BMI The Ridgeway Hospital

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services 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.

Overall summary

BMI, The Ridgeway Hospital is operated by BMI Healthcare Limited . The hospital provides outpatient, diagnostics, surgery and medical care including oncology and endoscopy services to adults and children and young people (CYP). Treatment is provided to privately funded and NHS patients.

Specialities offered by the service for inpatients and outpatients include gynaecology, ears, nose and throat (ENT), breast and cosmetic surgery, chemotherapy and oncology, paediatric services, refractive eye surgery, and other laser surgery.

Summary of findings

We inspected this service using our focused inspection methodology. We carried out an unannounced inspection on 19 and 20 March 2018, and a further unannounced inspection on the 28 March 2018.

We focused on specific parts of the service which were highlighted as concerns to the CQC from staff and members of the public. Additionally, we focused our inspection on areas previously identified as needing improvement in our last inspection. The key questions we asked during this focused unannounced inspection were, was it 'Safe' in surgery, and children's and young people's and was it 'Well Led' in medicine, surgery and children's and young people's.

Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. As this was a focused inspection, new ratings were only awarded for the key questions that were inspected. The overall rating for the service was not changed.

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

We found areas of practice, which required improvement in surgery, medicine and children and young peoples services.

- Issues such as sickness and performance management within the theatre department, had compromised staff morale and the running of the department.
- Infection control practices were not always in line with policy and guidance.
- Resuscitation and anaesthetic equipment was not always checked in line with hospital policy.
- Staffing shortages across pharmacy meant not all audits were completed. This impacted on the providers awareness of the safety of the service it delivered.
- Not all staff had completed their mandatory training within the timeframes expected by the hospital.
- The hospital did not have an in-date service level agreement with the local NHS Trust, for emergency transfer of children and young people and adults.
- Not all staff in the endoscopy unit took part in the World Health Organisations surgical safety checklist in a fully compliant manner and patient checks were not fully completed prior to medication being given.
- Chemotherapy team meetings were not held regularly and we could not be assured that there was an effective governance framework to support the service.
- The out of hours and on-call arrangements for chemotherapy services were not safely arranged.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with requirement notices that affected surgery, children and young people and medicine. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	Medical care services were a small proportion of hospital activity. The main service provided was surgery. Where arrangements were the same, we have reported findings in the surgery section. We inspected the well led domain only and rated this as requires improvement.
Surgery	Requires improvement 	Surgery was the main activity of the hospital and staffing was managed jointly with medical care. We inspected and rated surgery as requires improvement in safe, and well-led.
Services for children and young people	Requires improvement 	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. During this inspection, we inspected and rated the service as requires improvement in safe and well led.

Summary of findings

Contents

Requires improvement

Location name here

Services we looked at

Medical care; Surgery; Services for children and young people.

Summary of this inspection

Background to BMI The Ridgeway Hospital

BMI, The Ridgeway Hospital is operated by BMI Healthcare Limited and was built in 1984. It was extended in 1999 and 2011/12. It is a private hospital near Swindon and primarily serves the local communities of the Swindon area but also accepts patient referrals from outside this area.

The hospital provides surgery, medical care, including oncology, outpatient and diagnostic services and treats both adults and children. It provides care and treatment to both privately funded patients and NHS patients through contracts with the two local clinical commissioning groups.

The registered manager, James Lowe has been in post since April 2012. He is the hospital's executive director and accountable officer for controlled drugs and is supported by a senior management team consisting of a quality and risk manager, operations manager and a director of clinical services.

The hospital consists of an outpatients' department with 10 consulting rooms and two treatment rooms, an x-ray department, which includes an MRI screening unit; a physiotherapy department with a fully equipped gymnasium, hydrotherapy pool, six treatment rooms and two consultancy rooms.

We last inspected this service in 2016 and found overall, it required improvement. Paediatric services were temporarily halted until improvements were made to the governance of the service and safeguarding training and were reinstated in the latter part of 2017.

Since our last inspection, we received some concerns which prompted us to carry out an unannounced focused inspection on 19 and 20 March 2018 and a further unannounced inspection on 28 March 2018.

During this inspection we inspected the following core services and reported on the following,

- Surgery - Safe and well led
- Children's and young people - Safe and well led
- Medicine - Well led

Our inspection team

The team that inspected the service comprised two CQC inspectors, two specialist advisors one with expertise in paediatrics and another with expertise in theatres.

The inspection team was managed by Marie Cox, Inspection Manager and overseen by Mary Cridge, Head of Hospital Inspection.

Information about BMI The Ridgeway Hospital

Day case services are provided on a 12-bedded day care unit, which is open from Monday to Friday between 7.15am and 9pm, and some Saturdays. There are three operating theatres, two of which are laminar flow each with their own anaesthetic room. Laminar flow filters, remove bacteria, viruses and any dust particles from the air flowing in and out of theatre, creating an isolated clean environment. The ward consists of 28 single rooms and three double rooms. Medical oncology services are provided in a four- bedded oncology suite, which when not in use by oncology day patients can be used for post-operative day case patients.The hospital is registered to provide the following regulated activities:

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

The hospital provides surgical specialities such as gynaecology, general and orthopaedic surgery, ear, nose

Summary of this inspection

and throat and oral and maxillo-facial surgery, ophthalmology, reconstructive and cosmetic surgery, podiatry and urology services. Medical services provided are haematology and oncology treatment and endoscopy services.

Interventional services are provided to children and young people from the ages of three up to midnight on their 18th birthday. A paediatrician provides consultations to those children in the age group of three to 12 years of age. Interventional consultations are only scheduled during paediatric clinics when the senior children's nurse is available to assist or chaperone. Speciality consultants see children aged 12 upwards. Paediatric surgery is only carried out on children aged 16 years and above who are eligible for the adult pathway. During their stay a children's nurse is available for the registered nurses to consult with for advice.

During the inspection, we visited the main ward, theatres, the day surgery unit, and the outpatient department for CYP services. We spoke with 40 members of staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We spoke with six patients and one relative. During our inspection, we reviewed 20 sets of patient 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's most recent inspection took place in April 2016.

Activity (February April 2017 to February 2018)

In the period February 2017 to February 2018 there were 7832 inpatient and day case episodes of care recorded at the hospital. Of these 3459 were NHS-funded and 4373 other funded. In total, 561 of all NHS-funded patients and 942 of all other funded patients stayed overnight.

Nine children aged 16 and 17 years attended the hospital as day case or in-patient, with 376 children aged three to 15 and 78 aged 16 to 17 seen in the outpatient department.

During our inspection there were 132 consultants working at the hospital, 55 of these were consultant surgeons. All were employed under practising privileges, whereby a medical practitioner is granted permission to work in an independent hospital or clinic. Resident medical officers (RMO) were employed via an agency and rotated on a week on, week off rota. The hospital employed 54 registered nurses, 25 care assistants as well as having its own bank staff.

Track record on safety

- One Never event in 2017, which related to the wrong side anaesthetic block.
- 412 patient incidents, 346 no harm, 49 low harm, 16 moderate harm, 1 severe harm, 0 death.
- One serious injury reported, investigated and downgraded by Clinical Commissioning Group.

No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).

No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).

No incidences of hospital acquired Clostridium difficile (C.diff).

No incidences of hospital acquired Escherichia coli (E-Coli).

Services provided at the hospital under corporate contracts:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Are services safe?

We rated safe as requires improvement because:

- There was a disparity with the reporting culture in theatres and on the wards.
- Systems and processes were in place to protect patients and staff from healthcare associated infection but not all staff in all the departments adhered to practice.
- The endoscopy unit did not have accreditation from the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy standards for endoscopy services.
- Some bedrooms and corridors were still carpeted as the refurbishment programme had been halted. We were told funds had been released for this to commence after the time of our inspection.
- The storage of intravenous (IV) fluids was not always safe.
- There were no audits of medicine reconciliations, which meant the service, could not be assured of safe practices around medicines administration.
- The pharmacy department was small and cramped and staff told us they found it a challenging environment to work in.
- Not all staff had completed their mandatory training within the timeframes expected by the hospital.
- The current service level agreement with the local trust, for the emergency transfer of patients was still in draft format.
- Systems and processes in some areas of the hospital had not been used successfully to manage sickness and poor performance.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- We did not see evidence the organisation used performance management processes effectively when working with underperforming staff.
- The service had identified the lack of Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation standards for endoscopy services as a weakness. We were not assured progress towards this was monitored effectively.
- The Oncology and Cancer Services meeting group had met once since November 2016. Processes to manage operational challenges such as out of hours were not in place.

Summary of this inspection

- There was a lack of processes to ensure that all employees who were involved in invasive procedures in the endoscopy department carried out good safety practice, as set out in the National Safety Standards for invasive procedures (NatSSIPs).

However:

- The hospital had a clear vision and a set of values, which had quality and safety as a priority.
- There was a strong representation for children and young people reflected in the strategy and vision for this core service
- The hospital had a straightforward and effective governance and risk management structure, which had been put in place since our last inspection. This included structures and quality measures for children and young people.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	N/A	N/A	N/A	N/A	Requires improvement	Good
Surgery	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement

Notes

This was a focused inspection, new ratings were only awarded for the key questions that were inspected. The overall rating for the service was not changed.

Good

Medical care

Well-led

Requires improvement

Are medical care services well-led?

Requires improvement

Leadership and culture of service

Please see the surgical section of this report.

Vision and strategy for this core service

- The hospital had a clear vision and a set of values, which had quality and safety as a priority. The vision for the medical and surgical core service was the same and can be read in the surgical section of this report.
- The hospital business plan for the year of 2017-2018 outlined the key areas of improvement for the whole service. However, we were not assured progress was always monitored and reviewed. One weakness identified by the service was the lack of Joint Advisory Group (JAG) accreditation for gastrointestinal endoscopy. This is the formal validation that an endoscopy service delivers its care and treatment in line with nationally agreed standards. The hospital did not meet this accreditation because the dirty utility room/ sluice had one entrance and exit. The service provided us with a JAG action plan, but this did not identify dates or plans for achieving accreditation. However, we did see some improvements made to mitigate infection control risks, for example, all scopes were being cleaned externally via a contract at a dedicated decontamination hub.

Governance, risk management and quality measurement.

- The governance processes for the medical core service were much the same throughout the hospital. With exception of oncology and endoscopy services, we have reported about governance processes under this section of the surgery service within this report.
- The governance processes for the oncology service did not support the safe delivery of care. The executive director, a haematologist, and pharmacist, oncologists and onco-plastic surgeons, the chemotherapy sister and the breast care clinical nurse specialist attended the February 2018 Oncology and Cancer Services governance meeting. There were no standard agenda items discussed such as risk registers or incidents, therefore this was not an effective forum for managing all operational difficulties faced by the team. Minutes documented concerns due to the overreliance on one member of staff to provide all the nursing services and the knock-on effect when leave was taken. Meeting minutes stated the hospital was in the process of recruiting a further member of nursing staff. Further issues with on-call, out of hours cover were discussed and whilst ward cover for on call surgeons was good, this did not appear to be to the same for the oncology services. The service was in the process of formally arranging holiday cover, written on call and formal written rotas for consultants to make the service safer for patients post discharge.
- Prior to the February 2018 meeting, the Oncology and Cancer Services governance group had not met officially since November 2016. The provider did not give us information, which demonstrated that concerns, actions, incidents or risks since this previous meeting had ever been followed up on and communicated to the team. The hospital told us that regular meetings had been scheduled from February onwards.
- Not all employees who were involved in invasive procedures in the endoscopy department carried out good safety practice, as set out in the National Safety Standards for invasive procedures (NatSSIPs). Processes did not follow national guidelines in the preparation of patients prior to endoscopy. Staff in the endoscopy department carried out a daily huddle prior to the list beginning which aimed to identify any issues with decontamination, equipment and patient concerns. The first patient who was not in the room at the time was discussed with the consultant; staff did not have the patient records to hand but informed the surgeon of the patients name and allergy status from memory. The patient was then brought into the room but there was no checking of the patient's name and date of birth by the consultant prior to administration of a sedative, or prior to the procedure.

Good

Medical care

- We discussed the lack of completion of the World Health Organisations (WHO) checklist with the senior management team during feedback at the end of the inspection. We were provided with a completed WHO paper checklist, however this was not an accurate reflection of the practice we observed in the endoscopy unit. We asked what assurances the service sought to ensure good practice and were told compliance audits had not been completed since December 2017 having previously been completed monthly. The provider told us that moving forward audits in endoscopy would be part of the audit programme again.

Public and staff engagement

- This has been reported on in the surgical section of this report.

Innovation, improvement and sustainability

- The service had made improvements to prescribing chemotherapy. A single standardised prescribing model for chemotherapy via an electronic cancer e-prescribing system was introduced at the hospital in early 2018. The benefits included maximising patient safety and improved medicines management.

Requires improvement

Surgery

Safe	Requires improvement
Well-led	Requires improvement

Are surgery services safe?

Requires improvement

Incidents

- There was a disparity with the reporting culture in theatres and on the wards. Staff on the wards, told us they felt able to report incidents and there was a good reporting culture. However, staff in theatres felt differently. Issues were brought to light prior to and during our inspection of a challenging culture in the theatre department which staff told us made the reporting of incidents 'pointless'. Whilst this is discussed in the well led section of this report it is pertinent to point out significant changes took place in the management of the theatre department during our recent inspection and improvements were evident immediately.
- There was a clear structure of discussion around incidents, themes and trends. Incident reporting showed a wide range of topics and included abrasions, medication incidents, falls, staffing and equipment incidents. Incidents were discussed at the clinical governance meetings, which were held monthly, and the incident report was an embedded item in the meeting minutes. Specific incidents were discussed; actions were identified, and allocated to members of the team and added to the action log. Incidents were further discussed at the medical advisory committee (MAC) where types and numbers of risks were identified. For example in March 2018 the MAC meeting minutes identified there had been one fall, one medication error, one re-admission and two transfers out of the hospital. Incidents were then cascaded to front line staff via the heads of department at local meetings and this was clearly evidenced in the meeting minutes for the ward and theatre departments.
- During the previous inspection an action tracker had been used in relation to reporting and managing incidents, staff had stated this had become too large and unmanageable. In November 2016, staff were trained to use an electronic incident reporting system and training was rolled out for all staff. Between the period April 2017 to March 2018, the hospital reported 339 patient incidents, however we were informed 30 theatre personnel did not have access to the system due to the accounts being set up incorrectly or deleted during a system cleanse in September 2017. This was brought to light through a whistle-blower who told us they were unable to report incidents. This was in the process of being rectified during the period of our inspection however it would have had an impact on the number of incidents reported.
- In August 2017 the service reported a never event of a wrong side local anaesthetic of a patient undergoing a spinal invasive procedure. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. A root cause analysis (RCA) was completed which identified safety measures which would prevent the such an incident from re-occurring. The actions identified in the RCA were for the operational registers to be completed only when the procedure was completed, which we observed was carried out. The RCA also identified a "stop before you block" sticker which should be used for anaesthetists and their assistants in the anaesthetic room. We did not observe the "stop before you block" sticker being used and staff told us they had not received instructions on when to use it. This meant not all learning had been implemented to prevent future incidents of this nature.
- Mortality and morbidity (M&M) such as breast cancer lymph node biopsy reviews did not feed into service development. Although these were a standing agenda

item in the clinical governance meetings, the three sets of meeting minutes we reviewed only documented discussions of incidents and no discussion around this data, service plans or learning.

Duty of Candour

- Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with from all levels of the organisation had an understanding of duty of candour, when they would use it and the actions they would take. The service added duty of candour incidents to their incident tracker from February 2017 to February 2018. Duty of candour had been applied in four incidents.

Clinical Quality Dashboard.

- The service monitored safety via an electronic database, which enabled the hospital to compare its performance against other BMI hospitals. The database included patient incidents, the type of incident (such as a fall) and its contributing factors, and medication errors. The hospital used the results to improve practice and we saw evidence of incident discussions as a standard agenda item in meeting minutes such as the medical advisory committee meeting minutes.
- The ward collected monthly data for the NHS safety thermometer. The NHS safety thermometer is a collection of data submitted by all hospitals treating NHS inpatients. The data collected is a snapshot of inpatients suffering avoidable harm, usually on one day each month. TheNHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE), a blood clot which starts in a vein. During our last inspection, the hospital did not display the results as was considered best practice, however during this inspection we saw these were now displayed in the hospital reception area. This showed three NHS in-patients had accessed the service during the time of the audit and 100% had received harm-free care.

Cleanliness, infection control and hygiene

- Systems and processes were in place to protect patients and staff from healthcare associated infection but not all staff in all the departments adhered to practice.
- We witnessed poor practice where staff walked into the hospital canteen in their surgical scrubs. We saw one surgeon walk into the canteen after the completion of a morning list in surgical scrubs and still wearing a facemask. It was therefore evident the surgeon had not changed out of the theatre scrub suit prior to leaving theatre. After finishing a meal, the surgeon then removed the face mask screwed it up and placed it in the general bin without handwashing. This did not comply with the hospitals uniform policy which stated;
  - Masks must be discarded after each use.
  - Hands must be washed following removal of the mask.
- We witnessed other staff from theatres walking into the canteen in scrub suits to collect cutlery for their meals. This was not in line with best practice and we were not assured this was kept to a minimum. NICE clinical guideline 74 recommendations 1.2.5 and 1.2.6 which states:
  - Staff should wear specific non-sterile theatre wear (scrub suits, masks, hats and overshoes) in all areas where operations are undertaken. Staff wearing non-sterile theatre wear should keep their movements in and out of the operating area to a minimum.
- Audit work for much of the service showed poor compliance with hand hygiene. Audits for the period of January showed only 10% compliance to safe hand hygiene practices in the theatre department. The lead for infection control implemented a clinical practice rapid improvement tool for hand hygiene compliance and re-audited later that month which saw staff were 60% compliant and then re-audited in February, this showed further improvement in compliance of 90%. By March, however compliance had dipped again to 80%. This was consistently below the hospitals benchmark of 94%.
- However, we saw how staff on the wards and in the preadmission clinic decontaminated their hands in line with the World Health Organisations five moments for hand hygiene and NICE guidance (QS 61 statement

three). This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. All the patients we spoke with told us they saw staff decontaminate their hands before and after patient contact.

- The previous report had highlighted the use of carpets throughout the patient areas and patient rooms. The Health Building Guidance Note (HBN) 0.0_10 Part A, advised that, to facilitate cleaning flooring should be impervious, smooth and seamless, and where possible hard flooring should be run up the walls for a short distance. The note states carpets should not be used in clinical areas where spillages can occur and this includes corridors and entrances. However, during this inspection, some rooms and corridors were still carpeted and the refurbishment programme had been halted. We were told this was to be re-started and funds had been released for this to commence after our inspection. We saw the carpet cleaning schedules for the ward and day care unit which identified which areas had carpets and received twice yearly steam cleaning.
- The service had cleaning schedules for each department, which identified what was to be cleaned, how often, and by whom. This included fan cleaning, chairs and carpets and curtain cleaning schedules. We reviewed samples of the anaesthetic cleaning schedule checklist for the months of February, July and September 2017 and only 12 daily checklists and one weekly checklist had been completed.
- The areas we inspected were all visibly clean and free from dust. Any ward equipment which was stored in the corridors had stickers indicating it was cleaned within the last 24 hours. The ward sluice was visibly clean and tidy and the sticker on the commode showed it had been cleaned in the last 24 hours.
- Within the period from February 2017 to February 2018 there had been no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile, Carbapenemase Producing Enterobacteriaceae Isolate (CPE) or E-Coli. There were 23 surgical site infections reported between February 2017 and February 2018, these ranged across a variety of services. Of the overall total of in-patients and day care patients this represented 0.3 %
- Theatre staff adhered to policy and NICE guidance (NICE CG74) during the pre-operative and intraoperative phase of the patient pathway. We witnessed the correct use of sterile drapes, gowns, and antiseptic skin preparation.
- Hand gels were available at the entrance to every department and were easily accessible; we witnessed all staff using the gel on entry to and on leaving departments. Staff on the wards adhered to the infection control policy and wore minimal jewellery; hair was tied back and off the collar. All staff on the wards including reception staff wore clean and tidy uniforms. All staff adhered to the hospital's bare below the elbow policy.
- The hospital participated in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people known as patient assessors, assessing how the environment supported the provision of clinical care. The hospital scored above the national average for cleanliness.

Environment and equipment

- The previous inspection report identified the hospital was showing signs of wear and tear and this had not changed. The hospital participated in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE) and scored below the national average for condition, appearance and maintenance for 2017.
- The pharmacy department was very cluttered and small and staff told us this was a difficult environment to work in. We observed how the work surface was cluttered and bins were overflowing.
- The previous report stated patient rooms had baths and not walk in showers. This had been highlighted as a risk and a refurbishment programme had been in place. However, baths remained in some patient bathrooms. When a patient was identified as unable to use a bath and a room with a shower was unavailable then showers in the day care unit or physiotherapy department could be accessed.
- The ward had resuscitation equipment in an easy to access, visible place however checks were not always completed. The ward had a resuscitation trolley, a

paediatric grab bag and an emergency response bag. The defibrillator had a service due date of April 2018 and was visible to staff. The trolley was sealed with a tamper evident seal to show no one had opened it since its last check. Equipment was checked daily and weekly and logs showed these were mostly completed. The grab bag had four days of checks missing for March but all weekly checks had been completed. The resuscitation trolley had two daily checks missing for March and weekly checks completed and the emergency response bag had five daily checks missing. This meant the team could not always be assured the equipment was complete, in date and safe to be used.

- The theatre department had resuscitation equipment in an easy to access visible area. Daily defibrillator, suction and oxygen checks and checks of the whole trolley were all completed from the 5 March 2018. This meant the team could be assured all equipment was in date and safe to be used.
- The anaesthetic machines had logbooks to document daily safety checks. We reviewed the logbook in one theatre and saw that not all entries were fully completed. There was no entry for the 27 February to the 4 March and dates were left blank. This meant there was no indication if the equipment had or had not been in use, or was safe to use.
- The hospital had an environmental risk assessment, dated 29 January 2014 and due for review in 2019. This identified persons at risk such as employees, young people and visitors, current controls and instructions, and further controls were added for certain areas. These risks were still open and ongoing, however, they were not allocated to any department or staff member. This meant it was unclear who had responsibility for oversight of the risks.
- The servicing of electrical and biomedical equipment (EBME) such as oxygen saturation monitors and blood pressure machines were monitored and recorded on a hospital database. The oversight of which was held at senior management level. An external company had a contract to maintain and service all EMBE. We reviewed the asset spreadsheet, which held the service information for all the hospitals 708 pieces of EBME. The spreadsheet identified all items had been serviced and 190 pieces of equipment were awaiting their planned preventative maintenance (PPM). This was maintenance regularly performed on a piece of equipment to lessen the likelihood of it failing. We were shown email trails of planned visits by the engineer, who sent a spreadsheet listing pieces of equipment which needed PPM. We then saw consequent emails to the heads of departments whose responsibility it was to make sure the equipment was accessible to the engineer. This meant senior teams had a much-improved oversight on the safety of all pieces of equipment at the hospital since our last inspection.
- However, whilst we were assured EBME was serviced the date of the latest service was not always visible on the piece of equipment. We checked ten pieces of equipment all of which had an in-date electrical portable appliance test (PAT) date but none had service dates visible. This meant unless staff accessed the asset spreadsheet they could not be assured the equipment they were using was in date.
- Surgical instruments were well managed on the wards and in the theatre departments. Single use sterile items were disposed of in the correct manner and there were appropriate arrangements for the disposal of sharps to prevent accidental injury or cross contamination. The wards, pre-admission area and theatres had appropriate numbers of properly assembled sharps bins. These were labelled correctly and filled to the recommended level.
- We observed the efficient flow of clinical waste into and out of theatres. Theatres had a dedicated corridor at the back of each theatre so clinical waste could be removed safely and not be brought through the clean theatre.
- The maintenance of the facilities kept people safe and staff worked hard to maintain equipment and their environment to as high a standard as possible. The hospital employed two full time engineers who were responsible for the maintenance and upkeep of all mechanical equipment such as the generators, lifts, nurse call bell systems, back-up generators and medical gases. The engineers worked an on call 24-hour rota system across two sites. The senior engineer explained the monthly testing of the back-up generators, and how this was carried out at a specific time to get a realistic usage of electricity. We reviewed the departmental spreadsheet for all mandatory checks for the month of March 2018 and saw every check had been completed with nothing outstanding.

Requires improvement

Surgery

Medicines

- Medicine systems, processes and practices across the departments overall kept patients and staff safe. The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Theatres and the ward area had suitable cupboards to store controlled drugs. We checked a sample of the entries and stock in the theatre controlled drug record book and saw all stock was correct, and all entries were signed and dated. However, the theatre CD cupboard was not big enough to fit the CD record book inside and it was not therefore securely locked away.
- The recordings of fridge temperatures across the departments were in the main, fully completed. We reviewed checks for the blood fridge in theatres, from 5 March and saw two daily checks were missing and one weekly check was missing. We reviewed the medication fridge in theatre recovery and all checks for February and March were completed. We reviewed the medicine freezer in theatres from the beginning of the month and all were completed. The service had oversight of any incident when a fridge temperature alerted out of range and provided us with the evidence of actions taken when this had happened.
- The Royal Pharmaceutical Society's 'Professional Standards for Hospital Pharmacy' states Medicines should be safely and securely distributed from a pharmacy and . The ward stored all medicines in treatment rooms and medicine trolleys, which were locked and tethered to walls when not in use.
- Staff regularly reported medicine incidents and the hospital conducted investigations to try to prevent recurrence of errors. A recent rise in medication incidents was discussed in the pharmacy department meeting minutes. Seven incidents were reported in February, and it had been decided an external auditor would be employed to help the service focus on how to improve practice. The external auditor was on site during our second unannounced inspection.
- There was a lack of consistency in the safe storage of consumables such as intravenous (IV) fluids across the hospital. The storage of intravenous fluids (IV) on the wards was in line with the Department of Health – Health Building note 14. This stated medicines should be stored securely with clear segregation of medicine types. IV fluids were kept separately from other injectable fluids such as IV Potassium and all were locked away. However, IV fluids in theatres were kept in an open corridor by the changing rooms, which were accessible to other theatre staff or those visiting theatres. The theatre department had a warming cabinet which had IV fluids stored on the bottom shelf. This was not locked and in the main theatre department, accessible to anyone visiting the department
- Patients told us their regular medicines were discussed during their pre-admission appointment and again on admission. We saw medicine histories recorded in 13 sets of patient records. The pharmacy team checked patients' own medicines against the prescription chart and completed medicine reconciliation when they were able. However, due to staffing shortages this was not always prioritised. Medicines reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines from at least two sources. The hospital did not audit medicine reconciliations and so did not comply with National Institute for Health and Care Excellence (NICE) guidance NG5 of completing medicine reconciliation within 24 hours of admission.
- The pharmacy service was understaffed at the time of our inspection. A new pharmacy manager had been recruited who was due to start the following month. Other posts were also advertised. This reduced provision for pharmacy meant the service could not carry out all of the internal audits required or the necessary actions. Although there was a programme of medicine related audits, the hospital did not audit the safe and secure storage of medicines as recommended by the Duthie report and the Royal Pharmaceutical Society's document, The Safe and Secure Handling of Medicines: a team approach (March 2005). Audits completed, such as a controlled drugs audit for the periods of March 2017 to December 2017 fell short for some areas of the hospital standard of 95%. The areas audited were endoscopy, wards and theatres. The performance for storage and management of controlled drugs ranged from 72.22% to 88.24% in theatres.
- The pharmacy department was small, cramped and less than ideal. Staff told us how difficult it was to maintain a

safe working environment, we saw how surfaces were cluttered, and there was no space to work un- hindered by paperwork and computers. The senior management team recognised this was not acceptable and had arranged an external review of the department.

Records

- People's individual care records in theatres and on the in-patient ward were managed in a way that kept them safe. The notes we reviewed were accurate, comprehensive, legible and contemporaneous. Patients' records were stored securely on the inpatient ward in a locked filing cabinet, which had a coded access.
- Patients had pathways for specific procedures, and these were different for in-patients and day case patients. The local anaesthetic pathway for day-case ambulatory patients identified what other documents should be used in conjunction with this pathway. Staff told us this was particularly helpful especially when bank, agency and new members of the team were on shift.
- We reviewed four sets of inpatient records. All had procedure specific pathways, which demonstrated a multidisciplinary collaborative approach to patient care and were well maintained. All documentation was signed, dated, and legible, with clear communication from all team members for example, consultants, nurses and physiotherapists. Fluid charts, where necessary, were accurately completed, all in-patients had risk assessments in place and this included nutritional and pressure ulcer risk assessments. Every early warning chart was accurately completed and scored and when necessary escalated to the nurse in charge. Each pathway included a World Health Organisation (WHO) surgical safety checklist, which had been completed and included estimated blood loss and anaesthetic ASA (American Society of Anaesthesiologists) classifications.
- We checked 13 sets of day case patient records along with their medicine charts and all were clearly written and well presented. Risk assessments had been completed and this included the patient's height and weight and all allergies were clearly documented, along with patient's sensitivities when applicable.

Safeguarding

- Staff followed the systems, processes and practices put in place by the hospital to protect patients from abuse, neglect, harassment and breaches to their dignity and respect. Staff were aware of different forms of abuse.
- The hospital provided staff with a Continuity of Care Pocketbook. This pocket size guide included information / prompts on safeguarding and the top ten tips for safeguarding children
- Staff on the wards told us although they had never needed to raise an alert they were confident about who they would contact and how.
- Staff received mandatory safeguarding training. We asked for the breakdown of all safeguarding training compliance during the time of our inspection, please see below:

Training-Completion percentage

- Safeguarding vulnerable adults level 1- 95% (Hospital threshold 95%)
- Safeguarding vulnerable adults level 2- 88% (Hospital threshold 90%)
- Safeguarding vulnerable adults level 3 - 0% (Hospital threshold 90%)
- Prevent -94%- (Hospital threshold, not provided)
- Female Genital Mutilation- 30% (Hospital threshold, not provided)
- Chaperoning- 37% (Hospital threshold, not provided)
- Safeguarding children level 1 - 93% (Hospital threshold 95%)
- Safeguarding children level 2 - 90% (Hospital threshold 90%)
- Safeguarding children level 3 - 88% (Hospital threshold 90%)
- However, not all staff were completely up-to-date with their safeguarding mandatory training and the hospital provided us with these explanations for falling below their own thresholds.
  - For Safeguarding Vulnerable Adult's level 3, the clinical lead who was new in post had been booked on the external training.
  - For Safeguarding Adults Level 2, the service told us that 31 staff were reported as yet to complete however, 9 were new starters and 2 staff had been duplicated on the report.

Requires improvement

Surgery

Mandatory training.

- We received mandatory training rates for the whole of the hospital. There were 62 mandatory training modules, which covered all members of staff. Not all staff had completed their mandatory training within the timeframes expected by the hospital.
- The lowest completion rates were:
  - Medical gases (executive directors and hospital managers) – 0%
  - Female Genital Mutilation - 30%
  - Safeguarding (chaperoning) – 37%
  - Medicines management- 46%
  - Information governance – 54%
  - Adult basic Life Support (clinical staff)- 58%
- There was no hospital delivered training specifically on sepsis, this was included in the yearly deteriorating patient mandatory training module. However staff were aware of the hospitals sepsis policy, and could talk us through how they would escalate should a patient trigger specific scores on their early warning scoring system. We saw posters displayed around the wards to alert staff to sepsis. Whilst the training rates for Care and Communication of the Deteriorating Patient course was 21% at the time of our inspection, the hospital explained that in 2017 training transferred from the three yearly Acute Illness Management (AIMs) course to yearly Care and Communication of the Deteriorating Patient course. The service was in the progress of transitioning their staff over to this and training completion rates for all staff for the previous AIMs course was 86%.

Assessing and responding to patient risk

- The hospital identified and responded well to the changing risks to patients, including deteriorating health and wellbeing, medical emergencies and challenging behaviours.
- Staff in charge of departments attended the daily communications meeting held by the senior management team. The day's concerns, operational and patient risks, incidents and staffing concerns were discussed, and then communicated across all departments. Staff praised this method of communication and told us how it helped them understand pressures in other areas. During our inspection, flow in theatres was compromised due to sickness, the communication meeting enabled ward staff to understand theatres were not working at full capacity.
- A resuscitation meeting was held in the morning and evening and we were told these were well attended. We spoke with the resident medical officer (RMO) who assured us attendance was mandatory. We attended one resuscitation huddle and saw how patient issues, risks and roles were clearly defined for the day ahead. Pagers were tested and those patients who were not for resuscitation were identified.
- There was a hospital -wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response, including arrangements for the urgent provision of blood in cases of life threatening haemorrhage. All patients admitted were continually assessed using the National Early Warning System (NEWS). This was based on a simple scoring system in which a score was allocated to physiological measurements undertaken when patients were being monitored in hospital. We checked eight set of NEWS scores and saw scoring was entered correctly, actioned and documented appropriately.
- Emergency defibrillation scenarios were carried out for staff on the wards and outpatient areas. We saw evidence of how after a staged child cardiac arrest poor performance was identified and addressed with the staff member. This was discussed at senior level and all actions were documented.
- Key protocols and guidance were displayed for staff to see on the wards and in the theatre department, which included emergency transfer procedures, local toxicity for local anaesthetic management and sepsis management.
- Patients were cared for by their consultants and a 24-hour resident medical officer (RMO). The hospital had a 24-hour on call anaesthetic rota and 24-hour access to a microbiologist. The ward held a folder with all phone numbers of consultants, microbiologist and anaesthetists. Staff told us contacting out-of-hours (OOH) consultants was never an issue. Consultants were

on call for their patients and if they were unavailable, for example on leave, then alternative cover was arranged. This was arranged well in advance, communicated to staff and information logged in the OOH folder.

- If a patient, deteriorated and required emergency transfer to the local NHS trust staff would call the local emergency ambulance via 999. We asked if there was an up-to-date service level agreement but were told this was in the process of being updated. The hospital had a draft version but this had yet to be signed off by all parties. This had been entered as a moderate risk on the hospitals risk register and it was documented this may have an effect on using the services and there was a risk additional costs may be applied to the hospital. This was due to be reviewed in July 2018.

World Health Organisation (WHO) surgical safety checklist

- During our last inspection, it was identified staff in theatres were not fully completing the surgical safety checklist. During the latest inspection, we observed good practice amongst different theatre teams in completing all the steps of the World Health Organisations (WHO) surgical safety checklist. Each theatre held a team safety briefing prior to the start of the morning theatre list. We observed three such briefings where all the team introduced themselves, discussed equipment, anaesthetic choices and risk factors associated with a patient's operation. Staff felt the safety briefing enabled them to deliver safe care and treatment to patients, as they were aware of potential issues at the start of their list. They felt this enabled them to be proactive rather than reactive as they knew what potential steps would need to be taken for each patient.
- We observed four operations where we saw good practice across different theatre teams in completing all the steps of the checklist. This included, sign in, time out and sign out. We reviewed thirteen sets of notes for both in-patient and day-case patients. For day-case patients please see the medical, well led domain of this report. All sets of notes reviewed for inpatient stays contained a paper version of the WHO surgical safety checklist and this corroborated what we saw in the theatres. All steps were signed for and completed and included information on estimated blood loss and the American Society of Anaesthesiologists (ASA) classification level.
- Although the theatre staff reviewed the safety of care and treatment through local audit of the World Health Organisation's (WHO) surgical safety checklist, the senior management team carried out a secondary internal audit summary report which questioned the 'robustness of the BMI Healthcare WHO audit tool'. During this inspection, we reviewed four quarterly secondary WHO checklist audits where the service continued to identify issues with compliance. Issues were highlighted in February 2018 and discussed in the clinical governance meeting. The minutes recorded that a champion was identified to address continual poor practice. During our observations and checks of records, we were assured significant improvements had been made in the implementation of the surgical safety checklist.

Nursing and support staffing

- The hospital worked hard to ensure there were safe levels of staffing and used a planning tool to optimise levels of staffing across the wards and in theatres. This tool was used to plan staffing ratios and worked approximately on one nurse to six patients. However, staff told us it did not reflect the acuity of their patients and did not provide enough flex when the unexpected happened, therefore when the unexpected did happen extra nurses were employed often via an agency. The senior management teams recognised this and how vacancy rates (the numbers they were allowed to recruit) did not reflect the true need of the hospital. This had been recognised, challenged but remained the norm for the service as a whole. This risk was the highest risk on the hospitals risk register and when we reviewed the ward agency hours for March in comparison to vacancy rates, it was clear more agency was used to maintain patient safety and fluidity of the service, then the vacancies reflected. We reviewed the vacancies against the funded establishment figures, which showed minimal requirements, and this did not reflect what staff told us or the amount of agency used.
- Staffing ratios did not always meet the AFPP guidelines, which state there should be one per patient for the immediate postoperative period. Staff told us staffing ratios on the recovery area were not always adequate. During the inspection, we saw how one nurse was

recovering a patient from an anaesthetic, caring for another patient and trying to hand another patient over to a ward nurse. An agency nurse was on shift but had left the recovery bay during this time.

- Staff told us they found transporting patients to and from theatres a challenge. We saw staff refuse to collect a patient and at the same time refuse to bring a patient down to theatres because it would have left one registered nurse to 20 patients on the ward as other staff were off the ward at that time. Theatre flow was delayed for a short period of time. Staff told us this was a regular occurrence and the tool used by BMI did not reflect the reality of ward pressures.
- Arrangements for handovers and shift changes ensured patients and staff were kept safe. We observed one ward handover, which was clear and concise and lasted approximately ten minutes. Staff were allocated their patient caseload prior to the handover starting and this reduced surplus conversation. Within this, the daily communication meeting was discussed and this covered any day issues the hospital might experience, such as short staffing in theatres.

Medical staffing

- Surgery services were consultant delivered and led. The hospital had 24-hour medical cover by a resident medical officer (RMO). The RMO worked one week on and then handed over to another RMO for the following week's cover. Handover was pre-arranged from one RMO to another within plenty of time.
- Patient care was consultant led and consultants were on call for their patients during the inpatient period. Should a consultant be away, alternative cover was pre-arranged and handed over to ward staff. Staff told us that consultants were readily available during night shifts and weekends should the need arise.
- Handovers to the RMO happened from nurses during the resuscitation meetings and the evening handover. The RMO received no handovers from the consultants, unless there was a specific problem.

Emergency awareness and training

- The previous inspection report highlighted gaps in the business continuity plan, for example, a lack of action cards for an outbreak in infection/pandemic, loss of security systems. These had been put in place at this inspection, and were succinct and easy to follow.
- The fire officer for the hospital carried out a yearly fire lecture and a rolling safety programme. A member of the senior management team had a rolling programme for emergency scenario response such as water outage, and lift outage. A live evacuation was scheduled every three years and we saw the attendance register from the last scenario, which had been carried out in June 2016.

Are surgery services well-led?

Requires improvement

Vision and strategy for this core service

- The hospital had a clear vision and a set of values, which had quality and safety as a priority. The vision for the hospital was in line with what the senior staff told us, this was:
  - Efficiency and quality, the best outcomes for all their patients
  - Fair treatment for all and the best patient experience
  - Individuality of care
  - The importance of valuing staff.
- The hospital had a robust and realistic strategy for achieving its goals. The hospital business plan for the year of 2017-2018 reflected the strategic priorities and key successes for this period. Successes included the implementation of the BMI NHS fee structure on the Consultant body, which brought fees for NHS consultants in line with NHS parameters.
- Staff we spoke with all understood their role in achieving the hospital's vision and strategy. Staff told us they had an option to attend a yearly meeting around the values, projections and strategy of the hospital and BMI corporate wide.

Leadership / culture of service related to this core service

- There were a number of absences due to short and long-term sickness in the theatre team. This was a major concern for the senior management team (SMT) and resulted in the cancellation of two operations during our inspection. The CQC had been contacted anonymously about concerns of increased sickness rates, leadership and increased agency use. Staff told us this had been ongoing for a considerable time.
- We discussed these issues with the senior management team (SMT); although they recognised the challenges to the service, they had previously not addressed the human factors, which compromised the efficient running of one of their departments. They told us with the help of a new director of clinical services, in post since January 2018, issues such as performance and sickness had started to be addressed. Plans were being put in place to work alongside senior staff in the theatre department to offer the support needed to manage a challenging department effectively. The new director of clinical services alongside the SMT talked candidly about the issues within the department. Unfortunately, these issues had not been managed effectively for a considerable amount of time and after our first unannounced inspection, the theatre manager resigned not returning to work their notice.
- The SMT were in the process of managing this challenging situation and shared with us their interim plans. These included the support of those deputising in the absence of the theatre manager and having a dedicated staff member to help run the theatre floor. A workshop was chaired by the director of clinical services for the theatre department and we were told some very helpful, honest and open discussions took place. Ideas that came out of this workshop were being assessed and potentially being incorporated into the future running of the department
- Senior ward staff had the skills, knowledge, experience, integrity and the capability to lead effectively. Staff in all the department's reported they felt listened to and supported by the new director of clinical services. Staff across all departments mentioned a change in the culture of local senior management and all identified the new clinical lead was approachable, knowledgeable and available. The senior management team (SMT) were visible and all staff knew the names of the team. Staff said the SMT recognised staff on the wards and in theatres and knew them by their names. One staff member gave an example of how the SMT recognised those who went above and beyond their duties and were sought out and thanked.

Governance, risk management and quality.

- The hospital had a governance and risk management structure to support their delivery of care. We saw how the flow of information from the senior management team cascaded through the departments.
- We reviewed meeting minutes from the Clinical Governance Committee, Medical Advisory Committee, Children and Young Person's Governance Committee, Head of Departments meeting and theatre departmental meetings. All followed a standard agenda and were laid out in a clear and easy to follow format with incidents and risk featuring as standing agenda items across all meetings. It was clear how information flowed from senior level through to all departments.
- Staff on the ward corroborated this and told us risk and incidents were always discussed at team meetings, and key issues would be displayed in the staff room. Whilst staff reported occasionally team meetings were cancelled they were generally well attended. Staff on the wards reported communication around incident and risk had improved over the last few months and all were positive about the daily communications meeting.
- The clinical governance group met monthly and was attended by the senior management team and heads of all departments. It was this forum, which was responsible for reviewing surgical procedures and this was included as a standing agenda item. We saw in the meeting minutes how the implementation of new techniques and equipment were discussed and decisions made.
- The hospital used assurance systems and service performance measures, which were reported on and monitored. The hospital had an audit dashboard and the ability to compare their performance to other hospitals across BMI. Audit, results and action plans were discussed at the monthly clinical governance and heads of department meetings and audit results were embedded in the meeting minutes.
- In the previous inspection, we found a disparity with the audit of the World Health Organisations (WHO) surgical

safety checklist and the paper records. The audit claimed 100% compliance but paper records were only completed 70% of the time. The hospital continued to monitor this and carried out a further level of audits to ensure perceived compliance reflected actual performance. We reviewed eight sets of notes, which documented full completion of the checklist, and this was corroborated with practice we observed in the main theatre department.

- Employees who were involved in invasive procedures in the theatre department carried out good safety practice, as set out in the National Safety Standards for invasive procedures (NatSSIPs). The main theatre department used the WHO surgical safety checklist, which re-enforced safety processes such as, identifying patient and procedure and fostering open communication. However, as the checklist was only a lever to prompt safer behaviour, NHS England recommended organisations that provided NHS-funded care should consider creating local safety standards for invasive procedures (LocSSIPs). The hospital did not at the time of the inspection have a group which covered all invasive procedures including those performed outside of the operating department. However, they were developing their own set of local safety standards and these included the locking down of theatre lists a week prior to the operation date.
- There were clear processes for recruitment and for engaging all consultants under practising privileges, including those carrying out cosmetic surgery and surgical first assistants (registered healthcare professionals who provide continuous assistance under the direct supervision of the operating surgeon, whilst not performing any form of surgical intervention).
- There were 132 consultants engaged via practising privileges. There was a comprehensive system for approving and renewing practising privileges in the hospital and clear records in place to support this. The hospital had an electronic system with all the information required for consultants to practice. A tracking system was in place to show conversations and communications with consultants and their NHS trust. We reviewed five sets of consultant records and saw their latest appraisal information, indemnity arrangements, safeguarding training proof of identification, their responsible officer, curriculum vitae and the dates when all of this was due to expire. An electronic system alerted the team when a specific area was due for renewal. Copies of biennial reviews were also kept in these folders and we saw copies of conversations and scope of practice discussed during these meetings with the Executive Director.
- The previous inspection report highlighted how the hospital action tracker was unwieldy and difficult to use, the hospital had since replaced this with a live risk register. Risks were current and up-to-date and we saw there was an alignment between the recorded risks and what people said was on their worry list, for example staffing, fire dampers currently being installed, investment and refurbishment.
- During our last inspection, the hospital did not have an in-date service level agreement with the local NHS Trust. A service-level agreement (SLA) is the commitment between service provider and client where particular aspects of the service such as quality, availability and responsibilities were agreed. The hospital still did not have an in-date SLA, but an updated version at draft level. There was a risk, potential additional costs might be incurred from the trust and this was recorded on the risk register. Senior staff told us this was in the process of being completed and the register had a review date of July 2018.

Public and staff engagement

- Staff could attend local departmental meetings, and the daily communications meeting. Committees such as the Health and Safety Committee held monthly meetings and then had subcommittee meetings for example, the Water Safety Sub Committee.
- The hospital had a quarterly newsletter called the 'Ridgeway Read', which was 'for the staff by the staff'. This had details of local events, hellos to new members of the hospital team, staff lottery and BMI Perks.
- Minutes for all meetings were easily accessed, not only emailed to teams but also for example in the housecleaning department displayed for ease of access. Meeting minutes were displayed in the management offices.
- The 2017 BMI staff survey (BMiSay) was carried out by an external agency. Overall measures were lower than the 2016 survey. The hospital analysed the results showing

key strengths and areas for improvement, and shared plans for improvements with the staff. One example of where the service fell short was staff morale and the survey highlighted an introduction of a new employee recognition scheme.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The risks to the hospitals sustainability were identified in the 2017-2018 business plan and carried through to the risk register. Key areas for growth were identified and this included services for foot and ankle and gynaecology services.
- The hospital ran therapy days for patients recovering from breast cancer treatments. A range of treatments such as aromatherapy, reflexology and hot stone massage were available. A free treatment was available for all on the day and further treatments were offered at a reduced cost.

Requires improvement

Services for children and young people

Safe	Requires improvement
Well-led	Requires improvement

Are services for children and young people safe?

Requires improvement

Incidents

- There was one incident in relation to children and young people (CYP) between the periods of April 2017 to March 2018. This involved a child being seen accidentally by a general surgeon, this was booked by the main call centre during an extremely busy period. The service shared the action plans with us to ensure this did not happen again.
- Staff we spoke with could explain the incident reporting procedure and told us the different ways they received feedback.
- Staff we spoke with from all levels of the organisation had an understanding of the duty of candour, when they would use it and the actions they would take. Duty of candour (DOC), Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service added duty of candour incidents to their incident tracker from February 2017 to February 2018.There had been no incidents in relation to children where the duty of candour had been applied.

Cleanliness, infection control and hygiene

- Systems and processes were in place to protect patients and staff from healthcare associated infection, staff working with children and young people adhered to these practices. We saw how staff in the clinic decontaminated their hands in line with the World Health Organisation's five moments for hand hygiene and NICE guidance (QS 61 statement three). This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.
- Hand gels were available at the entrance to every department and were easily accessible; we witnessed all staff using the gel on entry to and on leaving departments. Staff in the clinic adhered to the infection control policy and wore minimal jewellery; hair was tied back and off the collar. All staff, including reception staff, wore clean and tidy uniforms. All staff adhered to the hospitals bare below the elbow policy.
- Age appropriate toys were made available for children. We reviewed the environmental risk assessment and saw when the department was open cleaning of the toys had taken place daily for the whole of March 2018.

Environment and equipment

- The design and maintenance of the department kept children, young people and young adults safe. Age-appropriate care was provided in dedicated environments that meet their specific needs. All inpatient beds accessed by children aged 16 years and above were in separate rooms with en-suite facilities.
- All paediatric clinics for children aged three to 12 years were held in dedicated clinics in the physiotherapy department. This ensured a quite area away from adults where children could play safely with age appropriate toys. All children aged 12 years onwards were seen in the outpatient's department.
- Checks were detailed on a daily environmental risk assessment and this included making sure, the treatment room door was kept locked at all times, windows had restrictive openings on them and plug sockets had covers in place and a hot water sign was visible on the drinks machine. The drinks machine was in the general outpatient's area and children who had appointment's here were aged 12 and above. We reviewed the checklist for the whole of March 2018 and saw all checks were completed.

- The children's clinic area had appropriate numbers of properly assembled sharps bins. These were labelled correctly and filled to the recommended level, daily checks were made and documented these should not be over three quarters full.

Medicines

- An emergency drug box for use in the outpatient's department contained paediatric medicines. This was sealed and dated and located on a dedicated paediatric resuscitation trolley next to the physiotherapy department. The daily environmental risk assessment required all staff to be aware of its location.
- For our detailed findings on medicines, please see the safe section in the surgical report.

Records

- Staff showed us where patient records were kept and this was in a lockable room. When a child/ young person arrived in clinic their records were brought out of the locked room and given directly to the consultant.
- We reviewed seven sets of notes for children and young people attending the clinics. These were clear and concisely written, all risk assessments were fully completed including height and weight and all entries were signed and dated with GMC numbers included where necessary.
- Audits were completed on children and young people admissions (aged 16 years and above). This included height and weight and if all the risk assessments were completed. Out of five children and young people admission notes audited, four risk assessments had been fully completed. The results of the audits were discussed at the CYP governance meeting and a reminder sent out to staff on the daily communications meeting to complete all assessments.
- There were no children and young people undergoing any surgical procedures at the time of our inspection.

Safeguarding

- Systems, processes and practices were in place to kept children and young people safe. All the staff we spoke with demonstrated a good understanding of the hospital's safeguarding policy and what they would do should they have a concern. Staff were provided with a Continuity of Care Pocketbook. This contained details on safeguarding, responsibilities of the practitioner and the top ten tips for safeguarding children.
- Since our last inspection, the hospital required all staff who had involvement in assessing and planning care for children and young people to be trained to level three safeguarding children. This was in line with the intercollegiate document, Safeguarding children and young people: roles and competencies for health care staff (Royal College of Paediatrics and Child Health, 2014) Young people were defined in this document as those who have not reached their 18th birthday.
- The majority of staff across the hospital had completed this training however, the completion of mandatory safeguarding training was not completely up to the hospitals targets:
- Safeguarding children level 1 - 93% (Hospital threshold 95%)
- Safeguarding children level 2 - 90% (Hospital threshold 90%)
- Safeguarding children level 3 - 88% (Hospital threshold 90%)
- Female Genital Mutilation- 30% (Hospital threshold, not provided)
- Chaperoning- 37% (Hospital threshold, not provided)
- The senior management team (SMT) had oversight of training compliance and had communicated the shortfalls in training to the heads of departments. The SMT told us that Safeguarding Children Level 1, had 18 staff yet to complete, however five staff were new employees and two staff were duplicated on the report. Safeguarding Children Level 3, had nine staff yet to complete however, two staff were new employees.
- In compliance with national guidelines, all non-clinical staff who came into contact with children and young people were required to complete safeguarding training. All the reception team had received training to level one and two in safeguarding children, and all training was in date.
- The hospital had a lead paediatrician who saw children and young people from three years upwards and was trained in safeguarding level two, and three. The ten

consultants who had children and young people's practising privileges (CYPPS) and saw children aged 12 and upwards were also trained to level two and three. We saw all of their training was in date.

- There was an organisation chaperoning policy, which applied to both adults and children, in line with the organisation's safeguarding adults and children policies, however this had only been completed by 37% of the required staff.

Mandatory training

- The environment and skills of the staff must be appropriate to the needs of children. Therefore, all staff should be trained in paediatric life support – a basic life support course with yearly update (such as the paediatric intermediate life support course or EPLS course). The hospital required all consultants with children and young people's practising privileges (CYPPPs) had an in date, paediatric basic life support (PBLS) and paediatric advanced life (PALS) support qualification. The 11 consultants who worked at the hospital with CYPPPs all had up to date training in PBLS and PALS. The resident medical officer (RMO) file showed evidence of up to date European Paediatric Advanced Life Support training (EPALS).
- However, mandatory training for other staff in paediatric basic life support (PBLS) and paediatric immediate life (PILS) support was poor, with completion rates for PBLS of 71% and PILS 67%. This meant not all staff received effective mandatory training in the safety systems processes and practices essential for the service.
- According to the standards set by the Royal College of Nursing, defining staffing levels for children and young people, registered staff must have completed a course of training specific to their setting. In the care of children and young people they must have undergone a period of competence assessment in effective communication, pain management and recognition of the sick child before carrying out care and delegated tasks. The previous report, highlighted the lack of a competency framework to ensure registered adults nurses and other clinical staff had appropriate skills to work with children and young people. The hospital employed a paediatric nurse who worked once a week during clinics held for ages three to 12 years. As clinics were regularly scheduled for children over the age of 12 it meant staff in outpatients, diagnostic imaging and physiotherapy had contact with children. However, these staff groups did not have their competence to work with children assessed.
- To mitigate the risk of this, teaching and training programmes were developed by the lead paediatrician and the paediatric nurse specialist for clinic staff. However, these had not commenced during our inspection but had been planned and we were supplied with dates for these future training sessions.

Nursing staffing

- Children and young people aged three to 12 years were assessed in clinic by staff who had the right knowledge and skills, to meet their needs. Clinics were held once a week by a paediatric consultant with practising privileges for this age range of children. The hospital employed a paediatric nurse once a week to attend and chaperone these clinics in line with the Royal College of Nursing, defining staffing levels for children and young people's services standards.
- Interventional services (phlebotomy) offered to children aged 12 and above were only carried out when a paediatric nurse was available and in the building to assist and chaperone. However, the paediatric nurse did not assess all the children aged 12 and upwards, Staff in the outpatient's department risk assessed this age range of children but they did not have paediatric competencies. The RCN standards state that a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children. The hospital were aware of this and had developed a training programme to mitigate this risk, however this had not started during the time of the inspection.
- Registered children's nurses were not employed in theatres or on the wards. Children who were operated on were aged 16 years and above and risk assessed at pre-admission to see if they were suitable for the adult pathway. Criteria included the patient's age, no additional pre-existing health conditions and the patient's minimum weight and height must be 40kgs and 1.45m. Staff in theatres and the ward areas who

cared for children and young people had not had their competence to work with children assessed. However, the hospital told us that throughout their stay a paediatric nurse was available for advice.

Medical staffing

- There were 11 consultants who offered children's services which included specialities such as dermatology, ear nose and throat, ophthalmology, audiology, spinal services and urology. The hospital employed one paediatric consultant who had children and young person's practising privileges and was the only consultant able to see and treat children aged three and above. All other consultants at the hospital had children and young person's practising privileges for children aged 12 and upwards at the hospital and within their substantive post at a local NHS trust.
- The hospital told us that as part of the annual appraisal process, a listing of all procedures performed at BMI Hospital was reviewed by the appraiser. This was to ensure that the consultants with practising privileges were only carrying out procedures that fell within their scope of practice in their substantive roles. Only consultants practicing at the local trust where the consultant paediatrician was employed were granted practising privileges for paediatric patients.
- All of the surgeons and the paediatrician who cared for children and young people had up-to-date safeguarding and an in date biennial review of their practising privileges.
- However, at the time of our inspection, anaesthetist's who operated on children assessed as suitable for the adult pathway (aged 16 and above) did not have children and young people's practising privileges.

Assessing and responding to risk

- A pre-admission risk assessment for children and young people was used to assess a young person's suitability for care under adult services. We saw audits checking the completion of these risk assessment and actions identified when not completed.
- An emergency response team was available 24-hours a day, seven days a week, and consisted of four members. The hospital's adult and children resuscitation procedure set out the following training requirements for the emergency response team:
  - The resident medical officer trained in advanced life support and European paediatric life support (EPLS).
  - Two registered nurses trained in immediate life support and paediatric basic life support
  - The fourth member of the emergency response team: a registered nurse with immediate life support, or a health care assistant with basic life support and paediatric basic life support training.
- During our last inspection the hospital had an out of date service level agreement (SLA) with the local NHS Trust for the emergency transfer of a deteriorating but this was only for adults. The hospital provided us with a copy of a new SLA, dated 1 April 2017 which included paediatrics, however this remained in draft form and had not yet been signed by both parties. The hospital was aware this was outstanding and had identified this on the risk register.

Emergency awareness and training

- Emergency scenarios were practised at the hospital and these included emergencies involving children and young people. In the minutes of the clinical governance committee meeting, we saw how a recent child resuscitation scenario had not gone as well as would have been expected. Performance was discussed and the minutes identified what actions were going to be implemented to improve performance.

Are services for children and young people well-led?

Requires improvement

Leadership and culture of service

- Staff who led the children and young people's service had the skills, knowledge, experience and integrity to lead effectively. There was a designated children's lead who reported to the board and was responsible for managing the quality assurance of the service. The paediatric consultant had strong links with the local NHS trust.
- Leadership of the service was organised and led by the director of clinical services. The consultant paediatrician supported the service and had safeguarding training

level three. This covered children and young people from the ages of three up to midnight on their 18th birthday. This was the only consultant able to treat children from three to 12 years in the outpatient department and spoke passionately of improvements planned and made since the last inspection. Some of the key changes in progress were representation of children and young people's services during the medical advisory committee, the development of (but not yet commenced) a teaching programme which was for registered nurses to gain competencies in caring for children and a child and young person's strategy.

Vision and strategy for this core service

- During the last inspection, it had been highlighted there was no vision and strategy for the children's service. In September 2017, a manual of objectives and strategic priorities for children and young people was produced. This included areas for development such as outpatient's department, staffing, consent and pre-assessment. Monitoring of key performance indicators was also included in this document and included safeguarding incidents, of which none had been reported during the reporting period, and the patient satisfaction survey, recently introduced. In conjunction with this manual was a policy, which had been developed in September 2017.
- The business plan identified the re-introduction of the paediatric services was completed in a controlled and compliant manner. We saw how this had been achieved in some areas by the improvement in the oversight of the service evidenced by regular governance meeting minutes. Safeguarding training had also been a priority and introduced for all the relevant staff since our last inspection in 2016. However, services had been re-introduced before registered nurses who cared for children from 12 to 18 years in the outpatients, theatres, recovery and the wards had completed the in-house training competencies. The hospital had dates planned but this had not been started during the time of the inspection.

Governance, risk management and quality measurement

- Staff were clear about their roles and understood what they were accountable for in the delivery of children and young people's services. Since the last inspection, the service had developed better governance structures and improved quality measures for children and young people.
- We reviewed three sets of children and young people's clinical governance meeting minutes and it was evident the children and young people's services had exposure to senior members of the hospital team. The executive director, governance lead, director of clinical services and the consultant paediatrician were standard attendees.
- The format of the children and young people's governance meetings was clear and easy to follow. Standing agenda items included audit, new legislation and policy, risks and training. Actions and reviews of actions were documented with dates and the initials of those accountable. There was a clear correlation of what was on the risk register and what staff said was on their worry list.
- The paediatric consultant also attended the medical advisory committee (MAC) meetings as a paediatric representative. There was a clear correlation between risks and issues discussed at the MAC, and the governance meetings to ensure messages were cascaded across all departments. The head of departments meeting minutes also included audit reports from the children and young people's services. Audits completed for children aged 16 -17 years of age included if height and weight were recorded, risk assessments completed, who the patient was discharged home with and if the patient episode had been reviewed at the children and young people's governance committee.
- At the time of the inspection the children and young people's, governance committee did not audit all their children and young people's services and this was identified in the minutes as an action. Part of the first wave of new audits was patient satisfaction the first having been completed in March 2018. This assessed waiting times, friends and family recommendation, the ease of the booking process, and discussions around medical history and medications.
- However, the hospital's current audit calendar from February 2017 which was provided to us as evidence was not up-to-date and stated the hospital were not

treating paediatrics at this time. Whilst we were provided with separate evidence staff had the correct disclosure and barring service (DBS) checks to treat children and specialist paediatric advice was available at all times, this was not reflected in the overall safeguarding section of the audit calendar.

Public and staff engagement

- The hospital had recently commenced a hospital satisfaction survey, which included questions such as time to discuss children's medications, the opportunity to ask questions, and the child's medical condition was fully explained. The first set of results showed a high satisfaction rate.

Innovation, improvement and sustainability

- The hospital business plan stated since the hospital stopped their children and young people's service there had been a negative reaction from the public and the local community. Whilst the hospital said, the service was not a major business driver for the hospital, due to the negative response to the cessation of services it decided to continue offering the service to the local community. The hospital improved their governance structure and safeguarding training to enable a safer service to the local communities.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff are fully involved in checking patients prior to starting any treatment, in line with the World Health Organisation's surgical safety checklist.
- The provider must ensure that there are systems and processes in place to monitor the safety of the services provided.
- The provider must ensure all staff comply with infection control policies and procedures.
- The provider must continue with the refurbishment and carpet replacement programme to ensure infection control compliance
- The hospital must ensure there is an in-date service level agreement for the emergency transfer of patients to the local NHS trust, signed by all parties and to include children and young people.
- The provider must ensure all staff are up to date with their mandatory training to meet the thresholds of the service.
- The provider must review the storage of IV fluids in the theatre department.
- The provider must ensure all staff involved with the treatment and assessment of children have the qualifications, competence, skills and experience to do so safely.

Action the provider SHOULD take to improve

- The provider should consider ways in which mortality and morbidity information feeds into service development.
- The provider should consider how it assures itself of the competence of anaesthetists when treating children and young people.

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 Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Regulation 12 (1)(2)(a)(b)(c)(h) 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; h. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated The service must ensure all staff are involved with the surgical safety checklist and the appropriate checks are completed prior to patients receiving medication. The service must ensure that all theatre staff adhere to infection control policies and procedures. The provider must continue to remove and replace the carpets in clinical areas and bedrooms

This section is primarily information for the provider

Requirement notices

The service must ensure that those registered adult nurses and other clinical staff who may be required to care and assess children and young people have the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance Regulation 17 (1) (2) (a) (b) (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The provider must ensure that there are systems and processes in place to monitor the safety of the services provided

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing.

Regulation 18 (1)

1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

The provider must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff in the theatre recovery to make sure that they can meet people's care and treatment needs and therefore meet the requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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