BMI The Hampshire Clinic

Quality Report

Basing Road
Old Basing, Basingstoke
Hampshire
RG24 7AL
Tel: 01256357111
Website:www. bmihealthcare.co.uk/hospitals/bmi-the-hampshire-clinic

Date of inspection visit: 24 to 25 April and 16 May 2018
Date of publication: 27/11/2018

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

The hospital provides surgery, medical care including endoscopy and oncology, services for children and young people, and outpatients and diagnostic imaging.

We carried out a responsive inspection to follow up on concerns relating to a number of recent incidents at the hospital. We also had concerns that governance systems and processes were not operating effectively. We carried out the unannounced part of the inspection on 24 and 25 April 2018, with an announced visit to the hospital on 16 May 2018 as part of our well- led inspection.

During this inspection we looked at the core services for surgery including, surgical intensive care, children and young people services, and medical care which included endoscopy and oncology. Children and intensive care are small services, please refer to the main Surgery report for further information.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Services we rate

We rated this hospital as requires improvement overall.

- The intensive care unit did not manage medicines including controlled medicines and intravenous drugs effectively which could impact on patients' safety.
- The service did not manage incidents effectively as these were not investigated in a timely way for improvement and learning.
- There was a National Early Warning System (NEWS) in use however; the patients' notes we reviewed included scores that were inconsistent. There were gaps in the observations on NEWS records as not all parameters were completed.
- The sepsis screening tool was out of date and did not reflect 2017 national guidance. Staff had not received updates on the management of sepsis in line with recent guidelines.
- The systems and processes for ensuring patients 'safety prior to surgery was not consistently followed. We were not assured safety briefings and debriefings were being completed in the operating theatres to safeguard patients.
- Not all the theatre team were in attendance at the safety briefings.
- Governance systems and processes for the management of incidents and never events were not operating effectively.

However;

- There was a process for safeguarding children and adults which staff were confident in using.

Summary of findings

- The Intensive Care Unit (ICU) doctors reviewed patients who had been recently discharged to the ward, identifying deterioration and providing support and guidance to the ward nurses. Staff from the ICU also worked on the wards if there were no patients in ICU, this enabled patients discharged from ICU to be provided with 1:1 care when needed.
- All paediatric patients who were under five had the 'red books' which contained their current health records. The paediatric nurses ensured these were available at the pre -admission assessments stage.
- There were designated paediatric nurses when children were admitted for care and treatment.
- Staff told us they had adequate staff to meet the patients' needs and they used their bank system and could access agency staff to cover for staff's shortages.

Following this inspection, we served the Hampshire Clinic with a Warning Notice under Section 29 of the Health and Social Care Act 2008, on July 2018. The notice required the provider to make significant improvements by 3 August 2018.

We told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with requirement notices and two warning notices that affected BMI the Hampshire Clinic. Details are at the end of the report.

Name of signatory

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Location	Requires improvement 	
Medical care	Requires improvement 	Medical Care services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section. We rated this service as requires improvement in safe, effective and well led, it was good in caring and responsive.
Surgery	Requires improvement 	Surgery was the main activity of the hospital. Staffing was managed jointly with medical care. We rated this service as requires improvement in safe and well-led, it was good in effective, caring and responsive.
Critical care	Not sufficient evidence to rate 	Critical care services were a small proportion of hospital's activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section. The hospital has a three-bed high dependency unit providing levels 1,2,3 care. We have not rated critical care service, because we do not have enough evidence due to the small number of people using the service.
Services for children and young people	Not sufficient evidence to rate 	Children and young people's services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section. We have not rated the children and young people service, because we do not have enough evidence due to the small number of children using the service.

Summary of findings

Contents

Requires improvement

BMI The Hampshire Clinic

Services we looked at:
Medical care; Surgery; Critical care and Services for children and young people

Summary of this inspection

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.

This was a focused unannounced inspection of the services provided at the hospital.

We inspected the following core services:

• Medical Care (including endoscopy and oncology)

• Surgery

• Children and young people

• Intensive care unit (ICU)

Our inspection team

The team comprised of an CQC inspection manager, three CQC inspectors, and four specialist advisors including a doctor and three nurses with expertise in surgery, medicine (including endoscopy) and intensive care. The inspection team was overseen by Mary Cridge, CQC Head of Hospital Inspection.

Why we carried out this inspection

We carried out a responsive inspection to follow up on concerns relating to a number of recent incidents at the hospital. We also had concerns that governance systems and processes were not operating effectively.

How we carried out this inspection

We carried out the unannounced part of the inspection on 24 and 25 April 2018, with an announced visit to the hospital on 16 May 2018 as part of our well led inspection. We used our inspection's methodology to assess treatment and care provided at the service.

Information about BMI The Hampshire Clinic

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

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

During the inspection, we visited two wards and the intensive care unit. We spoke with 14 staff including registered nurses, health care assistants, reception staff,

Summary of this inspection

medical staff, operating department practitioners, and senior managers. We spoke with six patients and their relatives. During our inspection, we reviewed 11 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 2015, which found the hospital was meeting all standards of quality and safety and the hospital was rated as good.

Activity

In the reporting period April 2017 to March 2018, there were 1,800 inpatient and 7,547 day case episodes of care recorded at the hospital.

Track record on safety between March 2017 and April 2018

- There were no never events declared by the service.
- The hospital declared 25 clinical incidents. Of these, three resulted in death,18 were no harm and four incidents of low harm. The service did not report any incidents resulting in moderate harm or severe harm. The service had 277 incidents reported in the last 12 months.
- No serious injuries were reported.
- 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 62 complaints, of these 11 were upheld. The most common reasons people complained were related to communications, billing payment process and care and treatment.

Services provided at the hospital under service level agreement:

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

What people who use the service say

Patients we spoke with told us they felt well prepared for surgery as they had received support from staff at their pre-admission assessments. They told us they received adequate information about their planned procedure and treatment. They said that staff treated them with care and respect and their privacy and dignity were maintained when receiving care. They were provided with food and fluids that met their needs and meal choices were good. Parents told us they were involved in their children's care as appropriate. They received 'very good' support from the staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The process for investigating clinical incidents, including root cause analysis, were not effective. The delay in investigations could impact negatively on patients and lessons may not be learnt and similar incidents may reoccur.
- Medicines in the intensive care unit were not managed safely, including controlled drugs.
- Risks assessments such as those for venous thrombosis were not followed up to ensure appropriate actions were taken.
- Processes designed to identify patients whose condition was deteriorating were not always followed. The National Early Warning System (NEWS) was used.
- However, the notes we reviewed included scores that were inconsistent. There were gaps in the observations and NEWS records as not all parameters were completed.
- In endoscopy, the post anaesthetic recovery scores and the post anaesthetic discharge scores in all the eight patients' records we reviewed were not fully completed or totalled.
- First response airway equipment in the endoscopy department was not stored in a tamper evident way. There was no list detailing what equipment should be held.
- The storage of clean linen was not safe in the endoscopy unit as the linen was at risk of becoming contaminated.
- There were no audits undertaken of the World Health Organisation (WHO) five steps to safer surgery checklist in endoscopy to check compliance.

However;

- There was a process for safeguarding children and adults which staff were confident in using.
- Staff followed operating theatre guidelines for the decontamination of reusable medical devices in line with national guidance.
- The paediatric nurses completed a pre-operative fasting checklist and followed the National Institute for Care Excellence (NICE) guideline for pre-operative fasting for children. Admissions were planned and staggered to ensure that children did not go without food and fluids for long periods.

Summary of this inspection

- There was an effective process to manage the decontamination of endoscopes used in the endoscopy unit.
- The electronic prescribing of chemotherapy was safe and working effectively. The system ensured that medication could not be prescribed, dispensed or administered until all safety checks had been completed.
- There were sufficient nursing and medical staff for procedures and chemotherapy treatments to be performed as planned.

Are services effective?

Requires improvement

Are services effective?

We rated effective as requires improvement because:

- The service did not have to CT scanning 24 hours a day, seven days a week. Out of hours patients were transferred to the local NHS hospital for CT scans.
- Five of the oncology policies we reviewed were overdue for review. This meant staff may not be delivering care based on current NICE guidance.
- Patients' care and treatment outcomes following endoscopy procedures were not monitored at the hospital. The hospital was introducing an electronic system in July 2018 to enable the consultant to input outcome data following a procedure.
- In endoscopy there was inconsistency in the completion of consent forms. This meant that there was no assurance appropriate consent was always obtained prior to a procedure being undertaken.

However:

- Patients told us that they had adequate information about pain relief and that their pain was appropriately managed. Pain control was discussed with the patient at pre-operative assessment and a choice of pain control methods was available.
- Patients had investigations and blood tests as part of their pre-operative assessment based on NICE guidelines to ensure they were fit for surgery.
- All the patients' records we reviewed contained nutritional assessment using a nationally recognised tool.
- There was effective multi-disciplinary team working in oncology and the endoscopy unit.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Patients we spoke with told us they felt well prepared for surgery as they had received support from staff at their pre-admission assessments and on admission.
- Care was provided in a respectful manner and staff ensured patients' privacy and dignity was maintained.
- During the inspection we saw that staff were caring, sensitive to the needs of patients and compassionate. Patients commented positively about the care provided by all the staff.
- Patients felt informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, and care after a chemotherapy treatment in a designated room in Enbourne ward.
- Staff supported patients and provided emotional support with their care and treatment as needed.

Are services responsive?

Good

Are services responsive?

We rated responsive as good because:

- There were effective admission processes including exclusion and inclusion criteria.
- Patients for elective surgery were offered a one stop pre-operative assessment with the average waiting time was two weeks.
- Care and treatment was co-ordinated with other providers.
- The needs of different people were considered when planning and delivering services. Staff took account of individual patients' needs when delivering care and treatment.
- Staff working in this service listened to concerns, complaints and followed their processes to record and report complaints.

However:

- The service treated people whose first language was not English, there were no information and leaflets available in other languages.
- There was no dementia pathway, patients over 75 years of age were not screened for dementia which meant these patients could be missed.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Although incidents were discussed, there was some evidence of learning from incidents. This was compounded by delays in investigations and outcomes being shared.

Summary of this inspection

- The risk register did not detail specific risks within the endoscopy department and the oncology service to enable these risks to be effectively managed.
- There were no specific management or user groups running at the time of the inspection which enabled staff to discuss operational and strategic issues.
- Oncology representation at the Medical Advisory Committee (MAC) was now in place. Post inspection we received information that oncology representation had been put in place in January 2018, with an oncology consultant at the MAC meeting held in January 2018'.
- There was no BMI cancer lead in post to drive improvement in the oncology service.

However:

- Internal audit reports, such as compliance with the WHO checklist were discussed at governance meetings and at the medical advisory committee as appropriate.
- There was a governance framework with health and safety committee and risks were linked to the governance framework.
- There were regular medical advisory meetings and the Consultants were involved
- Staff spoke passionately about the service they provided, the care they offered to patients and the vision they had for their services. Staff achievement was recognised through staff awards.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children and young people	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Medical care

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

Information about the service

Medical Care services were a small proportion of the hospital's activity. We looked at endoscopy and oncology as part of this inspection when assessing medical care.

Are medical care services safe?

Requires improvement

We rated safe as **requires improvement.**

- In endoscopy the post anaesthetic recovery scores and the post anaesthetic discharge scores in all patient records we reviewed were not fully completed or totalled.
- First response airway equipment in the endoscopy department was not stored in a tamper evident way, and there was no list detailing what equipment should be held.
- The storage of clean linen was not safe in the endoscopy unit, as the linen was at risk of becoming contaminated.
- There were no audits undertaken of the World Healthcare Organisation (WHO) five steps to safer surgery checklist in endoscopy to check compliance with use of the checklist.

However:

- There was an effective process to manage the decontamination of endoscopes used in the endoscopy unit.
- The electronic prescribing of chemotherapy was safe and working well. The system ensured that medication could not be prescribed, dispensed or administered until all safety checks completed.
- There were sufficient nursing and medical staff for procedures and chemotherapy treatment to proceed as planned.

Mandatory training

- The hospital's heads of department meeting records for March 2018 noted compliance with mandatory training overall at 85%. The target for the hospital was 90%.
- At the time of inspection compliance with infection prevention and control was at 78% against the hospital's target of 90%. When we reviewed the monthly heads of department (HOD) meetings, we could see the executive director (ED) had discussed with HODs the need for staff mandatory training to be up to date. The ED told the HODs that staff performance should be managed if staff did not comply with mandatory training requirements. During the factual accuracy process, we were provided with evidence for one staff member who did not complete their mandatory training, and how this was managed.
- Mandatory training included, infection prevention and control, control of substances hazardous to health (COSHH), equality and diversity and, basic life support.

Safeguarding

- Staff working in endoscopy and with oncology patients confirmed there had been no safeguarding incidents from March 2017 to March 2018.

- Staff could explain how they would respond if they witnessed or suspected abuse, and told us they would report it to the director of clinical services (DOCS), who was the safeguarding lead. Staff we spoke were also familiar with the term female genital mutilation (FGM) and confirmed FGM had recently been included as part of safeguarding training.
- The doctors had completed safeguarding adults level 3 training. Overall at the hospital staff compliance with adult safeguarding was 95% for level 1 and 92% for level 2. For safeguarding children compliance with level 1 was 96% and level 2 was 95%, this was above the hospital target of 90%. Female genital mutilation training was at 39% compliance; however, this training had not commenced at the hospital until early 2018.
- From April 2017 to March 2018, staff compliance with PREVENT duty training across the whole hospital was 97%. PREVENT raises awareness to stop individuals from getting involved or supporting terrorism or extremist activity.

For further information please see the surgery and children and young people reports.

Cleanliness, infection control and hygiene

- There was a room in endoscopy with a large sink and a cupboard for cleaning chemicals that was unlocked. The key was in the lock. When we inspected on 24 April 2018, the cupboard also had a bucket and mop for cleaning, clean linen on shelves and two oxygen cylinders were stood on the floor by a wall.
- We spoke with the endoscopy lead about the risks that included the linen becoming contaminated when the sink used. The lead explained a linen trolley had been ordered, but had been too small. The lead was not sure of the progress made to purchase a larger trolley for the storage of clean linen.
- When we revisited this room in the endoscopy department on the 25 April 2018, the cupboard with the cleaning chemicals was locked, and the oxygen cylinders had been removed from the cupboard.
- On Enbourne ward where oncology patients were cared for, the hospital submitted a hand hygiene audit with a compliance of 75%. The staff member that undertook the audit had not dated it. The hospital also did not submit an action plan to indicate action had been taken to address non-compliance by staff. This meant that patients were being put at risk of poor clinical practice, with no plan in place to drive improvements.
- The hospital had information stating a hand hygiene audit undertaken in endoscopy achieved a 100% compliance, but did not state when the audit was undertaken. It was not clear how frequently these were undertaken and the trend of compliance at the hospital.
- The hospital had policies and procedures to manage infection prevention and control (IPC). Staff could access these via the hospital intranet. Staff followed these policies and processes for the management of waste and decontamination. We observed the process by which the endoscopes were sent off site to be decontaminated, and tracking records used to evidence that endoscopes had been decontaminated when received back at the hospital.
- We observed staff cleaning equipment between each patient having an endoscopy procedure.
- Disposable aprons and gloves were readily available. We observed staff using them when delivering care and treatment to patients, to reduce the risk of cross infection.
- Staff adhered to the 'bare below the elbow' as stipulated in National Institute for Health and Care Excellence guidance when providing care and treatment.
- There was one incidence of E-coli in the blood stream infection of one medical patient in January 2018. The intensive care unit team were in touch with the local NHS Trust microbiologists and the antimicrobial therapy used was appropriate. The hospital undertook an internal investigation into this case, and no lapses in care were identified.
- In endoscopy there was a clear clean to dirty pathway for the management of endoscopes. The hospital had an agreement with an offsite facility, where the endoscopes were sent to be decontaminated in appropriate trays and packaging. The endoscope leads then arranged for decontaminated scopes to be returned in appropriate trays and packaging, ready for planned endoscopy lists.

Medical care

- Local infection prevention and control audits were undertaken in endoscopy and Enbourne ward. The environment in endoscopy scored 100%, and in Enbourne ward 93%. The hospital did not submit an action plan to improve the environment in Enbourne ward.
- Staff had three designated rooms, with vinyl flooring, on Enbourne ward for the care of oncology patients. This meant the floor surface was easier to clean. Staff told us the hospital was in the process of changing all patients' bedrooms to vinyl flooring, however, no timescale for the completion of this work was provided.
- When we reviewed the clinical governance and heads of department meeting minutes there were no references to cleaning audits being undertaken and staff did not inform us how cleaning was monitored. Patients on the patient satisfaction feedback forms from December 2016 to May 2017 rated bathroom cleanliness from 80% to 90%.
- For further information please see the surgery report.

Environment and equipment

- First response airway equipment was available in the endoscopy suite. The endoscopy lead told us this equipment was supplementary to the equipment on the theatre trolley in theatre recovery. The equipment on the 'emergency trolley was checked and stocked up'. The storage of the equipment was not tamper evident. There was no list detailing the individual items that needed to be held. Staff said as soon as an item used it was replaced. The lack of a detailed list meant that staff were not able to check they had not missed an item. This had the potential to cause a delay with patients' treatment if there was an emergency.
- The resuscitation trolleys we checked in theatre recovery adjacent to endoscopy and on Lyde ward was tamper evident, and equipment checks had been carried out.
- The number of decontaminated endoscopes and size of scopes received by the hospital enabled the scheduled endoscopy lists to proceed uninterrupted. This met the standards set by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. There were also enough monitors, cameras and printers.
- Equipment that we checked in oncology and endoscopy had been regularly serviced, and dates of when the next servicing was due documented.
- Patients in the oncology unit had access to a scalp cooler, and all staff were trained to use this equipment. Scalp cooling can reduce hair loss caused by chemotherapy.

Assessing and responding to patient risk

- Consultants assessed patients medically in the outpatient clinic for endoscopy procedures. Nursing staff also completed a pre-treatment assessment on a specifically designed pathway with patients prior to an endoscopy to check their fitness for the procedure.
- The endoscopy pathway had an endoscopy procedure monitoring chart, a post anaesthetic recovery monitoring chart to score and post anaesthetic discharge monitoring chart to score to enable staff to monitor patients' recovery from anaesthetic and their fitness to be discharged. Although patients were having intravenous conscious sedation immediately before endoscopy procedures, staff were not fully completing patients' observations during procedures, or following procedures as detailed in the pathway. Therefore, there was a risk staff would not identify early signs of patients' deterioration.
- In the endoscopy procedure room staff took observations of patients' pulse rate and oxygen saturations, but not their respiratory rate, temperature or blood pressure. Post procedure patients' temperatures were not recorded. This meant staff may not identify early signs of patients' deterioration. The pathway provided prompts of the observations that should be undertaken with 'time' interval columns, for the post anaesthetic recovery score and discharge score and two columns at the end where a score out of 10 and the time could be recorded.
- The World Health Organisation (WHO) guidelines (5 steps to safer surgery) was used to ensure compliance with the 5 steps to safer surgery in endoscopy. We observed the WHO checklist being used by staff, and all stages covered. In the eight endoscopy records we checked the checklist had been completed. However, we observed one checklist where an incorrectly completed consent form had not been commented upon in the relevant section in the checklist. Therefore,

there was no assurance that staff had observed the consent form had been incorrectly completed and taken appropriate action. We asked the hospital if compliance with the WHO checklist was audited for patients' having an endoscopy procedure at the hospital. At the time of the unannounced inspection in April 2018 the hospital told us no audits had been undertaken with the WHO safer surgery checklist compliance in endoscopy.

- The hospital had placed an emergency call bell in the new endoscopy suite. The procedure had been checked in an unannounced way and the response time by staff was within agreed procedure.
- The nurses completed an oncology nursing assessment, as part of a specifically designed care pathway, for oncology patients on admission. The patient's assessment included information about the risks of chemotherapy, and how these risks could be managed.
- A patient had come to the oncology department very unwell with neutropenic sepsis. Neutropenic sepsis is a life-threatening complication on anticancer treatment, the term is used to describe a significant inflammatory response to a presumed bacterial infection in a person with or without fever. Staff had followed the procedure for the immediate treatment of this condition, the patient was transferred to a nearby NHS trust and made a good recovery. The up to date protocol was displayed in the treatment room, so immediately available for staff to refer to.
- Oncology nursing staff used the United Kingdom Oncology Nursing Society (UKONS) triage tool to help identify the urgency of a problem such as neutropenic sepsis.
- The hospital had a transfer agreement with a nearby NHS trust and a policy for a patient who became unwell. Staff working in endoscopy would alert the consultant who was always present when endoscopy procedures took place.
- If the oncology consultant was not present during a chemotherapy treatment, staff would telephone the consultant. If immediate help was needed to stabilise the patient, staff would contact the resident medical officer who was on site 24 hours a day.

For our detailed findings on assessing and responding to risk, please see the safe section in the Surgery report

Nurse staffing

- There were five staff specifically dedicated to supporting the performance of gastrointestinal endoscopy procedures. This included a member of staff who was completing competencies in endoscopy with the support of an experienced endoscopy member of staff. The endoscopy lead confirmed the staffing skill mix and competencies were appropriate and were as planned for the endoscopy procedure lists that were scheduled at the hospital. No gastrointestinal endoscopy lists had been cancelled due to not having sufficient appropriately skilled staff.
- Staff from the endoscopy suite worked in main theatres when there was not an endoscopy list taking place to enable them to maintain their skills.
- Three registered nurses formed the oncology team. This included one member of staff currently undertaking a competency to undertake the role safely, the other two staff had completed these competencies. The team had recently needed to use an agency member of staff due to sickness. The agency nurse had specific training in oncology and the checking of chemotherapy treatments. These staffing levels ensured patients always received their treatment from staff competent in the administration of chemotherapy.
- Two chemotherapy-trained nurses were always on a duty when a patient was booked for a chemotherapy treatment. The oncology lead confirmed the skill mix and competencies of staff enabled the needs of oncology patients attending the unit were met effectively.

Medical staffing

- Two The medical staff, who undertook endoscopies and those providing oncology care, also regularly worked within the NHS.
- Medical staff 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 an independent hospital. A review of 11 of the medical staff files held by the hospital demonstrated that these were detailed including; the individual's scope of practice, CVs, training records and appraisals which were up to date.

- A resident medical officer (RMO) provided 24-hour, seven day a week cover at the hospital. The RMO cover was supplied though an agency who also checked their competency. This included ensuring the RMO was trained in advanced life support.
- The endoscopist saw patients on the ward after the procedure, to feedback findings and discuss the patent's ongoing plan of care. The leads reported timely access to the consultants if a patient's needs changed, and that there was a formal arrangement that the consultants provided cover for each other's patients if required.

Records

- We reviewed eight patients' paper medical and nursing records for endoscopy and three for patients having chemotherapy. We found eight out of eight records checked for endoscopy patients were not fully completed. Staff did not fully complete all the observations during the procedure, and the observations for the post anaesthetic recovery score and post anaesthetic discharge score were not fully completed or totalled. This posed risk of any changes in the patients' conditions may not be identified in a timely way for action to be taken.
- Nursing staff completed a specifically designed care pathway for an oncology patient having systemic anti-cancer therapy. Similarly, there was a pathway used for patients' having an endoscopy. These pathways both contained risk assessments that staff had fully completed.
- Staff working in endoscopy kept tracking and traceability records regarding the endoscopes, and these were fully completed. The theatre register in endoscopy was also fully completed.
- Records were legible, available at the point of care delivery and stored in a lockable cabinet when patients' undergoing a procedure in endoscopy or having a treatment intervention with the oncology staff on Enbourne ward.

Medicines

- Patients attending the oncology day unit received intravenous chemotherapy, for which safe systems had been put in place. This included the prescribing of chemotherapy and oncology medication record keeping electronically.
- Medicines were available in endoscopy and in the treatment room in Enbourne ward to provide immediate treatment for any adverse reactions to sedation or pain medicines.
- Chemotherapy spillage kits were available in oncology. The oncology lead also showed us spillage kits given to patients for use at home, in case of a medicine spillage.
- Medicines were stored in locked cupboards. Medicines that required storage below a certain temperature were stored in a locked fridge, specifically for that purpose. During our inspection, we saw that the checking of minimum and maximum temperatures took place. The leads told us staff were aware of actions to take if temperatures were not within the minimum and maximum range, and there was guidance on the recordings sheets. Intravenous fluids for oncology patients on Enbourne ward were stored in a room that could only be accessed by key pad entry.
- Piped oxygen was available in the endoscopy procedure room, and the endoscopy recovery bays.

For our detailed findings on medicines please see the Safe section in the Surgery report

Incidents

- Staff in endoscopy and those working with oncology patients were aware of how to report incidents. Staff we spoke with said that reporting incidents had positive outcomes for patient care.
- The hospital reported there had been thirteen incidents in endoscopy in the period from March 2017 to March 2018. There were three incidents where patients were found to have incorrectly completed wrist bands between June 2017 to August 2017. The hospital acted in relation to these incidents, this included a discussion with the ward administrator and follow up memo to the ward clerks. The memo asked ward clerks to write patients' wrist band details from the patient registration form and not from labels contained within the patient notes, as there may be some duplicate numbers. There were no further incidents relating to patients' wristbands being incorrectly completed in the data we received which covered the period up to 01 February 2018. There were no incidents reported in relation to oncology patients.

Requires improvement

Medical care

- We saw shared learning was promoted after an incident from the incident report submitted by the provider. This included action taken following the incident.
- The hospital reported two expected deaths from March 2017 from March 2018 of patients that had been treated in the oncology unit. A review of one of the patients was undertaken by an investigator from another BMI hospital. Learning from this incident took place; this included the consultant having closer working relationships with the hospital, and an additional medicine within a chemotherapy treatment schedule.
- Staff understood duty of candour (DoC) 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 were aware of their responsibility to inform patients when anything went wrong. They said that the consultants would initiate this and the clinical lead for the service would be part of the investigations.
- There had been no never events in the endoscopy service or involving the oncology patients during from March 2017 to March 2018. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Clinical Quality Dashboard or equivalent

- The hospital did not display safety information in endoscopy or in the area where the oncology patients were cared for. Safety information was monitored at monthly clinical governance meeting held at the hospital, this included venous thromboembolism assessment and patient safety incidents.

Are medical care services effective?

Requires improvement

We rated effective as **requires improvement.**

- Five of the oncology policies we reviewed were overdue for review. This meant staff may not be delivering care based on current national institute for care excellence (NICE) guidance.
- People's care and treatment outcomes following endoscopy procedures were not monitored at the hospital. The hospital was introducing an electronic system in July 2018, to enable the consultant to input outcome data following a procedure.
- In endoscopy, there was inconsistency in the completion of consent forms we reviewed. This meant that there was no assurance appropriate consent were always obtained prior to a procedure being undertaken.

However:

- Staff monitored a patient for any pain, and responded promptly if any pain relief required.
- Staff were encouraged to participate in training and development to enable them to deliver good quality care.
- There was effective multidisciplinary working.

Evidence-based care and treatment

- 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 date due ranged from November 2016 to March 2018. This meant that staff may not be delivering care based on current national institute for care excellence (NICE) guidance.
- The oncology lead told us that the policies that were overdue a review had been escalated to the Head of Clinical Services for the BMI corporate group in 5 April 2018.
- The Head of Clinical Services was in the process of appointing a new chair for the BMI Cancer Clinical Development group, to support the staff working in oncology. The endoscopy service was actively working towards Joint Advisory Group (JAG) accreditation. The service had self- assessed themselves against the JAG global rating scale (GRS). The GRS is a quality improvement system designed to provide a framework

for continuous improvement for endoscopy services to achieve and maintain accreditation. The service had then produced an action plan to support them in achieving JAG accreditation.

- Endoscopy staff booked procedures in line with British Society of Gastroenterology (BSG) guidance. This meant that sufficient time was given for procedures not to be rushed that could cause endoscopy staff to fail to detect abnormalities.
- The oncology unit had been awarded the Macmillan Quality Environment Mark (MQEM) in 2017, a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.

Nutrition and hydration

- Patients having a gastroscopy were advised not to eat anything for six hours and then to have water only two hours up to admission time to enable good views of the stomach.
- Patients who were due to attend for a colonoscopy, was given detailed advice on how to prepare for the procedure. This included administering a laxative and advice regarding dietary and fluid intake.
- Nursing staff offered patients a drink and light snack prior to discharge after gastrointestinal endoscopy.
- Patients' having chemotherapy were offered drinks and meals depending on the length of their treatments which varied. Staff were also able to refer patients to a dietitian if required.

For further information please see the surgery report.

Pain relief

- Nurses monitored patient pain using a numerical pain scale. Patients undergoing a gastrointestinal endoscopy were offered a throat spray to reduce discomfort and/or intravenous sedation, to minimise any discomfort or pain. Medical staff also performed gastrointestinal endoscopies under a general anaesthetic where appropriate.
- Medical staff performed colonoscopies under intravenous sedation, to ensure a person was relaxed and comfortable during the procedure.
- Staff in oncology monitored patients' pain during chemotherapy treatments. There were also posters for patients in a lounge are for oncology patients advising patients to let staff know if they had any pain. Feedback from oncology patients was very positive about ensuring they were as comfortable as possible.

Patient outcomes

- The endoscopy senior nurse advised us there was no system for the monitoring and review of the clinical performance data for endoscopy procedures performed at the hospital. The endoscopy senior nurse lead advised they planned to introduce an electronic system to record the outcome of gastrointestinal procedures in July 2018, to support achieving JAG accreditation.
- The lack of data collection meant the hospital was unable to measure the outcomes of gastrointestinal endoscopy procedures, such as the average amount of sedation and analgesia used against other services. This meant the hospital did not how their performance compared with other providers, and if improvements in practice should be considered.
- Oncology patients were discussed in a multidisciplinary team meeting at a local NHS trust, and this provided opportunity for peer review and benchmarking. Oncology nursing and medical staff at the hospital monitored individual patient's outcomes as patients returned for review and further chemotherapy treatment cycles. This was recorded in patient medical notes.
- The service contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition Markets Authority (CMA).
- Two specific audits were under taken 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. Extravasation is the leakage of intravenously infused potentially damaging medications into the extravascular tissue around the site of infusion.
- We reviewed the audit undertaken of the UKONS management guidelines tool that completed in May and November 2017. The data submitted by the hospital stated that in May 2017 the hospital was 74% compliant

and in November 2017, 71% compliant. The hospital did not submit an action plan as to how the non-compliance with the management guidelines to be addressed to drive improvements in performance. The hospital had not undertaken an extravasation audit, as the hospital had not had a patient who had experienced extravasation.

- The hospital's quality accounts for 2017, stated that the Hampshire Clinic readmission rate was less than 1% per 100 discharges with 28 days.

Competent staff

- Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in an independent hospital following approval from the Medical Advisory Committee (MAC). The hospital checked consultant qualification, experience and carried out disclosure and barring service (DBS) checks. The hospital had an effective process for ensuring updated evidence of GMC registration, insurance, competence and revalidation was in place.
- When we reviewed the MAC meetings from April 2017 to January 2018, there was regular review of consultant practising privileges. For example, during this period there were examples of consultants' practising privileges being withdrawn due to retirement, maternity leave and staff moving to work at a new NHS Trust.
- Medical staff performed endoscopy procedures, supported by nurses with specific endoscopy skills. Staff working in endoscopy were competent in various aspects of endoscopy including supporting the patient through a procedure, management of specimens and the preparation of endoscopes being sent for decontamination off site. Staff working in endoscopy who we spoke with stated they had completed specific competencies, to ensure they could work safely within the endoscopy unit. We saw two staff records, one where the competency document had been signed off, and the other where the member of staff stated they had completed the competencies but these were not documented in the staff member's folder.
- Nursing staff in oncology were competent in the use of vascular access devices and chemotherapy administration. A staff member told us that they had attended specific training including a guide to cancer immunotherapy in April 2017 and dialogues in cancer care in November 2017. We noted in the oncology staff member's file we looked at, this included evidence that they had completed oncology competencies.
- We observed a member of staff who had expressed an interest in developing their competency in working with oncology patients, while they were shadowing an experienced chemotherapy nurse. The patient whose treatment they were involved in told us they were happy to support this learning style.
- The hospital had a system of undertaking staff appraisals at the hospital. We reviewed one for an oncology member of staff's appraisal that had been completed. The staff member had found the appraisal valuable in supporting their development. We saw that the doctors had appraisal records and these were all up to date. However, we were not provided with appraisal completion rates for endoscopy or oncology.
- Clinical supervision for nursing staff was not in place. Staff we spoke with were not concerned about this, as due to the size of the service debriefings for staff were readily available within the team and or manager support.

Multidisciplinary working

- There was effective multidisciplinary team (MDT) working in oncology and the endoscopy unit, both with in the hospital and externally with GP's. During our inspection, the administrative, pre-assessment, endoscopy and oncology medical and nursing staff worked well together to ensure patient pathways were effective. This included discharge summaries that were sent to GP's.
- The medical staff liaised with colleagues in the NHS, if the finding following endoscopy procedures indicated further medical treatment would be required.
- Oncology staff told us the consultants' patients treated at the hospital were discussed at cancer MDTs within the local NHS Trusts. In the three oncology patient records we looked at, there was no record of these MDT discussions, therefore we could not confirm that these discussions had taken place or the outcomes of these.

Medical care

- The oncology staff explained that if a patient required end of life care, there were links with local hospices for patients to be referred to for their needs to be effectively met.
- Staff in oncology worked closely with the breast care specialists at the local NHS Trust. The oncology nurses' ensured patients were given the contact details for the breast care specialist nurses at the hospital for support.
- We observed there was effective team working between all staff groups. A daily morning communication meeting facilitated this, where a member of each department was present. The meeting enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.

Seven-day services

- The endoscopy procedures were planned interventions. Endoscopy operating sessions were available from 8am to 8pm Monday to Friday, according to consultant availability.
- The oncology service was available Tuesday to Thursday from 10am to 4pm. Staff administered chemotherapy treatments Tuesday to Thursday. For patients who were receiving chemotherapy there was seven-day support available through an out of hours contact number to oncology trained staff, if patient' had concerns or any adverse effects.
- Pharmacy was available Monday to Friday. The hospital had a process for out of hours pharmacy support, that staff understood how to use.
- The hospital operated an on-call system for senior managers seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed eight endoscopy consent forms. All the forms detailed the risks and benefits. One consent form was signed at the initial patient's consultation, but not confirmed by the patient as happy to go ahead on the day of the procedure, which did not follow best practice guideline/ hospital policy. The consultant also signed a consent form, but had not printed their name. On a second consent form the patient had signed in the witness box, which is used if the patients unable to sign, but has indicated their consent.
- The hospital undertook consent audits across the hospital quarterly. From the information we received, it was not clear how many of the consent forms were from the endoscopy or oncology service. Ten sets of notes were audited a quarter.
- Compliance with the majority of the 16 standards was 94% in September 2017 and 93% in December 2017. Consultant compliance with providing their signature and full name in block capitals was 90% in September 2017 and 80 % in December 2017. The hospital had put an action plan in place to address the gap in compliance. The hospital figures for confirmation that consent obtained on the day of procedures was 100% for each quarter.
- Consultant gastroenterologists and colorectal surgeons sought consent for patients having an endoscopy procedure when they assessed patients at their consultation. This was good practice, as it gave patients time to reflect on their decision to undergo the procedure.
- The oncology consultants sought consent from patients, which included a discussion of the risks and benefits, before patients admitted as a day case for chemotherapy. The consent process was supported with written information about the specific chemotherapy treatment for patients to take away and read.
- Staff understood the consent to care and best interest process. They told us of action they would take if someone lacked capacity. The hospital from April 2017 to March 2018 had 95% compliance with staff who had received training in patient consent.
- The BMI consent for examination or treatment policy dated April 2018, included guidance about obtaining consent in patients' who lack capacity. Staff told us if they were concerned about patients' understanding, they would seek advice from their manager.

Are medical care services caring?

Good

We rated caring as **good.**

Requires improvement

Medical care

- During the inspection, we saw that staff were caring, sensitive to the needs of patients and compassionate. Patients' commented positively about the care provided by all the endoscopy and oncology staff.
- Patients felt informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, and care after a chemotherapy treatment in a designated room in Enbourne ward.
- Staff supported patients' emotionally with the care and treatment as needed.

Compassionate care

- Staff treated patients with dignity and respect, and maintained their privacy. For example, all private conversation between staff and oncology patients took place with the door to the room where they received treatment was closed, this ensured they could not be overheard.
- Patients' and their relatives found staff to be compassionate and caring. A patient and relative we spoke with in oncology told us they were happy with the care and felt supported. A relative of a patient wrote in a thank you card, 'he really appreciated the care you gave him and your sense of humour'. A patient in endoscopy department gave feedback to the hospital that they had been 'made to feel at ease/ comfortable by all staff I came into contact with. All very considerate and caring'.
- We observed how friendly, kind and supportive all staff were in helping patients to have a smooth patient journey, and we could see patients were feeling at ease and comfortable. A patient commented how they found the staff respect for their team colleagues reassuring, knowing that if a team member needed help, they would approach a colleague. In feedback to the hospital a patient commented 'all the staff were extremely helpful from start to finish'.
- In the Patient Led Assessments of the Care Environment (PLACE) in 2017 privacy, dignity and well-being scored 94% compared to 87% in 2016.

Emotional support

- We observed staff explaining to patients about the care and treatment that would be undertaken to reduce their anxiety, and providing reassurance when procedures undertaken or treatments given. An oncology patient in a thank you card wrote 'you haven't sugar coated anything nor overdramatised. You are a truly amazing role model and I am so grateful I have you as my chemo nurse'.
- Patients were referred to clinical nurse specialists and counselling services and through their GPs if needed or requested.
- Patients could have emotional support from family and friends at any time, as there were no restrictions to visiting times.

Understanding and involvement of patients and those close to them

- To support patients to make an informed decision about their care and treatment, staff provided patients' undergoing an endoscopy with relevant information both verbal and written.
- Patients who needed oncology treatments told us and described in written feedback that staff kept them informed about their care, involved in any decision-making and listened to.
- Patients in oncology and endoscopy found medical and nursing staff caring in their approach clearly explaining ongoing plans. For example, following an endoscopy procedure a consultant visited the patient and provided feedback on findings and ongoing plan of care.
- Patients received appropriate information to support them in understanding how to manage their condition. For example, oncology patients were given a booklet, to help them recognise if they were developing side effects from treatment and how these should be managed.

Are medical care services responsive?

Good

We rated responsive as **good.**

- The hospital planned services in a way that met the needs of those people who chose to access services. These people were happy with access to services, and facilities provided.

- Care and treatment was co-ordinated with other providers.
- The needs of different people were considered when planning and delivering services. Staff took account of individual patients' needs when delivering care and treatment.
- Staff working in this service, listened to concerns, complaints and communicated lessons learnt.

Service delivery to meet the needs of local people

- The lead in oncology advised us the oncology service was awarded the Macmillan environment quality mark in 2017. This is a detailed quality framework, used for assessing whether cancer care environments meet the standards required for people living with cancer. Patients were happy with the environment for their care and treatment, and felt comfortable.
- Since our inspection in 2016 the endoscopy diagnostic unit had been relocated and upgraded, to support the achievement of Joint Advisory Group (JAG) in gastrointestinal endoscopy accreditation. The hospital was aiming to achieve JAG accreditation by January 2020. The new unit opened in January 2018.
- The hospital told us that approximately 30% of the endoscopy patients were NHS funded, others were on an insured (private) and self-pay basis. All the oncology patients treated at the hospital were insured (private).

Meeting people's individual needs

- The patients' ambulatory care generic endoscopy pathway included a pre-procedure assessment questionnaire, to support staff awareness of any individual needs patients' may have. This included a question about patients' mental health, with space to briefly comment on the impact of the issue for a patient. The pathways had been completed well and used properly.
- When we looked at the chemotherapy patient pathway, this included a prompt 'cognitive and perceptual abilities, are there any barriers to understanding treatment?' In the two sets of notes we looked at, this section had been completed.
- From April 2017 to March 2018 dementia training compliance across the whole hospital was 96%. In the Patient Led Assessments of the Care Environment (PLACE) in 2017 dementia scored 91%, in 2016 the score was 64%.
- The oncology unit had a variety of leaflets that patients could access. Leaflets included 'a guide for people with cancer and dementia' and 'Cancer and your sex life men/women'. The endoscopy service also had several information leaflets, to support patients' understanding of conditions that can affect the gastrointestinal system.
- 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 concerns.
- The endoscopy unit had a lift for people unable to use stairs, and there was a lift to the oncology beds on Enbourne ward, providing level access for patients' if required.
- Staff told us that a translation service was available at the hospital if needed.

Access and flow

- Consultants saw patients who were referred by their GP as an outpatient before an endoscopy procedure to check patients met the admission criteria, assess patients' and discuss a plan of treatment. This meant staff could plan for the flow of patients.
- Consultants undertook endoscopies according to a patient pathway, minimising the time patients waited for treatment and care. Patients in their feedback to the hospital commented about consultants seeing them promptly. The hospital told us from April 2017 to March 2018, there had been 3,068 endoscopy procedures. These were not all gastrointestinal procedures.
- NHS consultants referred oncology patients to the hospital following diagnosis at a NHS hospital. A patient could have chemotherapy treatment Tuesday to Thursday. The hospital told us from April 2017 to March 2018 there had been 412 oncology patients. An oncology member of staff said approximately three to

five patients were seen a day. The oncology nurse said that depending on the treatment needs of patients, treatments could take 15 minutes to several hours to complete.

Learning from complaints and concerns

- Patients were actively encouraged to leave comments and feedback via the BMI patient satisfaction survey, 'How well did we do?' The hospital made changes following feedback from patients'. The hospital ordered new signage in March 2018 for the hospital car park, to help patients with finding the new endoscopy unit.
- We saw written information was available in-patient treatment areas, guiding them on what to do if they had a complaint or a concern. Staff were aware of what to do if a patient had any concerns, or wanted to make a complaint. Staff told us they would listen to the patients' concerns to try and resolve the, and seek support from their line manager if needed.
- From March 2017 to March 2018 there were no complaints from oncology patients' accessing the oncology service. Two complaints were received about endoscopy care and treatment. One complaint was received from a patient's relatives regarding endoscopy records and a second from a patient's GP regarding a patient' care at the hospital. Both complaints were resolved informally.
- Complaints received were discussed at the monthly clinical governance meeting and heads of department meetings. The lead for oncology and theatre manager attended these meetings. This meant that any lessons learned could be shared with staff working in oncology and those working in endoscopy as needed.

Are medical care services well-led?

Requires improvement

We rated well-led as **requires improvement.**

- The risk register did not detail specific risks within the endoscopy department and the oncology service, to enable these risks to be effectively managed.
- There were no specific management or user groups running at the time of inspection which enabled discussion of operational and strategic issues by staff working in these services.
- There was currently no BMI Cancer lead in post to drive improvement in the oncology service.

However;

- Staff spoke passionately about the service they provided, the care they offered to patients and had a vision for their services. Staff achievement was recognised through staff awards.
- Patients were given opportunities to feedback about their experiences.

Leadership and culture of service

- The senior management team at hospital included the executive director and director of clinical services who were responsible for the day to day management and development of the hospital.
- The endoscopy lead nurse reported to the theatre manager. The endoscopy lead and staff working in endoscopy told us they felt well supported.
- The oncology lead was also the manager of all the inpatient wards, and highly regarded by patients' and staff.
- Staff we spoke with felt valued, and told us about the opportunities they had to develop their knowledge and skills.
- Staff described the atmosphere as 'happy, friendly and open'. Staff felt able to raise concerns, and that senior staff were approachable and visible. They described the executive director as having an 'open door' policy.

Vision and strategy

- The vision for the healthcare team at the Hampshire Clinic was through innovation and daily improvement to provide a patient experience that was a national model for exceptional outcomes, high consumer values and caring service, supported by progressive teaching and evidence based clinical practice. This was underpinned by the strategy to deliver first class care, through safe systems and facilities focused on delivering a good patient experience.

- Both the oncology and endoscopy service reflected this vision and strategy, and talked about plan for developments in both oncology and endoscopy. Staff spoke passionately about the service they provided and the care they offered to patients.
- Key areas for action in the oncology service included ensuring better treatment, living beyond cancer and building for the future.
- The endoscopy service had a two-year plan to achieve joint advisory group (JAG) in gastrointestinal accreditation. The relocation and upgrade of the endoscopy unit, was a large step in the journey for the service.

Governance

- The service governance processes are the same throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.
- The oncology lead completed a BMI corporate cancer integrated audit for 2017 management plan for the hospital. One of the audit standards was 'there is evidence of regular cancer management meetings with formal minutes'. The oncology lead described the aim of the meetings to discuss both strategic and operational issues. An initial meeting held in July 2017 with the director of clinical services as chair, with a plan to hold bi-monthly. At the time of our inspection in April 2018 no further meetings had been held. However, any incidents relating to oncology were discussed at the monthly clinical governance meetings. This included a discussion around IT when the electronic prescribing of chemotherapy initially introduced at the hospital.
- There was no endoscopy specific user group at the hospital, and the hospital did not participate in the BMI endoscopy network group. The theatre manager was responsible for ensuring issues relating to governance in endoscopy were raised at the heads of department meeting and clinical governance committee.
- The endoscopy service from April 2017 had been represented at the quarterly MAC meetings. The MAC minutes from April 2017 do not list an oncology consultant as a member. On April 2018 MAC agenda, a consultant from oncology listed as a member, but gave apologies for that meeting.Post inspection we received information that oncology representation had been put in place in January 2018, with an oncology consultant at the MAC meeting held in January 2018.

Managing risks, issues and performance

- There was a hospital wide risk register with 20 open risks identified. Low risks were reviewed annually, medium risks six monthly and red risks three monthly. There were no red risks. The risks were overarching and not specific to endoscopy or oncology.
- A risk described as medium was 'failure of infection prevention and control processes'. For endoscopy, the risk description contained a statement 'endoscopy unit now commissioned so risk reduced'. The risk of clean linen being contaminated as stored in the same room as the cleaner's bucket, large sink and chemicals was not detailed. The risk was next due for review in October 2018. The detail about the storage place for clean linen within the endoscopy unit not being on the risk register, meant there was a failure to specify what action was being taken to ensure the identified risk was reduced or removed. Also action within a timescale that reflected the level of risk and impact on people using the service.
- A further risk was described as 'failure to effectively monitor compliance with national policy'. This risk was rated as low, and due for review in April 2019. The risk description did not mention endoscopy or oncology. For oncology this was concerning, as there was currently no BMI lead for cancer services and of the oncology policies that we reviewed, five were overdue for review. This meant the provider was not assessing all risks of the service complying with national policies .
- The BMI group produced a monthly clinical governance and quality and risk bulletin, including lessons learned, to enable shared learning from events across BMI Healthcare and topic specific learning. The bulletin included safety alerts in relation to medical devices, drug alerts and learning from root cause analysis (RCA) investigations following incidents. The October 2017 bulletin talked about a few themes that had emerged following RCA. A theme mentioned was failure to calculate patients national early warning score (NEWS) score correctly, and escalate a deteriorating patient to a consultant. In endoscopy the scores that were not being calculated in full were the post anaesthetic recovery and

discharge scores which are a patient safety score, which is used to determine the degree of recovery of patient from sedation. This meant signs of patient deterioration may not be identified promptly, and the patients' records did not have complete documented assurance of patients' recovery from sedation

Managing information

- Clinical staff could access information using a computer with individual log in details and passwords about patients, for example, referral letters, blood test results, x rays and other investigation results.
- Staff sent discharge letters to GPs, that included the reason for endoscopy procedures, findings, prescribed medication, any medication changes and details of follow up. They also placed a copy of the letter in patients' medical records at the hospital.
- Staff in oncology sent a letter to the patient's GP detailing chemotherapy treatment.
- Staff could access information on the hospital intranet, which included clinical policies and standard operating procedures. However, not all information current as policies and procedures had not been updated.

Engagement

- Patients were encouraged to leave feedback using a patient's satisfaction questionnaire and for NHS patients by the friends and family tests. Patient feedback forms were available in the patients' bedrooms where oncology patients were treated and in the new endoscopy unit. We saw results of the survey displayed where oncology patients treated, but not within the new endoscopy unit.
- Results of the monthly surveys from March 2017 to March 2018 showed 99% would recommend the service, although response rates were relatively low at 34%. Patients' comments about the endoscopy service were very positive about the facilities in the new unit, and quality of care given by staff.
- We did not see any specific survey results completed by oncology patients. The thank you cards we read were positive about the care delivered by the staff working in oncology.
- The hospital participated in various charitable events which staff were invited to contribute to, and this included the annual Macmillan coffee morning. BMI group carried out an annual staff survey. The last survey had been carried out in June 2017. The hospital was in in the top 20 percent of the BMI Hospitals group with some questions in the survey. These included questions 'I am committed to doing my very best for BMI Healthcare' and 'I am fully trusted to do my job'. The hospital is ranked in the top 10 of all BMI hospitals for staff engagement. The ten least positive results included 'I am paid fairly for the job I do (compared with the amount I could earn elsewhere for a similar job)' and 'communication is good between departments outside of my hospital or corporate site'. The hospital developed an action plan following the staff survey results.
- The hospital had a recognition system for staff called 'Above and Beyond' awards. The hospital had recognised the oncology lead with a long service award in 2017.

Learning, continuous improvement and innovation

- The endoscopy lead was working through an endoscopy action plan towards the achievement of JAG accreditation. The hospital had set a target date of January 2020.
- The oncology lead had escalated their concerns with no BMI cancer lead in place to the BMI corporate team, to drive innovation, improvement sustainability for the service.

Requires improvement

Surgery

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

Information about the service

Surgery was the main service provided at this hospital. The hospital has 62 registered beds. Facilities for surgery include four operating theatres and an intensive care unit. In the reporting period April 2017 to March 2018, there were 1,800 inpatient and 7,547 day case episodes of care recorded at the hospital.

Are surgery services safe?

Requires improvement

We rated safe as **requires improvement.** This was because:

- The process for investigating clinical incidents, including root cause analysis (RCA), was not effective and included long delays in investigations. The delays in root cause analysis could impact negatively on patients as lessons may not be learnt and similar incidents may re-occur.
- Medicines, including controlled drugs, were not consistently managed safely.
- Nursing staff we spoke with did not raise any concerns and were not aware that the current arrangements for storage of medicines was not in line with national guidance.

However:

- There were twice yearly meetings where mortality and morbidity was discussed and the outcomes of these discussions shared with staff.
- There was a process for safeguarding children and adults which staff were confident in using.
- The surgical paediatric pathway was detailed and these were fully completed.
- We observed staff followed hand washing procedures in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'.

Mandatory training

- The hospital had a mandatory training policy and all newly appointed staff completed specific training when they joined the service. Mandatory training included infection control, fire safety, safeguarding, Intermediate life support and health and safety.
- The mandatory training included e- learning and some face to face training. Staff told us it was at times difficult to complete the e- learning modules in work time. The senior nurse monitored compliance and staff were sent reminders when mandatory training updates were due.
- All non-clinical staff completed basic life support training. The paediatric nurses, staff working in recovery and the resident medical officer (RMO) had also completed the emergency advanced paediatric life support (EPAL) training. Clinical staff and allied health care professionals had completed both paediatric and adult immediate life support training.
- The mandatory training rate for theatre staff was below 90% according to the latest report in May 2018, an action plan was put in place to achieve compliance. Staff told us that high workload and staffing were the two main barriers in achieving mandatory training including e- learning.

Requires improvement

Surgery

Safeguarding

- Staff had completed training in adult safeguarding as part of the service's mandatory training programme. Staff we spoke with could tell us the actions they would take to protect patients from abuse.
- Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Most staff had completed training on how to recognise and report abuse and they knew how to apply it.
- The hospital had an identified adult safeguarding lead, this was the Director of clinical services. The lead nurse for adult and young people also provided support to them in this role. There were clear processes which staff followed to report actual or suspected abuse to responsible bodies.
- All staff involved in the care of patients had enhanced disclosure and barring service (DBS) checks and we saw a record that these checks had been completed and were up to date in the staff records we reviewed.
- The service had in early 2018 introduced training for staff to raise awareness and enhance their skills in the recognition of female genital mutilation (FGM). However, staff were not aware of the policy for FGM and training compliance rate was 39% .
- Staff we spoke with were not aware of the organisation and other policies and procedures relating to PREVENT directive. From April 2017 to March 2018, staff compliance with PREVENT duty training across the whole hospital was 97%.
- The PREVENT training raises awareness to stop individuals from getting involved or supporting terrorism or extremist activity.

Cleanliness, infection control and hygiene

- The wards, theatres rooms, reception and other areas we inspected were visibly clean and well maintained.
- There was a cleaning schedule in theatre which was complete and up to date. The theatre manager confirmed that they followed a six-monthly deep cleaning programme for the operating theatres.
- Staff followed best practice during surgery which included drapes around the surgical site and the use of sterile gowns and gloves. These were discarded in line with their internal infection control process to minimise the risk of cross contamination.
- We observed staff followed hand-washing procedures in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'. Antibacterial hand gel dispensers were available at the entrance to the wards and in the main reception area and in other clinical areas. We observed hand gels were used in between patients to reduce the spread of infection or cross contamination
- We saw evidence that those patients admitted for elective surgery were screened for Methicillin-resistant Staphylococcus aureus(MRSA).
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff followed guidance on sharps management which included no re-sheathing of needles. The sharp bins were clearly labelled and tagged to ensure appropriate disposal and to prevent risk of cross infection.
- There was adequate supply of personal protective equipment (PPE) such as gloves and aprons. We observed staff adhered to 'bare below the elbow' policy in clinical areas and used PPE as appropriate.
- In the operating theatre, there were clear procedures for the decontamination of reusable medical devices in line with national guidance which the staff followed.
- Access to the operating theatre was restricted to avoid unauthorised people entering the area. There was a clean and dirty utility area to ensure that the risk of infection transmission was minimised.
- The sluices on the wards were clean and well-maintained. Staff ensured that soiled and infected linen were placed in colour coded bags and disposed of appropriately.
- All the rooms were single occupancy with en-suite facilities which staff said was effective and supported them when isolating patients suspected of infection until any tests results were received.

- The service had an annual legionnaire testing programme and we saw that they were compliant with this programme. Legionella is water borne bacteria that can be harmful to people's health.

Environment and equipment

- The environment was well maintained and there was adequate seating in the reception area. There were consulting rooms on the ground floor which were in good decorative condition.
- Patients on the wards were accommodated in single rooms which had en-suite facilities. The rooms were comfortably furnished which patients said met their needs and included a bedside nurse call bell system. The emergency and resuscitation trolleys we reviewed on the ward and in the operating theatres had been checked regularly.These included appropriate resuscitation equipment for paediatric patients. We saw the equipment lists and daily check lists had been signed according to the hospital resuscitation policy and was in line with the Resuscitation Council guidelines.
- We saw that theatres had difficult intubation trolleys for adults and children that were compliant with the Association of Anaesthetist of Great Britain and Ireland (AAGBI) Society guidance.
- In the operating theatres, we saw the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic related equipment' (2009) was being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate logbooks being kept and we saw these were completed.
- The theatres and anaesthetic rooms were clean and well maintained and single use equipment was available and disposed of safely.
- The operating theatres were on the first floor which was easily accessible from the ICU and the wards ensuring patients were not transferred significant distances to and from theatre and could be returned swiftly if their condition deteriorated.
- There was a process for the recording of implants and single use instrument kits unique identifying labels were attached to the patients' records for audits purposes and enabled staff to trace these if required
- The service did not have access to an echocardiograph machine and therefore transferred patients to the local trust for this investigation. This meant that there may be a delay in diagnosing or treating some patients. We were told this cost of the machine had been agreed but it was unclear if or when this would be purchased.

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

- There was a National Early Warning System (NEWS) in place. The NEWS scoring tool is a recognised tool used as a guide which looks at a patient's vital signs such as respiration rate, blood pressure, oxygen saturation level, pulse. Any changes in these parameters could indicate deterioration in a patient's health and requiring prompt actions.
- The nursing staff on the ward told us that a sepsis policy was being developed and training would follow. However, we saw no evidence of plans to develop this policy or training. We saw a sepsis flow chart in one patient's records which was out of date and did not reflect the latest NICE 2017 and NHS England guidance. This may put people at risk of receiving care which may be outdated.
- The NEWS charts on the wards were complete which were included in the recovery and discharge checklists. There was a clear process which the staff followed for deteriorating patients on the ward. Staff told us they would contact the resident medical officer (RMO) for advice and support. The RMO would then escalate to the consultant for further advice and treatment as needed.
- Staff used the national early warning system (NEWS) for patient who were fit for discharge from ITU and continued to use this on the wards. We noted that when a patient's trigger showed a NEWS of five and above, there was no evidence the escalation process had been followed.
- Admissions to the hospital were planned and staff used their elective surgical procedures care pathways. All patients had a pre-admission assessment completed which was sometimes by telephone for some day care patients.
- The surgical pathways had clear pre-assessment processes. We reviewed the care pathways for paediatric

and adult assessments. Clinical risk assessments included the American Society of Anaesthesiologist (ASA) score.This is a system used to assess patients' fitness for surgery such as healthy patients and those with mild systemic deficiency at the pre- operative stage. Patients with severe health concerns would be excluded following discussions with the surgeon and anaesthetists.

- Other assessments included vital signs, urinalysis, risk of pressure damage using a nationally recognised tool, thrombosis risk assessment, bleeding risk assessment and falls risk assessment.
- The venous thromboembolism (VTE) risk assessments were completed by the nursing staff. However, where patients had been assessed as high risks such as familial history, high BMI and known bleeding risks.
- The assessments were not reviewed in line with the hospital's procedures to confirm that the risks had been considered by consultants as part of patients' treatment plans. This could impact on patients as these assessed as high risks may not receive the appropriate treatment.
- The service had undertaken an audit of VTE risk assessment in January 2018 which highlighted that they had poor response from consultants signing to say that they had seen the risk assessments. There was no action plan and monitoring process in place to address this. A senior staff said that they continued to remind the consultants to complete this.
- The service used the World Health Organisation (WHO) guidelines (5 steps to safer surgery) checklist. The surgical safety checklist is guidance to promote safety of patients undergoing surgery. This sets out what should be done during every surgical procedure to reduce the risk of errors. The checklist must be read out loud, and must include all sections of the checklist including the 'sign in' before anaesthesia is commenced, the 'time out' before starting surgery, and the 'sign out' before any member of the team leave the operating theatre.
- We observed the use of the WHO checklist in theatre as part of observations of patients' care. We found there were inconsistencies in the application of the WHO checklist which included a lack of engagement from the team. We observed one instance where the anaesthetist was not present during the WHO checklist process which meant the whole team was not engaged in the process.
- Staff told us consultants did not all follow the same process for the WHO checklist. For example, one consultant undertook the checklist after the patient had been prepared for surgery and theatre drapes were already in situ. Other consultants in line with best practice followed the WHO checklist prior to preparing the patient. A senior manager told us this caused confusion for the staff at times due to the inconsistent approach of using the checklist.We raised this with the registered person during our feedback following the inspection.
- In theatre we observed visual and verbal count of swabs and instrument checks were completed which was in line with Association for Perioperative Practice (AFFP) guidelines.
- There were clear processes with which staff were familiar for the identification and escalation of the deteriorating adults and paediatric patients on the wards. Staff told us they would escalate to the resident medical officer (RMO) in the first instance. Advice and support was available from the admitting consultants who could attend the service within 30 minutes.
- The hospital had a service level agreement (SLA) with the local NHS trust for the emergency transfer of patients. Staff felt confident with this process as the consultants also worked at the local NHS trust. However, we were not provided with this SLA or evidence of the frequency of its use as requested. At the factual accuracy stage, we received a copy of the SLA which gave details of the contract period as twelve months. The document did not have the commencement of the contract. Staff confirmed that arrangements for the urgent provision of blood in cases of life threatening haemorrhage were in place.
- We were told that microbiologist advice was available 24 hours a day, seven days a week. This was provided by the local NHS trust under a service level agreement and the medical staff would call the microbiologist for advice.

- There was an escalation process that staff followed such as contacting the RMO for initial assessment following any changes in a patient's condition to requesting that the consultant attend the hospital to review a patient.
- Following the unexpected death of a patient, the service had identified that intentional rounding (a process of checking on patients on a regular basis) had not been completed. There were no intentional rounding audits to demonstrate compliance and the impact it was having on the safety of patients.
- Managers told us the intentional rounding process had been re -affirmed and all inpatients must be checked on a two- hourly basis. Records seen showed this was not fully embedded in the current practice and compliance was not being monitored. The provider told us this was due to the early stage of implementation of this process.

Nursing and support staffing

- The service used a ward labour tool for acuity of inpatients and a staffing tool for day care patients. Their criteria included a senior staff member per shift to offer advice and support. However, this did not include night duty. The provider told us at the factual accuracy stage that there was a designated nurse in charge at night.
- Staff told us they usually had adequate staff to meet the patients' needs. Staff from the ICU also worked on the wards if there were no patients in the ICU and provided 1:1 support to patients as needed.
- The service used their own bank staff to cover any shortfalls in staffing and tried to use regular agency staff for continuity although staff said this was not always possible. A copy of the last month duty roster seen indicated that there were adequate staff including registered nurses to provide care and support to patients.

Medical staffing

- All medical staff worked under practicing privileges arrangements. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. These were granted following an application process which included checks such as two references and a DBS check. The granting of practicing privileges was monitored by the MAC and consultants would only carry our surgical procedures which they undertook in the NHS.
- All patients were admitted under a named consultant and they remained under their care for the duration of their care and treatment as inpatients.
- There were appropriate arrangements for out of hours cover. The resident medical officer provided 24- hour, seven days a week cover and they were the initial point of contact in an emergency and they lived on site. The RMOs worked 12 -hour shifts and therefore there was always one RMO in the hospital.
- Anaesthetists were available to deal with any emergencies in the immediate post-operative period until the patients were ready to go back to the ward.
- Patients received 24-hour consultant led care and in cases of emergency a senior staff confirmed that the consultants and anaesthetists would be in attendance within 30 minutes. The registered manager discussed that one of the criteria for accepting new consultants was that they should be working locally and able to attend the service in an emergency within approximately 30 minutes.
- During a Medical Advisory Committee (MAC) meeting which we attended, the team considered the distance that consultants lived and worked as part of the agreement to join the service under practicing privileges.
- There were twice daily ward rounds on the wards undertaken by the RMOs.
- We carried out a review of 16 medical staff files which were detailed and contained the necessary checks such as disclosure and barring service (DBS). Other documents included the scope of practice, CVs, training records and appraisals. We found these were all current and administration staff followed their internal processes ensuring the consultants submitted their evidence of updates and training as needed.

Records

- The compliance rate for record keeping audits varied between 93 to 97%. The results of the audit highlighted some inconsistencies in the completion of records.

There was low compliance in some areas such as the WHO checklist (80%). The evidence of discharge checklist being completed (80% for two consecutive months). Risk assessments for infection control completed on admission varied between 60-90%. Nutritional risk assessments were on average 90% and completion of operation note/report and Venous thromboembolism (VTE) assessment were not compliant with the provider's target of 100%. The re-audit showed that there was some improvement in some areas.

- Patients' care records were stored safely and securely which prevented unauthorised access to their records. The computers were password protected and we observed that these were locked when not in use. This was in line with the Data Protection Act 1998.
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre- and post -operative records.
- We reviewed 10 sets of medical and nursing paper records and saw these were fully completed including preoperative assessments providing details of the patient's treatment plan and a summary of their progress and any specific issues.
- There were two processes for discharge summary letters in use; private patients received a copy of their discharge summary and a copy was also sent to their GPs. NHS patients did not receive a copy of their discharge summary as this went to the NHS office based at the service and then sent to the patients and their GP. Patients discharge summary would not be available if needed in an emergency post discharge and may cause delays in their care.
- Integration of medical notes were followed by consultants working under practising privileges and these notes were retained by the hospital. This ensured that the staff had the necessary information to provide care and support to patients.

Medicines

- The service had an in-house pharmacy and this was staffed Monday to Friday. A pharmacist was available to offer advice and support to the staff. The Resident Medical Officer (RMO) had access to the pharmacy out of hours and at weekends and the pharmacist was available on call as needed.
- The pharmacy team undertook daily visits to the ward and carried out medicines reconciliation for inpatients. This ensured that patients medicines were reviewed on admission and they continue to receive their medicines appropriately.
- The Controlled Drugs, Safe Management of Medicines and Epidural policies were out -of- date and therefore there was a risk that they do reflect the latest and up- to -date national guidance.
- Nursing staff we spoke with did not raise any concerns and were not aware that the current arrangements for storage of medicines were not line with national guidance. We were told the service's pharmacist had audited the controlled drugs and had not raised concerns about their storage.
- In the wards medicines were stored securely and this included in medicines trolleys which were secured to the wall. However, the room temperature where medicines were stored were excessively hot and above the recommended temperatures. This could affect the efficacy of medicines. Staff confirmed that they did monitor the room temperatures daily but did not understand the impact of these excessive temperature on the effectiveness of medicines.They did state this issue had been raised with managers but to date no actions had been taken to ensure the medicines were stored at the correct temperatures.
- Emergency medicines were available on the resuscitation trolleys including those for the treatment of anaphylactic shock. Anaphylaxis is an adverse allergic reaction which can be life threatening and requires immediate treatment.
- There was piped oxygen in patient rooms and these were set up ready for post-operative patients. Staff confirmed that oxygen therapy was prescribed as needed.
- Medical gases were stored safely and in an upright position in line with best practice.

- We reviewed 11 treatment charts and noted that patients' allergy status was recorded to ensure the safety of patients.
- Staff told us and we observed that the Resident Medical Officer (RMO) would refer to antibiotics' prescribing protocols and consultation with the surgeons prior to prescribing antibiotics. We were told that advice could be sought from the microbiologist at the local trust. Staff were unable to tell us if this was part of a service level agreement with the local trust.

Incidents

- The service had declared that they had no 'Never events' in the reporting period of March 2017 to April 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- During March 2018 there were three unexpected deaths, 18 incidents of no harm, and four low harm.
- Following a recent rise in patients' incidents, which we were told were being investigated by a member of staff from one of the provider's other hospitals, senior managements told us they were waiting for the outcomes of investigations before developing an action plan. The number and rise of incidents did not demonstrate that sufficient organisational learning had taken place.
- The service was not meeting their targets of 60 days for completion of root cause analysis (RCA) following incidents of harm. The director of clinical services told us that RCA training was available, although they had not completed the practical part of this training.
- We requested the outcomes for some of the incidents. We were told that these were not available as the internal process of investigations took a long time. This delay could impact negatively on patients as similar incidents could reoccur due to a failure to learn from incidents in a timely manner.
- The service had a system for recording and reporting incidents. All nursing staff were aware of the internal process for reporting incidents. They gave an example of using the process, this related to medicines prescribing and management where wrong dosages were identified and appropriate actions were taken. The anaesthetist was informed of the error and this was rectified.
- Another instance occurred when the RMO and staff did not check the operation records. In both instances these were discussed at clinical governance committee meetings and ward meetings and action plans developed to mitigate these risks. The provider stated that as part of learning from incidents staff were responsible for reading and signing to confirm they had read the minutes of meetings which included learning points.
- There were mortality and morbidity meetings at which cases were reviewed and the findings of these reviews shared with staff to facilitate learning.
- Staff understood duty of candour (DoC) 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 were aware of their responsibility to inform patients when anything went wrong. They said that the consultants would initiate this and the clinical lead for the service would be part of the investigations.
- Staff were not aware of training in the duty of candour (DoC) but said it was about being honest with the patients when 'things don't go to plan'. We were not provided with any DOC records as requested despite there being incidents that would have required this duty to be undertaken. We were not therefore assured that processes were followed to safeguard people.
- Following the inspection and at the factual accuracy stage the provider confirmed that staff training in duty of candour was available.

Safety Thermometer

- Falls, infection rates and thromboembolism were monitored for inpatient areas, this monitoring showed that action plans were developed to address shortfalls identified. The service did not display safety information on the wards for patients and visitors to view.

Requires improvement

Surgery

Are surgery services effective?

Good

We rated effective as **good.** This was because:

- Patients told us that they had adequate information about pain relief and that their pain was appropriately managed. Pain control was discussed at pre-operative assessment and choice of pain control was available.
- Patients had investigations and blood tests as part of their pre- operative assessment based on NICE guidelines to ensure they were fit for surgery.
- The patients' records we reviewed contained a nutritional assessment using a nationally recognised tool.
- The granting of practicing privileges was monitored by the MAC and consultants would only carry our surgical procedures which they undertook in the NHS.
- There was a process which staff followed for investigating complaints and concerns.

However:

- Policies and procedures were not regularly reviewed and updated to ensure these were in line with current best practice and guidelines to support staff practice
- There was no psychological support available to patients undergoing complex surgical procedures or those receiving care and treatment in the critical care unit.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance such as the Royal College of Surgeon and National Institute for Health and Clinical Excellence (NICE).
- Surgery was carried out in line with evidence based care and professional guidance. The service followed The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).
- Patients had investigations and blood tests as part of their pre- operatively assessment based on NICE guidelines to ensure they were fit for surgery.
- The service measured clinical indicators such as venous thromboembolism assessment compliance, national early warning score documentation, infection control, consents and adherence to the WHO checklist. These were discussed at their Clinical Governance Committee and governance meetings.
- Clinical guidelines were developed and reviewed in line with the Royal College and the Intensive Care Society.

Nutrition and hydration

- Patients for surgery were given fasting information in accordance to the Royal College of Anaesthesia guidelines. This meant they did not fast for extensive periods of time. Patients told us that they received some information during the pre- admission assessment stage and again prior to admission for their elective surgery.
- The patients' records we reviewed contained nutritional assessment using a nationally recognised tool. The service used the malnutrition universal screening (MUST) tool. MUST is a screening tool to identify adults who may be at risk of malnutrition, under nourished or obese.
- Staff told us that patients would be referred to their GPs if needed. At the factual accuracy stage the provider told us that they had access to dietician as part of their service level agreement.
- Patients were prescribed anti-emetic medicines (medicines to prevent/ relieve sickness) for patients' post- surgery. This was followed by a gradual re-introduction of food and fluids.

Pain relief

- Patients told us that they had adequate information about pain relief and that their pain was appropriately managed. Pain control was discussed at pre-operative assessment and a choice of pain control methods was available.
- Patients' records showed that anticipatory pain relief was prescribed and pain was assessed in recovery and on the wards.

- Patient controlled analgesia (PCA) was available for patients. Epidural pain relief (via the spine) and nerve route 'blocks' for specific surgical cases were also available.
- Pain assessment was part of the NEWS score cards. We saw that appropriate pain score was also used to assess patients' pain. This ensured that pain management was monitored and patients received pain control medicines in a timely way.

Patient outcomes

- Patients undergoing hip replacements, knee replacements and cataract extractions were sent information about the patients' reported outcome measures (PROMs) survey. Patients who elected to take part completed a paper version of the survey.
- The latest PROM report indicated that the service was not an outlier for hernias and hips and there was a positive adjusted health gain for patients following hip replacements and hernia.
- Readmission rates for this core service was low compared with other services within the group. Patients did not always return to the service as they were admitted to the local NHS trust.A senior manager told us that they were informed by the surgeons if patients were admitted at the local NHS trust. However, there was no data about this at the service, as the service did not record these admissions.
- The service contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition Markets Authority (CMA).

Competent staff

- As part of the inspection we reviewed 11 consultant surgeons and anaesthetists' files which were detailed with the individual's scope of practice, CVs, training records and appraisals. These were up to date. There was a process for checks to be undertaken which showed the renewal due date for indemnity cover, General Medical Council (GMC) registration and appraisals 'information. A senior staff member told us that consultants would be alerted if anything was out of date and we saw letters had been sent out to remind staff of this. Consultants practising privileges would be suspended until this was acted upon and the chair of the MAC would also be informed.
- The granting of practicing privileges was monitored by the MAC and consultants would only carry our surgical procedures which they undertook in the NHS. As all the consultants held NHS contracts they maintained their skills by working in the busy NHS trust and had their appraisals completed by their NHS Medical Director.
- During the inspection, we reviewed staff training records and found these were not always maintained appropriately; as these were disorganised and we found certificates for training in the incorrect staff files and loose which meant that management of personal data was not always carried out safely and in line with data protection. It was not possible to confirm staff had completed the necessary training which may impact on patients' care.
- Nursing staff registrations were checked against the Nursing and Midwifery Council (NMC) registers, nurses would not be allowed to practice until they could provide up to date registration evidence.
- There was a training programme which offered staff a variety of training courses to maintain their skills such as customer care, pain management, safeguarding children.
- There was an appraisal system in place and this was monitored. The theatre staff had not all completed their appraisals and we were told this was due to work pressures and the appraisal system was not easy to use.We were told that there was no plan to review this.

Multidisciplinary working

- We observed effective multi-disciplinary working to support the patients. Staff told us they worked well as a team. This was evident on the wards and in the operating theatres.
- Patients benefited from the care and expertise of the multi- disciplinary teams including physiotherapists and paediatric nurses.

- There was an identified physiotherapist who provided care to patients and the records we reviewed demonstrated that this included respiratory management and rehabilitation components of individual's care.
- There was no speak and language therapist (SALT) or psychological support available to patients. The nursing staff were trained or competent to undertake basic SALT screening to identify those patients who would benefit from SALT input into their care. They would also be referred to the community SALT team via their GPs.

Seven-day services

- The service did not provide intervention cardiology and these patients were also transferred to the local NHS trust. However, a senior manager confirmed that there was no formal agreement for these transfers. Managers had no awareness that if the trust was under excessive pressure there may be delays which could impact on the patients receiving care and treatment in a timely way.
- The service did not have access to CT scanning 24 hours a day, seven days a week. Patients were transferred to the local NHS for CT scans out of hours and at the weekends. This may result in a delay in diagnosis or commencing treatment. At the factual accuracy stage the provider told provider has told us that they had an SLA with the local Trust.
- Consultants were available out of hours seven days a week to support clinical decision making and there was always an RMO on site.
- Theatre staff and pharmacy staff were on call during the out of hours and weekends and were available if needed.
- The in-house physiotherapy team provided care and support at the weekend if needed, as they were on call.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service's consent audit found that information provided to the patients was recorded in 40% of cases. The name of the professional performing the procedure was recorded in 80% in the 'statement of patient section'. Also, evidence that both the consultant and the patients' signature was written in block capitals achieved 80%. An action plan was developed and result shared with staff to achieve compliance.
- The service had policy and procedures for consents which were aligned to Mental Capacity Act 2005 (MCA) which the staff had access to.
- Staff understood the consent to care and best interest process. They told us of action they would take if someone lacked capacity. The capacity to consent was assessed as part of their pre-operative assessment process.

Are surgery services caring?

Good

We rated caring as **good.** This was because:

- Staff interacted well and treated patients, children and their parents with care. Patients were complimentary about the staff and the care they received.
- Patients' privacy and dignity were maintained always when receiving care. Patients were treated with care and respect always.
- The result of patients' survey was positive and patients were satisfied with the care they were receiving
- Patients were involved in their care and information was available in child friendly language such as pictorial as appropriate.

Compassionate care

- The patients we spoke with were positive about the care and treatment they were receiving at the service.
- We observed staff treating patients with compassion, kindness and respect. Staff introduced themselves to the patients before starting any care interventions and sought their consents.
- Patients told us they were treated with care and respect. They told us the staff were 'very caring and kind' and they received care and support that met their needs.

- Staff ensured patients' privacy and dignity was maintained. We observed patients being transferred from the trolley to the operating table and saw this was the case.
- The service took part in the friends and family test (FFT) survey. The result of 2017 survey showed 99% of patients were "Extremely likely" or "Likely" to recommend this hospital.

Emotional support

- Patients for elective surgery were supported and given information to ensure they had the information they needed regarding their care.
- Patients we spoke with told us they felt well prepared as they had received support from staff at their pre-admission assessments and on admission. A patient told us that they were anxious and received continuous reassurance from the staff and this 'made a big difference'.
- Staff told us that relatives were supported to remain with patients with dementia to provide a friendly face and reassurance. However, they treated very few people who were living with dementia.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them as appropriate in the decisions about their care and treatment. Patients we spoke with all confirmed that their treatment had been discussed with them and they felt able to make informed decisions about their care.
- There was discharge planning information available to patients, and staff were available to offer support and information post -operatively.

Are surgery services responsive?

Good

We rated responsive as **good.** This was because:

- There were effective admission processes including exclusion and inclusion criteria which staff adhered to.
- Arrangements were in place as consultants and theatre staff were on call and would attend for any emergency surgery on inpatients.
- Patients for elective surgery were offered a one stop preoperative assessment to ensure they were fit for the planned procedure.

However;

- The service treated people whose first language was not English, there were no information leaflets available in other languages.

Service delivery to meet the needs of local people

- The hospital worked with local commissioning groups to support a specific group of NHS patients and treated patients with advanced bowel cancer. This meant that if the local Trust who undertook most of this work did not have the capacity the patients' treatment was not delayed as it was provided at the hospital.
- As an independent hospital, most of the patients using the service were insured, self-funded and self-referred patients. Therefore, service development was informed by which services these patients used.

Meeting people's individual needs

- The premises were well maintained and there was level access for people with limited mobility and wheelchair users. A passenger lift was available for access to above ground floor levels.
- There was a variety of hoists and pressure relieving equipment for the safe management of patients. There was no bariatric equipment as staff told us these patients would not be accommodated for care and treatment at this hospital. However, at the factual accuracy stage the provider confirmed that this type of equipment was available at the service.
- There were some arrangements for dealing with patients with complex needs such as dementia, and a learning disability. Additional needs were identified at their pre -admission assessment. There was no flagging system at the service for identifying patients who were especially vulnerable. There was no dementia pathway, patients over 75 years of age were not screened for dementia which meant these patients would be missed.

Requires improvement

Surgery

- There was a variety of meals provided for patients which they said met their needs. Facilities were available for special diets including cultural dietary needs as required. The chef saw the patients on admission and menu plans could be devised.
- Patients expressed a high degree of satisfaction with the food and fluids and said they were offered choices. Comments included 'the food is very good'. The staff provided support with meals as needed and hot and cold drinks and snacks were available always.
- Arrangements were in place for people with limited mobility and wheelchair users, hearing loops were available for people with hearing difficulty.
- The service also treated a number of people from overseas and staff said some of them had complex needs and spoke very little English. They used an online translation service for some part of the time and relied on their family for support.There were no leaflets in other languages. At the factual accuracy stage the provider said they had also recently introduced a local Arabic translator.

Access and flow

- There were effective admission processes including exclusion and inclusion criteria. Patients' suitability for surgery and any concerns from the pre-assessment was discussed with the anaesthetist. This ensured that patients met their criteria for surgery.
- Patients' discharge planning began at the pre-admission assessment process with involvement of allied health professionals as needed. Patients progress was discussed with the multi- disciplinary team which included physiotherapy and follow up appointments.
- The waiting times from referral to treatment was on average two weeks and considered patients' choices and availability.
- Staff followed their discharge pathway, a summary of the treatment or procedure was included in the discharge letter to their GPs.
- Patients for elective surgery were offered a one stop pre-operative assessment and the average waiting time we were told was two weeks.

Learning from complaints and concerns

- Between March 2017 to March 2018, the service had received 62 concerns or complaints. Staff we spoke with were confident in using their internal policy and procedures to record and escalate any concerns or complaints. The clinical lead was responsible to review all concerns locally and escalated to the head office as appropriate. Records showed that patients received timely responses including the opportunity of meeting was offered.
- An action plan was developed from the surveys to improve the service and learning was shared. Some of the actions included improving signage to the newly refurbished endoscopy suite, replacing broken toilet and retuning of televisions.
- The hospital was also focusing on the bottom five deteriorated scores for complaints and concerns such as pain assessment or management, explanation of call bell systems to improve the outcomes for people using the service.
- Information was available to patients on how to raise a concern or complaint. This included details on how to escalate to external bodies such as Independent Health Sector Complaints Adjudication Service (ISCAS).
- Information received from the service showed that one complaint was referred to ISCAS and the outcome of the investigation was dated April 2018. This raised some issues relating to the management of the complaint including timeliness of response, addressee and lack of payment details. An action plan was developed.

Are surgery services well-led?

Requires improvement

We rated well-led as **requires improvement.** This was because:

- Evidence of learning from incidents was not effective as this was compromised by delays in investigations and outcomes being shared.
- Patients' risks were assessed however action plans were not developed and compliance was not managed.

- There were no specific management or user groups running at the time of inspection which enabled discussion of operational and strategic issues by staff working in these services.
- There was a lack of assurance and sufficient organisational learning, actions had not been developed while waiting for outcome of investigations.

However:

- The consultants also worked at a local NHS trust and attended meetings at the trust where cases were discussed, some of these were patients treated at the service as part of a NHS contracts.
- The nursing leadership was visible and involved in the day to day management of the service.
- There was a governance framework with Clinical Governance Committee and risks were linked to the governance framework.
- The hospital had a recognition system for staff called 'Above and Beyond' awards and included a long service award.

Leadership and culture of service

- The senior management team at hospital included the executive director and director of clinical services who were responsible for the day to day management and development of the hospital.
- Staff we spoke with felt the organisation supported them to deliver the patients' care. They told us that the Director of clinical services promoted a positive culture and valued staff.
- The surgeons told us they had good working relationship with the staff and senior management to deliver care and meet patients' needs. They worked at the service under practicing privileges.
- The staff told us and we observed the nursing leaders were visible and were involved in the day to day management of the service and providing support to the staff.

Vision and strategy

- The team was working with the corporate vision. The vision for the team at the Hampshire Clinic was through innovation and daily improvement to provide a patient's experience that was a national model for exceptional outcomes, high consumer values and caring service, supported by progressive teaching and evidence based clinical practice.
- Staff's vision was to provide individualised care based on the needs of people and putting the patients first.
- The strategy was to deliver first class care, through safe systems and facilities focused on delivering a good patient experience. However, this was not fully developed and management were unable to evidence how the strategy impacted on the care patients were receiving.

Governance

- There were policies to support the governance of the service. These key policies provided staff with guidelines and processes included risk management, incident reporting and information governance. However, these were not reviewed and updated at regular intervals to ensure that they reflected current practices and guidelines.
- There was a governance framework with several committees including a Clinical Governance Committee and a risk committee which had clear lines of reporting. There were monthly governance meetings and agenda items included, key performance indicators, clinical audit plan, patients' safety incidents and the risk register were discussed.
- Reviewing incidents was a standard agenda item on the monthly clinical governance committee meeting and we saw evidence of this from meeting minutes. However, there was some evidence of learning; this was compounded by delays in investigations and outcomes being shared in a timely way.
- Although patients' risks were assessed, this was not followed by staff. This included the venous thromboembolism assessments where patients who were identified as high risks of bleeds. Records did not show that these were followed up to ensure patients' safety.
- The meetings included the Medical Advisory Committee (MAC), Heads of Department (HOD), and Clinical Governance Committee where risks were discussed.

- Most of the consultants also worked at the local NHS trust and attended meetings at the trust where cases including those of NHS patients being treated at the hospital were discussed. We were told that all incidents and deaths relating to patients who had been treated in the ICU were discussed at the bi-annually morbidly and mortality meetings at the trust. These discussions facilitated some shared learning. Consultants working at the hospital were engaged in developing the service.
- As the hospital had SLAs with the local NHS trust the MAC chair and the Executive Director worked closely with the local NHS hospital and the medical director to ensure effective communication.
- Internal audit reports such as compliance with the WHO checklist were discussed at governance meetings and at the MAC as appropriate for lessons learnt and to improve compliance.

Managing risks, issues and performance

- The service used their internal electronic tool to document risks. However, many of risks on the risk register were issues or 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.
- We saw the hospital wide risk register which had 20 open risks identified these included failures to recruit, effectively manage and escalate clinical incidents and insufficient investment in facilities. There were actions plans developed to work through these risks although we were told that progress was slow in some areas.
- The service followed their process where low risks were reviewed annually, medium risks six monthly and red risks three monthly.

Managing information

- Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system and in paper formats. However, we noted that several policies and procedures had not been reviewed and some were out of date. For example, the medical devices policy was out of date and had not been reviewed since 2015. The sepsis screening tool was out of date and did not reflect 2017 national guidance. The lack of up to date policies and procedures could impact on care delivery as staff would not have up to date information.
- A senior manager told us that the policies and procedures were reviewed at corporate level and cascaded to them. It was unclear how corporate policies and procedures were adapted to reflect local practices. Staff were not aware of the frequency for policy reviews which meant that they could be working with outdated policies.
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre- and post -operative records.
- Following care and treatment letters were sent out to patients GPs detailing procedures undertaken and any follow ups they may require. However, there was an inconsistent process for private and NHS patients which may impact on their immediate care post- operatively.
- There were a variety of leaflets and information available to patients which included post op care and exercises post- surgery.

Engagement

- There was a process for seeking patients' views. The service had recently changed the patients' feedback to an electronic process. This resulted in a drop-in patients' responses and following feedback, they had reintroduced the paper formats which staff said was positive.
- There was an annual staff survey and the last survey was undertaken in June 2017. The hospital was in in the top 20% of the BMI Hospitals group in some questions in the survey. These included questions 'I am committed to doing my very best for BMI Healthcare' and 'I am fully trusted to do my job'.
- For this service , the ten least positive results included 'I am paid fairly for the job I do (compared with the amount I could earn elsewhere for a similar job)' and 'communication is good between departments outside of my hospital or corporate site'. At the time of inspection, the hospital had not submitted an action plan along with the staff survey results.

Requires improvement

Surgery

- The hospital had a recognition system for staff called 'Above and Beyond' awards and included a long service award. Staff said they felt proud to work for the service.

Learning, continuous improvement and innovation

- The service was focussed on improving the service provision to meet the needs of people. They were looking at increasing the private GP facility with a new GP who was due to start in April 2018. Notices were planned to be displayed in the reception area to inform patients of the new service.

Not sufficient evidence to rate

Critical care

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

Information about the service

Critical care services were a small proportion of hospital activity. The unit consisted of three beds. The patients cared for in the intensive care unit were mainly post-operative patients following complex abdominal surgery commissioned by the NHS. They were mainly planned admissions to the unit and included patients following orthopaedic surgery.

Are critical care services safe?

Not sufficient evidence to rate

We have not rated the safe section the intensive care unit (ICU) service. We currently do not have enough evidence due to the small number of patients receiving care.

- Medicines were not always managed safely. Insulin was found in an unlocked fridge in the intensive care unit (ICU).
- Potent injectable drugs were not stored separately and this could pose risks to patients' safety.

Mandatory training

Please see the Safe section of the surgery report for details about mandatory training.

- Staff in the intensive care unit stated that mandatory training was identified for each specific role. However, we were not provided information on which staff were required to complete specific training when we requested this. There we could not be assured that staff had completed the necessary training for their role.

Safeguarding

Please see the Safe section of the surgery report for details about safeguarding**.**

Cleanliness, infection control and hygiene

Please see the Safe section of the surgery report for details about infection control and management.

Environment and equipment

- The service had a three-bedded intensive care unit which contained appropriate equipment and the environment was well maintained.
- The resuscitation trolley in the ICU was not always checked daily in line with the hospital's procedure and the tamper evident tag had not been applied correctly. This posed a safety risks as the resuscitation trolley could be opened and closed without the safety tag being broken, which meant equipment could be removed without staff being aware of this and may not be available for use in the event of an emergency.
- The operating theatres were on the first floor which was easily accessible from the ICU ensuring patients were not transferred significant distances to and from theatre and could be returned swiftly if their condition deteriorated.

Please see the Safe section of the Surgery report for details about environment and equipment.

Assessing and responding to patient risk

Not sufficient evidence to rate

Critical care

- We reviewed 12 sets of patients' notes which included NEWS scores that were inconsistent, such as gaps in the observations, not all parameters completed and the frequency of observations not being completed as per protocol.
- Staff used the national early warning system (NEWS) for patients who were fit for discharge from ITU and continued to use this on the wards.
- There was a NEWS audit that took place monthly, however none of the audits we reviewed included any records in the category of five and above, these were records for patients who were critically ill or deteriorating. Therefore, we were not able to evidence that escalation, such as referral to a doctor or increased observations had taken place to ensure these patients received appropriate intervention, as the sample was restricted to those scoring of NEWS below two.
- The service did not have an outreach service and it was unclear if there was a standardised approach for the detection of the deteriorating patient with a clearly documented escalation response in ICU. There was a monitoring of the acutely unwell adult with potential for deterioration procedure dated 2017, which stated the purpose was to standardise the approach to recording vital signs.

Please see the Safe section of the Surgery report for details on assessing and responding to risks.

Nurse staffing .

- The ICU nursing establishment was 5.7 whole time equivalents (WTE) for the three level three beds. This establishment was supported by bank nurses who knew the service and worked in the ICU at the local NHS Trust. We were told the ICU only used agency staff on rare occasions.
- Staff in ICU told us that staffing levels were in line with national guidance such as 1:1 nursing for level three patients. The last three months rota we reviewed demonstrated that planned numbers of staff on duty were always achieved.

Medical staffing

- The medical cover for the three -bedded ICU was provided by Acute Care Partnership LLP, who are a group of NHS intensivists and anaesthetists who also worked in the local NHS trust.
- They provided 24 hour seven days a week cover at the service and any potential or actual admission was discussed prior to transfer into the critical care unit. Each consultant was on duty for a 24-hour period, they were available to attend the unit within 30 minutes of being called and provided handover to their peers via the telephone. The rotas we saw demonstrated that there was always a consultant on duty.
- There was a resident doctor based on the intensive care unit when there was a patient in the unit. The resident doctor was a middle grade doctor with either intensive care or anaesthetic experience who was known to the consultants and worked in the local NHS trust and had advanced life support skills. These doctors undertook 12- hour shifts and provided handovers face to face.

Please see the Safe section of the Surgery report for further details on medical staffing.

Records

Please see the Safe section of the Surgery report for details on records management

Medicines

- A review of the policies on the ICU found some medicines policies were past their review date, for example Ketamine policy should have been reviewed and reissued before February 2018. This meant that care and treatment may not have been provided in line with the most recent best practice and guidelines.
- In the ICU a lockable cabinet was labelled to store epidural medicines but these were not stored in this location but on a shelf adjacent to other intravenous medicines. This posed high risk of these drugs being administered via the wrong route which could have a catastrophic outcome for patients including fatality. We brought this to the attention of the senior management team during our inspection.
- Controlled drugs (CDs) were stored in a locked cabinet along with other medicines. There was a controlled drug's cabinet in this locked cabinet but CDs were not

stored in this, as it was labelled for the storage of epidural drugs. This was not in line with national guidance, as governed by the Misuse of Drugs Act 1971 as well as medicines legislation.

- Nursing staff in ICU we spoke with did not raise any concerns and were not aware that the current arrangements for storage of medicines were not line with national guidance. We were told the service's pharmacist had audited the controlled drugs and had not raised concerns about their storage

For our detailed findings on medicines please see the Safe section in the Surgery report.

Incidents

- The service did not have data on incidents which occurred in the ICU when we requested to see them. Staff told us that all incidents for the service were reported using their internal reporting system.

For our detailed findings on incidents please see the Safe section in the Surgery report

Safety Thermometer

- We saw no evidence in ICU that the service monitored pressure ulcers, falls or catheter associated urine tract infection.

For our detailed findings on safety thermometer please see the Safe section in the Surgery report

Are critical care services effective?

Not sufficient evidence to rate

We have not rated the effective section the intensive care unit (ICU) service. We currently do not have enough evidence due to the small number of patients receiving care.

Evidence-based care and treatment

- There was some evidence of clinical guidelines which were developed and reviewed in line with the Royal College and the Intensive Care Society.
- The critical care unit took part in the Intensive Care National Audit and Research Centre (ICNARC) unit national audits to measure the effectiveness of the care and treatment provided

For our detailed findings on evidence based practice please see the effective section in the Surgery report.

Nutrition and hydration

For our detailed findings nutrition and hydration, please see the effective section in the Surgery report.

Pain relief

For our detailed findings on pain relief, please see the effective section in the Surgery report.

Patient outcomes

- The ICU cared for around 60 patients annually and these were mainly elective surgical patients including those undergoing complex abdominal surgery and orthopaedic patients.
- The patients cared for in the intensive care unit were mainly post- operative patients following complex abdominal surgery commissioned by the NHS. The success rate of 80-% survival at 5 years and 70% survival at 10 years was above the national average.
- We were told that the national mortality rate for these complex abdominal patients was between 3-5% but was only 1% at the service. There was no evidence/ data available to support this and we told that all data relating to these patients was held by the NHS trust who commissioned the service. The ICNARC data we reviewed showed no red flags but due to low numbers outcomes it was not comparable with other units.

For our detailed findings on patient's outcomes please see the effective section in the Surgery report

Competent staff

- During the inspection, we reviewed staff training records in ICU and found these were not always maintained appropriately. The records were disorganised and we found certificates for training in the incorrect staff's files and loose. The service was not working in line with data protection regulations as the management of personal data was not always carried out safely. It was not possible to confirm whether staff had completed the necessary training from the records we reviewed.

Not sufficient evidence to rate

Critical care

- We were told that all permanent staff who worked in the ICU held the intensive care unit qualification plus advanced life support (ALS).The staff's files for these nurses containedsome evidence of the statutory and mandatory training individuals had completed. However, we noted the certifications for basic life support (BLS) were not consistently completed and the section on the certificate to document the skills that had been assessment was not always completed, this meant we could not be assured staff were competent in this skill. The files included a core competency document that was used to demonstrate the nurses had appropriate skills, we found the majority of these had not been completed.
- Nursing staff in ICU provided care to a limited range of patients and there was no formal rotation to other ICUs. Therefore, they had difficulties maintaining some skills such as haemo-filtration. While these skills were not often required; in an emergency there may be a delay in starting treatment. The nursing and medical staff we spoke with acknowledged this was an issue but there were no plans in place to address this.

Multidisciplinary working

- There was an identified physiotherapist who provided care to critical care patients and the records we reviewed demonstrated that this included respiratory management and rehabilitation components of individual's care.

For our detailed findings on multidisciplinary working please see the effective section in the Surgery report.

Seven-day services

- The service did not provide intervention cardiology and these patients were also transferred to the local NHS trust. However, a senior manager confirmed that there was no formal agreement for these transfers. Managers had no awareness that if the trust was under excessive pressure there may be delays which could impact on the patients receiving care and treatment in a timely way.

For our detailed findings on seven-day services, please see the effective section in the Surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

For our detailed findings on consent and mental capacity, please see the effective section in the Surgery report.

Are critical care services caring?

Not sufficient evidence to rate

We have not rated the caring section the intensive care unit (ICU) service. We currently do not have enough evidence due to the small number of patients receiving care.

Compassionate care

- During our inspection there were no patients in the critical care unit, therefore we were unable to assess or comment on if compassionate care was provided.

Emotional support

- During our inspection there were no patients in the critical care unit, therefore we were unable to assess or comment on if patients and their relatives were provided with emotional support.

Understanding and involvement of patients and those close to them

- During our inspection there were no patients in the critical care unit, therefore we were unable to assess or comment on if patients and their relatives understood and were involved in their care.

For our detailed findings on caring, please see the caring section in the Surgery report.

Are critical care services responsive?

Not sufficient evidence to rate

We have not rated the responsive section the intensive care unit (ICU) service. We currently do not have enough evidence due to the small number of patients receiving care.

Service delivery to meet the needs of local people

- The service had a service level agreement with the local NHS hospital for the treatment of patients following major abdominal surgery and these patients were nursed in ICU.

Not sufficient evidence to rate

Critical care

For our detailed findings on service delivery to meet the needs of local people, please see the responsive section in the Surgery report.

Meeting people's individual needs

For our detailed findings on meeting people's individual needs, please see the responsive section in the Surgery report.

Access and flow

- The bed occupancy in the intensive care unit was 6.5%. Between January and March 2018, the unit treated 30 patients which included 26 were planned admissions and four emergencies. During this period 29 days were level 3. There was 55 days level 2 and 32 days level 1. There were four delayed discharges and one readmission to ICU.

For our detailed findings on access and flow, please see the responsive section in the Surgery report.

Learning from complaints and concerns

For our detailed findings on learning from complaints, please see the responsive section in the Surgery report.

Are critical care services well-led?

Not sufficient evidence to rate

We have not rated the well-led section of the intensive care unit (ICU) service. We currently do not have enough evidence due to the small number of patients receiving care.

Leadership

- The senior management team at hospital included the executive director and director of clinical services who were responsible for the day to day management and development of the hospital.
- Medical leadership in the critical care unit was provided by an intensivist who had the appropriate skills and knowledge to lead the service and provide safe and effective care

For our detailed findings on leadership, please see the well-led section in the Surgery report.

Vision and strategy

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

Culture

For our detailed findings on culture, please see the well- led section in the Surgery report

Governance

For our detailed findings on governance, please see the well- led section in the Surgery report

Managing risks, issues and performance

- The risk register that we reviewed for the critical unit did not include actual risks relevant to the ICU such as staff not having some specific skills or lack of assurance that these skills had been maintained were not included. Staff we spoke with told us that they had been informed by the hospital senior managers that the BMI corporate office had instructed all hospitals in the group to include specific risks on their risk register. Some of the risks were not relevant to the service being provided, therefore the risk register did not reflect current risks on the critical care unit and no mitigation had been developed to manage risks which could result in patient harm.

For our detailed findings on managing risks, please see the well- led section in the Surgery report.

Managing information

For our detailed findings on managing information, please see the well- led section in the Surgery report.

Engagement

For our detailed findings on engagement, please see the well- led section in the Surgery report.

Learning, continuous improvement and innovation

For our detailed findings on learning and continuous improvement and innovation, please see the well- led section in the Surgery report.

Not sufficient evidence to rate

Services for children and young people

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

Information about the service

Children and young people's services were a small proportion of hospital activity. The hospital had designated paediatric trained nurses to provide care and support to children and young people. Children were admitted for elective surgery and parents were supported to stay with their children during their admission.

Are services for children and young people safe?

Not sufficient evidence to rate

We have not rated safe for services for children and young people. We currently do not have enough evidence due to the small number of patients receiving care.

Mandatory training

- The consultants completed mandatory training as part of service level agreement (SLA) with the hospital. The training included health and safety, safeguarding adults and children at level three, infection control, moving and handling, and advanced life support.

For our detailed findings on staff's mandatory training, please see the safe section in the Surgery report

Safeguarding

- The service had policies and procedures for safeguarding children. The paediatric nurse was the lead for safeguarding children and reviewed information to ensure that staff acted on the latest guidance.
- All nursing staff were trained to level two safeguarding children processes, the paediatric nurses and consultants treating children were all trained to level 3 in safeguarding children as required.
- The Child Health and the Safeguarding Children and Young People intercollegiate document (March 2014) details that "All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person required level 3 safeguarding children and young people training. In line with national Inter collegiate guidance the safeguarding lead was trained at trained at Level 4trained to level four.
- The paediatric nurse lead worked closely with other staff within the group which included quarterly meetings and learning was cascaded to the other staff.
- There were clear processes for reporting and referring any concerns relating to children safeguarding to the local authority. Staff were confident in using the process and shared with us two recent examples where safeguarding was initiated.

For our detailed findings on safeguarding, please see the safe section in the Surgery report

Cleanliness, infection control and hygiene

- Infection control policies and procedures were followed, all the areas we inspected including the theatre, ward and children rooms were clean and well maintained.

For our detailed findings on infection control, please see the safe section in the Surgery report

Environment and equipment

Not sufficient evidence to rate

Services for children and young people

- The service had appropriate emergency resuscitation equipment to manage emergencies involving children and young people. These included face masks and airway equipment which were suitable for children.
- The resuscitation trolleys were kept in a secure area and these were tagged and tamper evident. Equipment was available to keep patients safe following anaesthetic and intravenous sedation. There was difficult airway management equipment suitable for children and young people.
- The service had a designated area where two rooms were set aside for providing care to children. The area was not secure which meant people could have free access to children. We raised this with staff at the time of the inspection.
- The governance report dated March 2018 showed that there was a plan to provide secure doors to the paediatric area. Staff were not aware of the timescale for completion or if the area had been risk assessed and mitigating actions proposed.

For our detailed findings on equipment and environment, please see the safe section in the Surgery report.

Assessing and responding to patient risk

- Admissions to the hospital were planned and staff used elective surgical procedures care pathways. All children and young people had a pre-admission assessment completed which was face to face.
- The surgical pathways had clear pre-assessment processes. We reviewed the care pathways for paediatric assessments. Clinical risk assessments included the American Society of Anaesthesiologist (ASA) score.This is a system used to assess patients' fitness for surgery such as healthy patients and those with mild systemic deficiency at the pre- operative stage. Patients with severe systemic deficiencies would be excluded following discussions with the surgeon and anaesthetists.
- There were specific Paediatric Early Warning System (PEWS) charts used for the treatment of children and young people. These were included in the post-operative pathways which were completed in the recovery areas and then on the wards. We found that these were detailed and appropriately completed. There were clear escalation processes according to any changes in PEWS which staff followed.
- There was information relating to paediatric resuscitation which included fluid management and emergency drugs calculations according to the child's weight.

For our detailed findings on assessing and responding to risk, please see the safe section in the Surgery report.

Nurse staffing

- The service had adequately trained staff with the appropriate skills to care for children. There were always two paediatric nurses when children were admitted to the service.
- There were three paediatric nurses and there were always two of them available when children were receiving care and treatment. The duty roster was flexible to accommodate them including the rare occasions if a child stayed overnight.
- The children were mostly admitted as day cases, however there was a contingency plan in place if a child needed to stay overnight to ensure they continued to receive safe and effective care from an appropriate staff.

For our detailed findings on nursing staffing, please see the safe section in the Surgery report.

Medical staffing

- All patients were admitted under a named consultant and they remained under their care for the duration of their care and treatment as inpatients.
- All medical staff worked under practicing privileges arrangements. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. These were granted following an application process which included checks such as two references and a DBS check.
- The granting of practicing privileges was monitored by the MAC and consultants would only treat children and

Not sufficient evidence to rate

Services for children and young people

young people if they also carried out these surgical procedures as part of their work in the NHS. There were designated consultant surgeons who provided care and treatment to children and young people.

For our detailed findings medical staffing, please see the safe section in the Surgery report

Records

- All paediatric patients who were under five had 'red books' which contained their current health records. The paediatric nurses ensured these were available at the pre-admission assessments stage ensuring current health records were up to date and current.
- We reviewed four sets of children records and found these were detailed and all were stored safely and securely.

For our detailed findings on records, please see the safe section in the Surgery report.

Medicines

- The service had an in-house pharmacy and this was staffed Monday to Friday. A pharmacist was available to offer advice and support relating to children drugs and dosages to the staff. The Resident Medical Officer (RMO) had access to the pharmacy out of hours and at weekends and the pharmacist was available on call as needed.
- The pharmacy team undertook daily visits to the ward and carried out medicines reconciliation for inpatients. This ensured that patients medicines were reviewed on admission and they continue to receive their medicines appropriately.
- The staff recorded the children's weights in kilograms on admission so that drug dosage calculations were accurate in line with medicines for children guidelines. There were drug formulas which had been developed for children resuscitation.
- The use of Buscopan had been approved by the (MAC) and was now used for children undergoing MRI/CT as this led to an improved image.

For our detailed findings on medicines please see the Safe section in the Surgery report.

Incidents

- The service had declared that they had no 'Never events' in the reporting period of March 2017 to April 2018 relating to children and young people. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There had been no incidents of harm relating to children and young people in the same reporting period.

For our detailed findings on incidents, please see the safe section in the Surgery report.

Safety Thermometer

For our detailed findings on safety thermometer, please see the safe section in the Surgery report.

Are services for children and young people effective?

Not sufficient evidence to rate

We have not rated effective for children and young people services. We currently do not have enough evidence due to the small number of patients receiving care.

Evidence-based care and treatment

- The paediatric nurses undertook pre-operative fasting checklist and followed NICE guideline for pre-operative fasting for children. Admissions were planned and staggered to ensure that children did not go without food and fluids for long periods.

For our detailed findings on evidence based care and treatment, please see the effective section in the Surgery report.

Nutrition and hydration

- The parents and children we spoke with were complimentary about the food choices and selection which was available to them.
- Parents were also offered meals so they could eat with their children and hot and cold drinks were available at all times.

Not sufficient evidence to rate

Services for children and young people

For our detailed findings on nutrition and hydration, please see the effective section in the Surgery report.

Pain relief

- Pain assessment was part of the PEWS score cards. We saw that appropriate paediatric pain score was also used to assess children's pain. This ensured that pain management was monitored and patients received pain control medicines in a timely way.
- Children and parents told us that they had received information about pain control at a very early stage such as during pre-admission assessment and staff were "very good" at monitoring pain in their child.

For our detailed findings on pain relief, please see the effective section in the Surgery report.

Patient outcomes

For our detailed findings on patient outcomes, please see the effective section in the Surgery report.

Competent staff

- The paediatric nurses undertook regular updates specific to their roles to ensure that their practice remained current. Staff said they were supported to revalidate and checks were carried out for nurses who were on the nursing and midwifery council (NMC)register.
- The surgeons were all employed at the local trust and surgery was their main area of practice. Evidence of staff's appraisal and revalidation was monitored and records showed these were all up to date.

For our detailed findings on pain relief, please see the effective section in the Surgery report.

Multidisciplinary working

- Paediatric staff told us that there was effective multi-disciplinary working with the ward staff and allied health professionals and they felt well supported.

For our detailed findings on pain relief, please see the effective section in the Surgery report.

Seven-day services

For our detailed findings on seven-day services, please see the effective section in the Surgery report.

Consent, Mental Capacity Act.

- There was a consent policy and procedure which was specific to children and young people. The paediatric nurses used specific consent forms for children and young adults. This was in line with Fraser guidelines and supported the best interests of children and young people receiving care.
- Children and young people who were under the age of 16 could consent to their own treatment if they had an understanding to fully appreciate what was involved in their treatment.
- Records showed that some children had also signed their consent forms along with their parents. For younger children we saw parental consent was sought in line with their consent procedures.
- There was information on chaperone which was available at the service. Staff told us that children and young people were accompanied by an adult with parental responsibilities and consent for examination and test was always obtained.

For our detailed findings on consent, please see the effective section in the Surgery report.

Are services for children and young people caring?

Not sufficient evidence to rate

We have not rated caring for children and young people services. We currently do not have enough evidence due to the small number of patients receiving care.

Compassionate care

- We observed that children and young people were treated with care and compassion always.

For our detailed findings on compassionate care, please see the caring section in the Surgery report.

Emotional support

- We observed good interactions with children and their parents who were complimentary about the staff and the care and emotional support they had received.

Not sufficient evidence to rate

Services for children and young people

For our detailed findings on emotional support, please see the caring section in the Surgery report.

Understanding and involvement of patients and those close to them

- Parents confirmed that they were involved and felt part of their child care as appropriate.
- Comments included 'the staff have been fantastic' and 'you can't fault the care' and that these staff were available for support and staff kept them informed.
- Older children were supported and staff told us a chaperone was available and they could talk to the doctors without parental presence if they chose.
- Information was available in child friendly language and children were involved in their care as appropriate.

For our detailed findings on understanding and involvement and those close to them, please see the caring section in the Surgery report.

Are services for children and young people responsive?

Not sufficient evidence to rate

We have not rated responsive for children and young people services. We currently do not have enough evidence due to the small number of patients receiving care.

Service delivery to meet the needs of local people

For our detailed findings on service delivery to meet the needs of local people, please see the responsive section in the Surgery report.

Meeting people's individual needs

- Information was available in pictorial formats for children to ensure they were involved and understood their care and treatment.

For our detailed findings on meeting individual needs, please see the responsive section in the Surgery report.

Access and flow

- Children inpatient services was a small part of the service provided at this hospital. Data we had received from the hospital showed that from April 2017 to March 2018, there were 31 inpatient episodes of care for children and young people.
- During the same period there were 150-day cases, the service saw 2,089 children and young people as outpatient and 964 were follow up consultation.

For our detailed findings on access and flow , please see the responsive section in the Surgery report.

Learning from complaints and concerns

For our detailed findings on learning from concerns and complaints, please see the responsive section in the Surgery report.

Are services for children and young people well-led?

Not sufficient evidence to rate

We have not rated well-led for children and young people services. We currently do not have enough evidence due to the small number of patients receiving care.

Leadership

For our detailed findings on leadership, please see the well-led section in the Surgery report.

Vision and strategy

- The vision for the service was to develop the paediatric care. This was at an early development stage and the senior paediatric nurse was meeting with the steering group to look at a way forward for paediatric care.

For our detailed findings on vision and strategy, please see the caring section in the Surgery report.

Culture

For our detailed findings on culture, please see the well-led section in the Surgery report.

Governance

For our detailed findings on governance, please see the well-led section in the Surgery report.

Not sufficient evidence to rate

Services for children and young people

Managing risks, issues and performance

- The service monitored risks and performance issues which were discussed at their quarterly medical advisory committee (MAC) meetings. Minutes from January 2018 meeting showed that they gathered information from all consultants and anaesthetists who treated children under the age of 19 years as part of their policy.
- This information was also used to ensure that all consultants could evidence they had completed children safeguarding training at level 3 and offered support to them to be compliant.

For our detailed findings on managing risks, please see the well-led section in the Surgery report.

Managing information

For our detailed findings on managing information, please see the well-led section in the Surgery report.

Engagement

For our detailed findings on engagement, please see the well-led section in the Surgery report.

Learning, continuous improvement and innovation

For our detailed findings on learning, continuous improvement and innovation, please see the well-led section in the Surgery report.

Outstanding practice and areas for improvement

Outstanding practice

The Hampshire Clinic was recognised as one of the centres providing care for patients with Pseudomyxoma and Peritoneal malignancy.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that arrangements are in place for the safe management of medicines at all times.
- The provider must ensure that effective processes are developed for incidents that affect the health and safety of people using the service. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, and prevent further occurrences.
- The provider must ensure that care and treatment is provided in a safe way and patients' health risks are taken into account when providing care. Risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed.
- The provider must ensure that the equipment used for providing care or treatment is safe for such use and managed safely at all times.
- The provider must ensure staff follow the pathway and guidance for assessing deteriorating patients.
- The provider must ensure that infection control policies and procedures are in place and followed for the prevention and spread of infection.
- The provider must ensure policies and procedures are reviewed at regular intervals to support staff in the safe delivery of care.
- The provider must ensure that all staff providing care and treatment have the qualifications, competence, skills and experience to do so safely.
- The provider must ensure that risks are assessed and systems are in place and doing all that is reasonably practical to mitigate risks.
- The provider must ensure that staff apply the safety checklists to provide consistency in care practices and safeguard patients from risks of harm.

Action the provider SHOULD take to improve

- The provider should address arrangement for the security of children receiving care at the service.
- The provider should evaluate and develop timely action plans where shortfalls are identified such as complaints management and learning shared.
- The provider should have a process to enable patients' access to information in other languages to meet their needs.
- The provider should review the governance arrangement in the core services such as oncology and endoscopy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Care and treatment must be provided in a safe way for service users. The provider must ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way. Medicines were not managed safely to safeguard patients and meet regulations. Medicines were not segregated to minimise the risks of errors and medicines were not stored safely and securely as required. Infection control processes were poor in endoscopy as clean patient linen in endoscopy was stored in an area where it may become contaminated. Staff in endoscopy were not following the endoscopy pathway about the observations taken to monitor patients during and after endoscopy procedures. There was limited evidence of audit being carried out to confirm the effectiveness of infection control procedures and practices. There was no safe system in place for checking of supplementary resuscitation equipment in endoscopy.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/ or welfare of people who use the services.

This section is primarily information for the provider

Requirement notices

Policies and procedures were not updated and reviewed to ensure staff's practices were current to safeguard patients from receiving inappropriate and unsafe care.

The risk register did not reflect all current risks at the service and no mitigation had been developed to manage risks. This included risks we identified during the inspection.

Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.

Risks were not reviewed and specific action plans were not developed where risk assessments identified risks to patients' safety such as VTE and bleeding risks to safeguard patients.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Critical care nurses did not have access to regular update and training to ensure they were competent in specific skills such as hemofiltration. There was a lack of assurance that these skills had been maintained to deliver safe care and treatment. Staff had not received sepsis update and training in line with the NICE guidelines for sepsis management.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not stored safely in the critical care unit. The drug fridge which was contained Insulin was unlocked. This was not in line with NICE guidance or the Medicines Act, and unauthorised staff or other people could have access to insulin. Epidural drugs were not stored safely posing risk of epidural drugs being administered inappropriately. This posing serious risks to patients. The Controlled drugs, Safe Management of Medicines and Epidural policies staff showed us were out of date. The meant there was a risk staff may not be storing, administering or disposing of medicines in line with best practice or NICE guidance. In the endoscopy unit, there were inadequate arrangements in place for the management and control of spread of infection. Venous thromboembolism assessments (VTA) were not always fully completed. There were no evidence these assessments were reviewed when patients' risks were identified which could impact on safety and welfare of patients receiving care. In line with the provider's guidance National Early Warning Scores were not always escalated when the scores were above and appropriate action taken.

This section is primarily information for the provider

Enforcement actions

Resuscitation equipment was available in the endoscopy suite and the critical care unit. However, the equipment was not tamper evident and therefore there was risk equipment may not be available when needed in an emergency.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of effective governance to ensure policies were kept under review and updated in a timely manner to reflect best practice and national guidance. There was limited evidence of audit being 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. There was limited evidence that root cause analysis following incidents were completed in a timely manner. This impacted on action plan being developed and learning to mitigate these happening again. The risk register did not accurately reflect current risks at the service such as medicines management, policies and procedures. In Oncology the risk of policies not meeting national guidance was not on the risk register.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not aware of the sepsis policy for sepsis management or the provider's sepsis care pathway. The sepsis screening tool was out of date and did not refer to the 2017 NICE guidance. Staff had not received training or update in line with the current guidelines. Critical care nurses did not have access to regular update training to ensure they were competent in specific skills such as hemofiltration and there was a lack of assurance that these skills had been maintained.