day of our visit, there were three patients booked for an endoscopy procedure. We inspected the clinical record for each and looked at the following:

Pre-operation assessment

Observations during procedure

Stage 1 recovery

Stage 2 recovery.

During the procedure, clinical observations were monitored. During the stage 1 recovery period clinical observations were monitored at five-minute intervals and at stage two this was reduced to 40-minute intervals. One of the patients had their procedure without sedation so close clinical monitoring was not needed.

The clinical record formed the endoscopy pathway which was a generic document used by the BMI organisation. We were told the endoscopy pathway was now under revision by a corporate endoscopy group. The clinical scoring was a simplified 'in house' system which did not reflect the national early warning score (NEWS 2) but it was clear from the system when an escalation of care would be needed. There was a standard operating procedure available for 'deteriorating patients in endoscopy' which included a scoring system based on NEWS 2. Patients needing this level of monitoring would be transferred to the critical care unit. Staff told us that the observations and recording for recovery stages 1 and 2 were audited daily; the service provided the audit outcomes for the previous five months which showed the monitoring scores were 100% completed.

Since our previous inspection, staff had been able to access e-learning for NEWS 2. The sessions were tailored for endoscopy staff.

Staff told us that a morning huddle took place each day, which was used to identify concerns or potential issues for the day. The huddle highlighted information from the corporate senior team such as any patient safety alerts that may affect the service.

We concluded staff recognised and managed the deteriorating patient safely and effectively.

During our previous visit in April 2018, we saw the World Health Organisation (WHO) guidelines (5 steps to safer surgery) being used by staff in endoscopy. We asked the staff if compliance with the WHO safer surgery checklist

was audited for patients' having an endoscopy procedure at the hospital, and at that time, they told us no audits had been undertaken. During this visit, we inspected practice and found that observational audits were undertaken. The audit process involved 24 checkpoints including patient identification and consent; points on appropriate equipment and decontamination; team members, and consultant authorisation. The hospital provided the audit results for November and December 2018 which showed that the service was 100% compliant.

We concluded the provider regularly undertook the WHO safer surgery checklist compliance in endoscopy.

Records

Staff kept detailed records of patients' care and treatment. Records were up-to-date.

During our previous inspection of the endoscopy service, staff were not fully completing patients' observations during procedures, or following procedures detailed in the pathway. The post anaesthetic recovery and discharge scores for eight of the eight patient records we inspected were not fully completed.

At this inspection, there were three patients booked for an endoscopy procedure. We inspected the clinical record for each and looked at the following:

Pre-operation assessment

Observations during procedure

Stage 1 recovery

Stage 2 recovery.

For each stage, the documentation was fully completed, dated and signed appropriately.

We concluded staff were fully completing patients' observations during procedures and following procedures detailed in the pathway.

Clinical Quality Dashboard or equivalent

The hospital used safety monitoring results well. Staff collected safety information and shared it with staff. Managers used this to improve the service.

During our previous inspection the meeting minutes provided by the hospital did not include details for a 12-month period, and did not provide trends of patient's safety. This meant it may take longer for the hospital to notice either improvement or deterioration in safety performance. At this inspection, the hospital provided us the meeting minutes of the monthly clinical governance committee for the months of October, November and December 2018. These minutes provided trends on patient's safety such as patient events, the top five risks facing the hospital, staff completion of mandatory training and others.

We concluded the hospital could identify either an improvement or deterioration in safety performance.

Are medical care services effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

During our previous inspection we found five policies or guidelines that had not been reviewed as planned in oncology. This included the clinical guideline for management of cytotoxic extravasation (leakage of cytotoxic medication into a patient's skin), that had been due for review 2016. The other four oncology policies/ guidelines review due date ranged from November 2016 to March 2018. We were concerned that staff may not be delivering care based on current National Institute for Clinical Excellence (NICE) guidance. The oncology lead told us at the time that the policies that were overdue a review had been escalated to the head of clinical services for the BMI corporate group in April 2018.

At this inspection, we re-visited the oncology department and discussed the concerns raised on the previous visit. We highlighted concerns around the lack of effective governance to ensure policies were kept under review and updated in a timely manner to reflect best practice and national guidance. On this visit we saw that this issue had been addressed, and the oncology team told us that they now belonged to oncology cluster groups, along with a corporate cancer steering group. The steering group and the cluster groups worked together to ensure policies were maintained in line with national standards, and best practice was shared throughout the group.

Medical care

We concluded staff delivered care based on current NICE guidance.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

During our previous inspection, we found there was no system for the monitoring and review of the clinical performance data for endoscopy procedures performed at the hospital. At this inspection, the hospital had not yet been achieved Joint Advisory Group (JAG) accreditation. It had introduced an electronic system to record the outcome of gastrointestinal procedures to support achieving Joint Advisory Group (JAG) accreditation. We saw staff had worked hard to address all areas of concern and these improvements should impact positively on the hospital's JAG accreditation.

At our previous visit, staff told us that two specific audits were undertaken within oncology. The two audits were a twice-yearly audit of the United Kingdom Oncology Nursing Society (UKONS) triage tool forms used and an audit completed if a patient should experience cytotoxic extravasation. The hospital had not undertaken an extravasation audit, as the hospital had not had a patient who had experienced extravasation.

At our previous inspection, we were concerned that the audit undertaken of the UKONS management guidelines tool had shown that the service achieved 74% compliance in May 2017 and was 71% compliant in November 2017. The hospital did not submit an action plan as to how the non-compliance with the management guidelines were to be addressed to drive improvements in performance.

During this visit, the oncology staff explained their procedures when using the triage tool and we saw the records in the department. The practice was audited twice a year hospital provided audit data for October 2018 which showed that the service achieved 99% compliance.

We were assured that the oncology service was safe and the leadership had ensured that improvements had been made and maintained since the previous inspection.

Are medical care services well-led?

Governance

The service governance processes are the same throughout the hospital. We have reported about the governance processes under this section in the surgery service within the report.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

During the previous inspection visit, the risk register did not detail specific risks within the endoscopy department and the oncology service to enable these risks to be effectively managed. Following this visit the hospital provided updated risk registers and we could see from the monthly Heads of Department (HODs) meetings how the risk registers were reviewed and updated. Each department could discuss their local concerns at the meeting, and evidence of decision making and progress and outcomes. The hospital generated a monthly top five risk across the hospital.

Surgery

Safe	
Effective	
Responsive	
Well-led	
Overall	

Information about the service

Surgery was the main activity of the hospital. Staffing was managed jointly with medical care. The services were safe, effective, responsive and well-led.

Summary of findings

The hospital used the latest NICE 2017 and NHS England guidance on sepsis. All relevant staff had been trained on this policy. Consultants reviewed assessments undertaken as part of the patient's treatment plan. The hospital had one standard process for the World Health Organisation surgical and endoscopy safety checklist. Staff undertook regular two hourly review of all patients during their stay. The hospital had a new incident management policy in place since November 2018. Staff training records were correctly filed in the relevant staff's file. The service improved the availability of face to face translation service and language line to staff and patients. The senior leadership team introduced new processes that enabled better governance.

Surgery

Are surgery services safe?

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records.

At our previous inspection, we were concerned there was no sepsis policy nor a training programme to implement the policy. At this inspection, we found that the hospital used the latest NICE 2017 and NHS England guidance. As part of their e-learning training programme, BMI introduced a method of assurance that staff were made aware of new and updated policies that must be read. When staff signed into the e learning programme the new and updated policies were flagged and staff could not move forward in the programme until they had accessed and read the flagged policies. The hospital had ensured all clinical staff had completed an on-line sepsis training programme.

At our previous inspection, certain assessments such as familial history, high body mass index (BMI) and known bleeding risks had not been reviewed by the consultants as part of patients' treatment plans. At this inspection, we found the hospital had introduced a system whereby consultants had to annotate notes and provide rationale on why these assessments were not reviewed.

A recent audit (January 2019) confirmed assessments undertaken, including VTE, had been reviewed by consultants. At our inspection, we inspected five patient notes and we found assessments undertaken had been reviewed by the consultant as part of the patient's treatment plan.

At the previous inspection, we found inconsistencies in the application of the WHO checklist which included a lack of engagement from the team. Staff told us consultants did not all follow the same process for the WHO checklist. At this inspection, we found theatre staff, including consultants, had attended a training programme on WHO surgical safety training. There was now in place one standard process for the WHO checklist. There were plans in place to provide two additional training programmes in 2019.

At the previous inspection, managers told us the intentional rounding process had been re-affirmed and all patients were checked every two hours. When we checked, we found these were not undertaken. At this inspection, we inspected five records and found this was completed in all of them. The compliance was monitored through an audit of 50 notes. The standard set was that checks were made at a minimum two hourly on a 24-hour basis. The service met that standard 98% of the time.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

At the previous inspection, we found the Controlled Drugs, Safe Management of Medicines and epidural policies were out of date. We found epidural bags were stored within the main cabinet in intensive therapy unit (ITU). At this inspection, the policies had been reviewed and updated. The epidural bags were stored in a separate, securely locked and positioned cupboard. Pre- prepared epidural infusion bags were now managed as formal controlled drugs.

At the previous inspection, vials of potassium were held in the main drug cupboard. At this inspection, they had been removed and were stored in a secure, medicines management cupboard. To further assure patient safety, the service introduced an additional protocol that required two trained staff to access and administer potassium

At the previous inspection, we found the room temperature where medicines were stored were excessively hot. This could affect the efficacy of medicines. At this inspection we found there was a daily documented check by ward and ITU staff of temperatures within the wards and ITU. Pharmacy staff undertook their temperature monitoring. They had been instructed to report any non-conformance directly to the senior management team. There had been no report to the senior management team at the time of this inspection.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

At the previous inspection, the number and rise of incidents, and the delayed review process, showed

insufficient organisational learning from incidents. The service did not meet their target of 60 days for completion of root cause analysis (RCA) following incidents of harm. The RCA training was available but senior staff had not completed it. We had requested the outcomes for some of the incidents. We were told that these were not available as the internal process of investigation took a long time.

At this inspection, we found the service had introduced a new incident management policy in November 2018. The executive director and head of quality improvement attended an RCA training session in July 2018. The quality and risk manager developed a tracker for all root cause analysis and shared the timelines at appropriate committees. All RCA were completed and signed off. The learning was shared with wards and theatres. Since July 2018, the service undertook two RCAs. One was completed and signed off within the target of 60 days. The other was not completed within 60 days, however, will be signed off on 12 February 2018. The RCA will have been completed in 76 days. The service partially met the target of completing all RCA's within 60 days. The lessons learnt commentary box was populated on the electronic incident reporting system. This ensured the person reporting the incident also got the feedback. We requested the outcomes of recently incidents and the hospital provided these within the deadline set. The BMI Group clinical governance bulletin included the shared learning across the company was shared at the monthly clinical governance committee meeting. We inspected the minutes of the October, November and December 2018 minutes of the clinical governance committee and found the bulletin had been shared at all these three meetings. The hospital sought support from the local clinical commissioning group on shared learnings from incidents. The hospital introduced an internal safety alert 48-hour flash-which shared learnings from serious untoward incidents. This reinforced the policies that supported safe practice in the relevant areas. We were shown a copy of two such internal safety alerts.

Are surgery services effective?

Competent staff

The service made sure staff were competent for their roles.

At the previous inspection, we inspected staff training records and found these were not always maintained appropriately. At this inspection, we inspected five staff training records and found certificates of training correctly filed in the relevant staff's file.

Are surgery services responsive?

Meeting people's individual needs

The service took account of patients' individual needs.

At the previous inspection, we found there were no leaflets in other languages to support people whose first language was not English. At this inspection, the hospital had sought advice from an organisation that specialised in producing multilingual medical advice resource and had selected translated leaflets for the endoscopy department. It had alerted all medical secretaries of the availability and access of these leaflets. It had identified the language that was spoken by most of its overseas patients and had made available the BMI Treatment for International patients' brochure available in that language. It had raised awareness amongst its staff and patients of the availability of face to face translation service and language line.

Are surgery services well-led?

Governance

The hospital used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

At the previous inspection, key policies provided to staff were not reviewed and updated at regular intervals to ensure they reflected current practices and guidelines. There were delays in investigations of incidents and outcomes being shared in a timely way. Staff did not follow up patients' who were identified as high risks of bleeds.

At this inspection, the senior leadership team had strengthened the overall governance of the hospital. The hospital systematically revised its processes for updating policies and ensured there were no paper policies on the ward which could be out of date. Staff accessed policies on the intranet and this reflected current practices and

guidelines, to ensure they referred to the most recent agreed versions. The evidence of learning was further strengthened by ensuring communication systematically cascaded to front line staff through staff communication and staff meetings. For example, the hospital director wrote to all consultants that if a high-risk patients who came for their surgical procedure and did not have venous thromboembolism assessment undertaken, they would be returned to the ward for the assessment to be completed. We inspected the clinical governance committee meeting minutes of August 2018 and this highlighted how the hospital director had positively handled an incident of non-compliance and created an environment in which excellence in clinical care would flourish. This policy formed part of the new BMI policy and was issued by the group chief pharmacist and implemented as of 01 November 2018.

In November 2018, the senior leadership team together with a senior nurse from a ward, with senior management experience, undertook their own inspection of well led and found they had no assurances the audits undertaken on the ward had improved patient outcomes. As a result, the hospital director and the senior nurse championed the formation of the clinical audit and effectiveness committee that would help senior leadership team have an oversight of the outcomes. We saw the audit schedule and the audit results formed part of the standard agenda of the hospital's newly formed clinical audit and effectiveness committee. Their first meeting was planned in February 2019.

Managing risks, issues and performance

The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

At the previous inspection, we found the service used their internal electronic tool to document risks. However, many of risks on the risk register were issues, not risks, or were not relevant to the service. We were told that all BMI services were informed by the corporate office that specific risks should be included on the risk register. At this inspection, the service had identified The Hampshire Clinic's top five risks. These risks were displayed throughout the organisation and all senior staff we spoke with knew of these risks and mitigations in place or actions being taken.