BMI The Ridgeway Hospital

Quality Report

Moormead Road, Wroughton, Swindon SN4 9DD
Tel:01793 814848
Website: www.bmihealthcare.co.uk

Date of inspection visit: 19, 20 and 29 April 2016
Date of publication: 06/09/2016

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Ridgeway Hospital is an independent hospital and part of BMI Healthcare Limited. It provides care and treatment to both privately-funded patients, and to NHS patients, which is free at the point of use.

The hospital provides surgery, medical care, including oncology, outpatient and diagnostic services, and some limited privately-funded services to children and young people. Specialties include general surgery, orthopaedic surgery, ear, nose and throat procedures, gynaecology, haematology, oncology treatment, ophthalmology, oral and maxillo-facial surgery, reconstructive and cosmetic surgery, podiatry and urology services.

The hospital has an outpatient department, which includes diagnostic and screening services, including an open MRI scanner. There is a large physiotherapy department, which includes a hydrotherapy pool and fully equipped therapy gymnasium.

There are 49 beds, of which 34 are for inpatients, 12 for day-case patients, and four within the oncology suite – the Webster Suite. There are three operating theatres, each with their own anaesthetic rooms, and operating from 9am to 9pm on Mondays to Fridays and 9am to 6pm on Saturdays.

We carried out a comprehensive announced inspection of The Ridgeway Hospital on 19 and 20 April 2016, and an unannounced inspection on 29 April 2016.

We inspected and reported on the following four core services:

- Medical care
- Surgery
- Services for children and young people
- Outpatients and diagnostic imaging

The overall rating for BMI The Ridgeway Hospital was requires improvement. Our key findings were as follows:

Are services safe?

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

We rated safety overall as requires improvement:

- The surgical safety checklists were not fully completed at all times, and this had not been identified by the hospital's routine audit.
- There was a lack of assurance of the servicing and maintenance of surgical equipment.
- Some entries in patient records, including within prescription charts, were not legible or fully completed.
- The hospital was mostly clean and infection control protocols followed. There were, however, some dusty areas in the recovery room. There was some inattention from staff required to be bare below the elbow in clinical areas. Some areas of the hospital were showing signs of age and wear and tear and cleaning made more difficult as a result.
- Not all clinical staff who had a degree of contact with children were trained to the appropriate level of child safeguarding.

However:

- Staff acted upon the principles of the duty of candour. They were open, honest, and would apologise to patients when things went wrong.
- The majority of staff were trained to recognise and respond to suspicions of abuse of vulnerable people. Not all staff who had some degree of contact with children were trained to the appropriate level. The director of nursing had the overall responsibility for safeguarding people, and was trained to the appropriate level.

Summary of findings

- There was a good culture of incident reporting among the staff, and learning from adverse events. However, the reporting system for staff to record incidents was still paper-based. Incidents were transposed to a database for analysis and this double-entry was inefficient.
- There was a safe level of both nursing, medical staff and support staff, with a good mix and range of skills and experience. The hospital had a resident medical officer available 24 hours a day, every day. There was minimal use of agency staff and a regular team of bank staff to fill vacant shifts.
- There were almost no hospital-acquired infections.
- Patient care was safe, and there was no avoidable harm to patients. Staff recognised and responded quickly to any deteriorating patients.

Are services effective?

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

We rated effectiveness overall as good.

- There were good outcomes for patients, with most on a par with the NHS and some slightly better.
- There was pro-active care and programmes to increase patients' chances of an enhanced recovery from orthopaedic surgery.
- The oncology operational policy had been devised by a member of the oncology team at The Ridgeway Hospital and was to be shared across the organisation.
- Patients gave valid informed consent where they were able to do so. There were assessments and procedures following legal requirements for patients who might have reduced mental capacity to make their own decisions.
- The hospital participated in relevant national audit and research programmes.
- There were minimal unplanned readmissions and inter-hospital transfers in an emergency.
- There were low levels of surgical site infections.
- There was an active programme of revalidation for nurses, and the hospital monitored all aspects of employment and practising rights for medical staff. These were up-to-date.
- There were appropriately trained staff to safely care, treat and provide support for children.
- The hospital provided evening outpatient appointments and diagnostic imaging was available seven days a week.

However:

- The hospital employee system was not able to provide accurate data for employed staff appraisals, and some departments were consequently showing poor results. This had been recognised in the hospital's risk register.
- The endoscopy unit did not meet the Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation.
- There was no skill set against which to assess staff working with children.

Are services caring?

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

We rated caring overall as outstanding.

- There was a strong patient-centred culture. All staff across the hospital were highly motivated to provide the best care and to patients, and this was highly valued by patients, staff and the leadership.
- Patients were given care and compassion that treated them as individuals, and respected and protected their human rights, including their privacy and dignity. All staff had empathy and understanding, and were supportive and positive.
- There was a high level of patient satisfaction with the service, including the Friends and Family Test results. All the feedback we received from patients about their care and support was positive and highly complimentary.

Summary of findings

- There was good emotional support for patients, particularly when they were anxious or nervous. Staff recognised and responded to these patients with understanding, compassion and kindness.
- The hospital respected patients had different needs. People were treated as individuals and the care they were given took account of their culture, religious, social and personal needs. All the staff wanted patients to have care that exceeded their expectations.

Are services responsive?

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

We rated responsiveness overall as good.

- Services were planned to meet local needs and provide timely and convenient independent medical care to both private and NHS patients.
- People were treated as individuals. This included taking time to support people living with dementia and meeting different levels of need.
- There was good physical access to and around the hospital for patients and visitors.
- Good bed management led to few cancelled or delayed operations. Surgery services met most referral to treatment times (monitored for NHS patients).
- The hospital was commissioned and established to treat non-emergency patients and provide elective medical and surgical services. Within this, there were no exclusion criteria for patients.
- There was an appropriate response to complaints, and all staff made aware of any comments, including compliments or criticism from patients and visitors. There was learning and action taken from any complaints or negative comments.

However:

- Patients and visitors reported issues with a lack of available parking spaces at busy times.
- Some patients reported finding the hospital noisy during the night.

Are services well-led?

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

We rated well-led overall as requires improvement.

- There was a detailed strategic vision for the hospital, although the key risks did not flow through the strategy or the future plans. Children and young people were not included in the strategic plan.
- The governance work did not show how audit work and the risk register were delivering improvements in safe and quality care. There were gaps in the audit work that meant some issues were not being picked-up or addressed. There was poor recording of the audit results at the clinical governance meetings and little evidence to show they had been considered, or of any value.
- The action tracker was too large and had become difficult to manage effectively. On the risk register, there were no dates to show when risks had been included, so they could not be examined for how long matters were taking to resolve.
- There were no quality measures to assess the performance or outcomes of children and young people's services.

However:

- There was strong, visible and approachable leadership throughout the hospital and good engagement with staff and patients.
- Staff told us they felt well supported by their immediate managers, and the senior leadership team. There was a strong culture of delivering kind and compassionate patient care.

Summary of findings

We saw several areas of outstanding practice including:

- There was outstanding care provided to surgical and medical inpatients and day-case patients, including oncology patients, and outpatients. Patients told us they could not fault the kindness, compassion and sensitivity of staff.
- There was an outstanding service to patients from the pharmacy team when medicines were prescribed to take home. Patients were given their medicines within an hour, and this therefore meant they were not delayed in going home.
- The senior management team were visible, approachable and supportive to both staff and patients. Engagement with staff and patients was welcomed in a positive and constructive manner.
- The organisation had an extensive and detailed patient satisfaction questionnaire. This provided useful information for the hospital and the wider provider organisation. It enabled the hospital to look for, and implement, improvements to patient care.
- The oncology operational policy had been devised by a member of the oncology team at The Ridgeway Hospital and was to be shared across the organisation.
- The provider had various staff recognition schemes, which made staff feel proud, valued and encouraged them to improve services for patients.

However, there were also areas where the provider needed to make improvements.

Importantly, the provider must:

- Ensure all surgical safety checklists are fully completed, and audit routines are able to provide full assurance.
- Review the medical equipment asset register to be able to provide assurance that all medical equipment is serviced and maintained as required.
- Ensure all surgical patient records are legible and complete and written in accordance with policy.
- Ensure within governance, all audit work, the risk register and action tracker provide assurance that the governance systems are delivering safe, effective, and quality care and treatment.
- Ensure all staff who have some degree of contact with children are appropriately trained in level two safeguarding children.
- Ensure all staff involved in assessing and planning care for children and young people are trained in level three safeguarding children.
- Develop a competency framework to assess the paediatric skills and training competencies for registered adult nurses and other clinical staff who may be required to work with children and young people. Young people must be risk assessed for care on the adult pathway by either a paediatric nurse or an adult nurse with paediatric competencies.
- Ensure the children and young people's service is being assessed and monitored through audit work, the risk register and patient experience, to provide assurance that the governance systems are delivering safe, effective and quality care and treatment.

In addition the provider should:

- Continue the programme of refurbishment, replacement, and remedial works to ensure all areas of the hospital and its equipment are safe, compliant with clinical requirements, and able to be cleaned effectively.
- Review practice to ensure all staff are bare below the elbow when in clinical areas.
- Continue to update patient rooms to provide shower facilities.
- Ensure all areas within the operating theatre recovery room are free from dust at all times.
- Review the storage and security of chemicals and products that should be locked away.
- Arrange for a regular review of antibiotic prescribing and key performance indicators for pharmacy staff to achieve. Provide the medical advisory committee with an annual report on antimicrobial stewardship.
- Ensure the business continuity plans are satisfactory for the services provided and there are simulation exercises at the required intervals.

Summary of findings

- Invest in an electronic incident reporting system for staff to record incidents at source, to make reporting more efficient and timely.
- Display the excellent harm-free care (NHS safety thermometer) results on the ward, as is best practice.
- Review the electrical testing of all surgical equipment to ensure the records are accurate and all equipment has been tested as and when required.
- Make sure the service level agreement with the local NHS acute hospital trust for emergency transfers of patients is updated and current.
- Ensure all staff have had their annual performance review and there are systems to demonstrate this.
- Look to provide pharmacist advice for staff out-of-hours.
- Allow patients to respond to staff knocking on doors before entering.
- Continue to investigate how to deliver improved parking facilities.
- Ensure patients are not disturbed by unnecessary noise at night.
- Confirm the correct weight criteria for young people's suitability for surgical treatment on the adult pathway.
- Improve feedback to staff following incidents in the outpatients' department.
- Review and improve clinical waste management systems in the outpatients' department.
- Ensure patient consent forms are fully completed and contain sufficient detail in line with hospital policy.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	We rated medical services as good overall because: • Staff knew how to report incidents and learning from incidents was shared amongst staff teams. • Staff undertook appropriate mandatory and training specific for their role. • Patients were protected from the risk of abuse. • Staffing levels met the needs of patients for both the oncology and endoscopy services. Staff were checked for their fitness and suitability to practise. • There was an effective response to deteriorating patients and staff had access to a triage tool to assist them in identifying oncology patients at risk of infection. • All medical patients were able to give valid informed consent, or the hospital followed legal principles for people with limited mental capacity. • In medical and oncology services, patients were treated with outstanding compassion, kindness, care and understanding by all staff. • Care was responsive and met the needs of people who used the service. • There was strong, visible and approachable leadership throughout the hospital and good engagement with staff and patients. However: • There was a lack of assurance of the servicing and maintenance of medical equipment. • Some patient records, including prescription charts, were not legible or fully completed. • The hospital employee systems were not able to demonstrate staff were having an annual review of their employment. • The governance work did not show how medical audit work and the risk register were delivering improvements in safe and quality care.

Summary of findings

- The governance work was not picking up some issues, including the lack of assurance of the medical equipment register, and status of staff appraisals.

Surgery

Requires improvement 

We rated surgery services overall as requires improvement because:

- Surgical safety checklists were not being fully completed at all times. This had not been identified by routine audit.
- There was a lack of assurance of the servicing and maintenance of surgical equipment.
- Some patient records, including prescription charts, were not legible or fully completed.
- Some clinical areas of the surgery services were showing signs of wear and tear and not able to be effectively cleaned.
- The hospital employee systems were not able to demonstrate staff were having an annual review of their employment.
- The governance work did not show how surgical audit work and the risk register were delivering improvements in safe and quality care.
- The governance work was not picking up some issues, including gaps in the surgical safety checklist, the lack of assurance of the medical equipment register, and the status of staff appraisals.
- There was no pharmacist advice available out-of-hours.

However:

- There was a good culture and process for reporting and acting on adverse incidents.
- There were almost no hospital-acquired infections in 2015.
- There were safe levels of nursing and medical staff in surgery areas, and all were checked for their fitness and suitability to practise.
- There was an effective response to deteriorating patients.
- The hospital was delivering good surgical outcomes to patients and a multidisciplinary approach to care and treatment.

Summary of findings

- Pro-active programmes encompassing pain relief, physiotherapy, and fluid and nutrition balances were providing effective recoveries for surgery patients.
- All surgery patients were able to give valid informed consent, or the hospital followed legal principles for people with limited mental capacity.
- In surgery services, patients were treated with outstanding compassion, kindness, care and understanding.
- Care was responsive and met the needs of people who used the service.
- There was strong, visible and approachable leadership throughout the hospital and good engagement with staff and patients.

Services for children and young people

Requires improvement

We rated children and young people's services as requires improvement because:

- Not all clinical staff who had some degree of contact with children were trained in level two safeguarding children.
- Staff involved in assessing and planning children and young people's care were not trained in level three safeguarding children.
- There were no set paediatric care skills to which staff had to be assessed as competent to work with children and young people.
- There were inconsistencies in documentation guidelines for the admission weight criteria for young people undergoing surgical procedures.
- Feedback from children and parents was not actively sought to help improve the service.
- There was no vision or strategy for the children's service.
- The governance arrangements for the children's service were not clear.
- There were no quality measures to assess the performance or outcomes of the children's service.
- There were no risks identified for the children's service on the hospital's risk register.

However:

Summary of findings

- The hospital had appropriate resuscitation equipment for children and staff were trained in paediatric resuscitation.
- The lead children's nurse and paediatric consultant had appropriate competencies to work with children. They were both contactable to provide advice to their colleagues.
- We observed good care provided to one child in the physiotherapy department, where both the parent and child were appropriately informed and involved in the care.
- The paediatric consultant represented children on the medical advisory committee and the service was discussed at this committee as required.
- Where possible the hospital aimed to be responsive to children and young people's individual needs.

Outpatients and diagnostic imaging

Good

We rated outpatient and diagnostic imaging overall as good because:

- Staff were aware of their responsibility to report incidents and had a good understanding of the Duty of Candour.
- Departments were visibly clean and well organised with completed cleaning schedules in place.
- Medicines were stored and managed safely in accordance with national guidelines.
- Patient records were accessible when required, they were stored and managed safely in the departments ensuring confidentiality was maintained.
- Staff were able to identify their responsibilities in respect of safeguarding patients and had received appropriate training.
- Staffing levels and skills were reviewed by the head of department to ensure people were safe and services were efficient.
- Staff followed national and local guidelines to ensure patients received effective care. They had a good understanding of their role in protecting people from unnecessary radiation exposure.

Summary of findings

- We observed effective, patient centred, multidisciplinary team working and there were good relationships between all members of the team.
- All patients were extremely positive and complimentary about the care they received at the hospital. They said they were kept informed with verbal and written information, which was easy to understand. They received telephone calls from their doctor following treatment to ensure they had no complications or concerns.
- Staff were passionate and proud of the care they provided and worked hard to improve patient experiences.
- Targets for referral to treatment times for NHS patients at the hospital had always been met in the reporting period and extra clinics were provided in departments if required.
- The length of appointments were monitored and adjusted to avoid long waiting times for patients and all patients we spoke with reported being seen quickly and sometimes ahead of their appointment time.
- A multidisciplinary team approach was taken to resolve complaints and staff were involved in this process.
- Staff said the senior management team were very visible and approachable.
- The heads of department were supportive and knowledgeable and kept staff up to date with developments and changes.
- Patient and staff opinions were sought and service improvements were made because of these.
- All staff said they felt valued and were proud to work at the hospital.

However,

- Staff reported they did not always receive feedback from reported incidents.
- There was a lack of assurance regarding the servicing and maintenance of equipment.
- The temporary closure of a treatment room had caused some delays in the outpatient department.

Summary of findings

- The governance work did not show how audit work and the risk register were delivering improvements in safe and quality care.
- Some patients we spoke with commented there was insufficient parking at the hospital.

Summary of findings

Contents

Requires improvement

BMI The Ridgeway Hospital

Services we looked at

Medical care; Surgery; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Ridgeway Hospital

BMI The Ridgeway Hospital is part of BMI Healthcare Limited. The hospital is located in Wroughton, close to Swindon. It serves the local population, and treats privately funded and NHS patients. Surgery and medical services are provided for inpatients, day-case patients and outpatients, and the hospital treats both adults and children. Children from three to 15 years can be treated as outpatients, and children aged 16 or 17 years can be treated as inpatients, day-case patients and outpatients.

The main hospital was built in 1984. It was extended in 2000 to add other services including physiotherapy and hydrotherapy, a dedicated day-case unit, which includes endoscopy, and the four-bed oncology unit (the Webster Suite). In 2011/12, the hospital had further development providing a third operating theatre, four extra consulting rooms, and an extended main reception.

The hospital has 49 beds. These include 33 inpatient en suite rooms, 12 single en suite rooms in the day-case unit, and a four-bed oncology suite. There are three operating theatres all with their own anaesthetic rooms.

Outpatients and diagnostic services have 12 consulting rooms, including a dedicated ophthalmic room and ENT room, plus a treatment room for minor procedures. Other services at the hospital include health screening, physiotherapy, hydrotherapy and sports and exercise medicine. For these services, there is a fully equipped physiotherapy gymnasium, hydrotherapy pool, six treatment rooms and two consulting rooms.

The registered manager and accountable officer for controlled drugs for BMI The Ridgeway Hospital is the hospital's executive director, James Lowe, who has been in the post since April 2012.

During this inspection we looked at surgery, medicine, outpatient and diagnostic imaging, and children's and young people's services. We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out a comprehensive announced inspection on 19 and 20 April 2016 and an unannounced inspection on 29 April 2016.

Our inspection team

Our inspection team was led by:

Inspection lead: Alison Giles, Care Quality Commission inspector.

The team included a team of CQC inspectors, including a pharmacist inspector, and clinical specialists: a consultant surgeon, two senior NHS nurses specialising in surgery and medicine, and a trained children's nurse.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- It is well-led?

To carry out this inspection we used a variety of sources of information. The organisation provided us with data, statements and evidence prior to our inspection. This followed a request to the organisation from CQC for a range of information we request from all organisations like BMI The Ridgeway Hospital to be provided before our inspection.

We visited the hospital on Tuesday 19 April and Wednesday 20 April 2016. We returned for an unannounced visit on Friday 29 April 2016. We met and spoke with 39 patients, and a number of their relatives and supporters. We talked with a range of staff including the executive director (also the registered manager), the director of nursing, the operations manager, the quality

Summary of this inspection

and risk manager, and the consultant surgeon who was chair of the Medical Advisory Committee. We held two drop-in sessions for all staff in the hospital to attend. We talked with doctors, the nursing and healthcare staff, physiotherapy team, members of housekeeping and catering, and administration and support staff.

We inspected all areas of the hospital looking at medical care, surgery, outpatients and diagnostic imaging, and services to children and young people. We spent time observing care in the operating theatres, outpatients department, oncology unit, the endoscopy suite, and the inpatient and day-case ward. We reviewed policies and procedures, training and staff records, and patient records where necessary.

CQC looks at hospitals in respect of core services. At BMI The Ridgeway Hospital we looked at the four core services provided, namely medical care, surgery, outpatients and diagnostic imaging, and services for children and young people. The BMI Ridgeway Hospital runs, however, as one cohesive unit and team. The governance structures, for example, cover all aspects of the hospital. Medical and surgery patients are treated within the same ward and many staff cover all areas of the hospital. There are, therefore, some areas of this report that come from the same evidence. It is inevitable that some sections within core services are consequently repeated throughout this report.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	☆ Outstanding	Good	Requires improvement	Good
Surgery	Requires improvement	Good	☆ Outstanding	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Not rated	Not rated	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	☆ Outstanding	Good	Requires improvement	Good
Overall	Requires improvement	Good	☆ Outstanding	Good	Requires improvement	Requires improvement

Notes

1. There was insufficient evidence to rate effectiveness in children's services due to the vast majority having attended as outpatients. The effectiveness of outpatients and diagnostic imaging services was not rated due to insufficient date being available to rate these departments' effectiveness nationally. We did not meet or observe enough care provided to children, and there was, therefore, insufficient evidence to rate caring.
2. The effectiveness of outpatients and diagnostic imaging services was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

Good

Medical care

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

Information about the service

Medical care provided at BMI The Ridgeway Hospital included planned (elective) endoscopy procedures and oncology. We were only able to examine endoscopy in detail as the oncology chemotherapy unit (Webster Suite) was open two days per week (Monday and Thursday) and our inspection took place outside of these days.

Oncology patients were cared for on the Webster Suite. This unit had beds for day-case patients to have chemotherapy. The endoscopy service operated Monday to Friday. Patients undergoing endoscopy procedures could have a local anaesthetic or sedation. Procedures under general anaesthetic took place in the operating theatres.

The endoscopy unit was located on the day ward and included a treatment room and a small decontamination room. Between January and December 2015, the most common procedure undertaken in endoscopy was diagnostic colonoscopy (a diagnostic test performed under sedation where the bowel is examined).

During the inspection, we spoke with 10 nursing staff, two consultants, and administrative staff. We also spoke with four patients and two relatives. We reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment being used. We reviewed eight patient care records and observed interactions between staff and patients.

Summary of findings

We rated medical care overall as good because:

- Staff knew how to report incidents and learning from incidents was shared amongst staff teams.
- Staff undertook appropriate mandatory and training specific for their role.
- Patients were protected from the risk of abuse.
- Staffing levels met the needs of patients for both the oncology and endoscopy services. Staff were checked for their fitness and suitability to practise.
- There was an effective response to deteriorating patients and staff had access to a triage tool to assist them in identifying oncology patients at risk of infection.
- All medical patients were able to give valid informed consent, or the hospital followed legal principles for people with limited mental capacity.
- In medical and oncology services, patients were treated with outstanding compassion, kindness, care and understanding by all staff.
- Care was responsive and met the needs of people who used the service.
- There was strong, visible and approachable leadership throughout the hospital and good engagement with staff and patients.

However:

- There was a lack of assurance of the servicing and maintenance of medical equipment.
- The hospital employee systems were not able to demonstrate staff were having an annual review of their employment.

Good

Medical care

- The governance work did not show how medical audit work and the risk register were delivering improvements in safe and quality care. The governance work was not picking up some issues, including the lack of assurance of the medical equipment register, and status of staff appraisals. This did not include the oncology service.
- There was no pharmacist advice available out-of-hours.

Are medical care services safe?

Good

We rated safety as good because:

- Staff demonstrated an awareness of how to report incidents and learning from incidents was shared.
- Staff were aware of their role in safeguarding patients and they protected them from the risk of abuse.
- Staffing levels met the capacity demands of both the oncology and endoscopy services. The patients' consultants provided medical cover and a resident medical officer provided 24 hour seven day a week cover for all specialities. Patients' consultants were also responsible for providing on-call cover and advice out of hours.
- The majority of mandatory training was up-to-date.

However:

- The medical equipment asset register did not provide assurance that all medical equipment had been serviced as required.

Incidents

- All staff we spoke with were aware of their responsibility to report incidents. Staff reported incidents on a paper incident reporting form. This was then submitted to the hospital risk manager for entry on to the corporate electronic reporting system. Staff gave us examples of when they would complete incident forms, this included equipment breakdowns or failure and medication errors.
- Serious incidents were investigated. We were given a copy of a root cause analysis investigation findings into an incident involving chemotherapy. The patient involved in this incident was not harmed and received their treatment safely. This investigation included lessons learnt and recommendations. The action plan stated these had been completed and this incident was discussed at the oncology governance meeting. Another incident reported also involved medication. The error was identified at the weekly meeting between the oncology service and pharmacy. This was investigated and actions taken to prevent recurrence.

Duty of Candour

- There was knowledge among staff of when to apply duty of candour and the hospital was open and honest, and apologised to people when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. All staff that we spoke with understood the principles of openness and transparency that were encompassed by the duty of candour.

Safety thermometer or equivalent

- Safety thermometers were not in use within the endoscopy and oncology service as both units were not inpatient areas. However, we did see from our review of patient records an endoscopy pathway of care and treatment, which included an assessment of risks of venous thromboembolism (VTE), mobility, falls, pressure ulcers and malnutrition.

Cleanliness, infection control and hygiene

- The endoscopy unit was visibly clean and tidy. We were not able to visit the oncology unit (Webster Suite) as it was being used for staff training during our inspection.
- Hand sanitizer points were available to encourage good hand hygiene practice for both staff and visitors. We observed staff in medical areas adhered to the requirement to be bare below the elbow.
- Personal protective equipment, such as gloves and aprons, were readily available for staff within the endoscopy unit to ensure their safety when performing procedures. We saw staff used them appropriately.
- The dirty utility room in the endoscopy unit did not meet the requirements for Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal validation that an endoscopy service has demonstrated it delivers against a range of quality improvement and assessment measures. The unit was not yet validated because the dirty utility room had the same entrance and exit, and the clinical sinks did not meet the requirements.
- The hospital infection control lead nurse provided support, advice and training to staff. They had undertaken some departmental audits. We saw the report for the day unit and endoscopy unit, which scored them at 87%. The areas of non-compliance were areas requiring improved cleaning, and the cleaning of trays used by staff when removing cannulas from patients. Both these had since been addressed.
- We observed staff cleaning the scopes once they had been used. The process involved making sure clean and dirty scopes were not exposed to each other. The member of staff was very knowledgeable about the process and made sure they were protected from possible risk of cross-infection. When equipment had been cleaned in endoscopy, a label was placed on it to indicate when it had been cleaned.
- Clinical waste including cytotoxic waste was disposed of safely using the correct coloured waste containers.

Environment and equipment

- Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment in the endoscopy department.
- Staff told us about the daily checks they undertook on each of the two endoscope washer machines and the other checks they undertook on other machines used in the dirty utility room. Staff documented when they had completed these checks.
- The medical equipment asset register did not provide assurance that all items had been serviced when required. We were sent details of equipment in the endoscopy and oncology departments. These had no dates of servicing for any of the equipment. However, when we were in the endoscopy unit a member of staff showed us the folders they had for each scope and the scope washers. In the folders were details of servicing undertaken and if they had any breakdowns. Scopes and the washer machines were serviced twice a year. We were shown evidence that, as part of one of the services, there was a yearly validation of the washer machines. We were not able to check on the equipment for oncology as the Webster Suite was not open for patients during our inspection, and the room was being used for staff training.
- The endoscopy unit did not have Joint Advisory Group accreditation and BMI Healthcare were aware of the inadequacies of the service. This included the limited decontamination area, which posed infection control risks in handling the scopes. BMI Healthcare and The

Ridgeway Hospital were reviewing all options at the time of our inspection to decide the best way forward. In the meantime, staff ensured their work practices alleviated the risks and safely met patients' needs.

- The hospital patient environment was showing signs of wear and tear and age in some areas, but was due for refurbishment in the coming 12-24 months..
- We were sent records of monthly environmental checks undertaken and these included fire alarm testing, emergency lighting, water temperatures in patients' room in the day care ward, automatic doors and the patient lift.
- Resuscitation equipment was maintained and ready for use in an emergency. The trolley was checked daily and records kept demonstrating checks had been completed. Security was maintained with tamper-evident seals.

Medicines

- We saw medicines were stored securely in locked rooms or locked cupboards and access to medicines was controlled appropriately. We reviewed the medication arrangements in the endoscopy department and saw medication was stored safely and the keys to the cupboard held securely. The staff told us they mostly used pain relief and sedation for some of the procedures. We observed one of the nurses prepare the medication prior to a procedure and the doctor checked this prior to administration. Records were maintained of all medication given.
- We saw allergies were recorded on the medication administration records we observed for patients undergoing endoscopy procedures.
- Controlled drugs were ordered, stored and recorded in accordance with the Misuse of Drugs Act 1971 and the associated regulations. The departments had suitable cupboards to store controlled drugs. The pharmacy department audited controlled drug storage and processes once every three months. We saw actions identified from the audits and an action plan was in place to help improve practice.
- The hospital provided a pharmacy service five days a week to support the hours of medical care. Medicine supply was available over 24 hours.
- The pharmacy supplied discharge medicines quickly, within one hour of receiving the prescription. Doctors and nurses could supply medicines directly to patients if discharge medicine was needed out-of-hours, which provided a responsive service for patients.
- The hospital had an organisational structure to manage medicine safety. The hospital staff reported and investigated medicine incidents. The pharmacy manager led the medicine governance meeting where medicine incidents, medicine safety alerts and clinical policies were discussed.
- The hospital had not carried out an audit of antibiotic prescribing in 2015 or 2016 to date. This was a requirement of the hospital's audit routine. Although we did not see any unusual antibiotic prescribing, the hospital was not able to provide assurance it was following best practice.
- Prescribing for oncology patients was done electronically. The chief oncology pharmacist for the BMI kept the system and protocols up to date. Protocols that linked to the prescription were available for the pharmacist to check to make sure they were correct.
- There was a risk assessment for there being a single chemotherapy trained nurse on the Webster Suite when chemotherapy was being administered (should be two for safety as described in the risk assessment). There was a list of actions and guidance, which included who was able to check the chemotherapy with the chemotherapy-trained nurse. Chemotherapy was only administered by a second nurse who had undertaken training to do this. The oncology team had recruited another nurse and they were due to start after our inspection.
- Chemotherapy was ordered a week in advance from external pharmaceuticals companies and the pharmacist reported on issues with supply.
- We were told by a senior nurse that in the oncology unit, emergency medicines, including extravasation kits were available for use. An extravasation kit is equipment used to remove an intravenous drug or fluid that has leaked from a vein into the surrounding tissue. There was an anaphylaxis kit, for treating a severe allergic reaction, on the unit.

Records

- We looked at eight sets of patient notes; seven were endoscopy patients and one oncology patient. We found these had been completed in full. However, some

of the consent forms we observed were very brief. For example, one word being used to describe potential risks. We also saw that some of the consultant records were not easy to read and were very brief. In three of the seven endoscopy patient records we viewed, we were not able to read the consultant's records of the procedure.

- The endoscopy generic care pathways included a number of sections, including recording the patient's physiological observation such as pulse and blood pressures prior to the procedure, and required risk assessments. All areas of the endoscopy pathways we reviewed had been completed and each was dated and signed by the nurse completing it.
- Following reprocessing/cleaning of endoscopes, records for tracking and traceability were produced. A copy was entered into the patient's notes and a copy entered against the patient's identifiable label in the unit's traceability register. Traceability records were seen in all of the seven sets of notes we looked at for endoscopy unit.
- Some patients had completed a health questionnaire prior to their admission and staff told us they reviewed those prior to their admission. This was to ensure patients had no health risks that could postpone the procedure. We also saw one patient had a telephone assessment prior to their procedure due to their medical history and medication. This was all documented.
- There were comprehensive chemotherapy booklets that patients brought with them at each treatment session and this kept a record of the treatment received.

Safeguarding

- Staff were aware of their duties and responsibilities to report any suspicions of abuse. There were policies and procedures to help staff with decision making and reporting when they had concerns. Staff were aware of what made a person vulnerable and what aspects of their care could be considered as abuse. This included people exhibiting the more obvious signs such as bruising or injuries, but also the less obvious, such as neglect or financial abuse. One of the nursing team had also escalated concerns in the past when a vulnerable patient had not wanted to leave the hospital.
- Staff were trained by the hospital to recognise and respond in cases of safeguarding, although not all had been trained to the appropriate level for work with children. The hospital did not provide us with the percentages of training among staff, but lists of staff who had completed their training or were overdue. From adding up the numbers we determined:
  - Vulnerable adult safeguarding training
    - 90% of all staff were up-to-date with their training at level one stage (mandatory for all staff).
    - 97% of staff required to do so (managerial staff) had updated their training at level two stage.
    - The one member of staff required to do so (the director of nursing) had updated their training at level three stage.
  - Child safeguarding training - see our children and young people's report section.
- The hospital had an appointed named nurse (the director of nursing) responsible for ensuring any suspicions of abuse were reported and monitored. All those staff we met were aware the director of nursing was the appointed lead for safeguarding. The responsibilities of the director of nursing extended from those areas of safeguarding described above, into reporting any concerns around forced slavery, forced marriages or female genital mutilation.

Mandatory training

- Most staff were up-to-date with refreshing their mandatory training, although there were some gaps to be filled. All staff were trained when they joined the hospital, and training was to be updated at various times set by the hospital. Most training was updated annually and some every two or three years. There were low levels of staff in some categories of worker, so just one or two staff not being up-to-date would have a high impact on the results. The information supplied by the hospital did not provide an overall percentage of staff who had completed their training (clinical governance meeting minutes for February 2016 reported 86.7%) but these were the highlights:
  - Between 64% and 100% of staff had completed the 17 different courses listed as mandatory (although not all courses were for all staff).
  - The courses at the lower end of compliance related to medical gases.

- Medicine management had been completed by 100% of staff.
- Equality and diversity training had been updated by 91% of staff.
- In adult basic life support (mandatory for all staff), 85% of non-clinical staff and 89% of clinical staff had completed their update, and 92% had completed their intermediate life support.
- When looking into the detail of one of the courses, we saw 74% of staff (61 from 82) had updated their infection prevention and control aseptic non-touch technique course.

- Staff and managers followed the BMI healthcare mandatory training matrix requirements. All staff, dependent on their role, had role-specific mandatory training. For example, information security, fire safety and moving and handling were applicable to all staff. There was other role specific training for staff who required the necessary skills. Oncology staff, for example, undertook intravenous administration. Most training was done by e-learning but face-to-face training was also provided. There were some elements of practical training supplementing the online system. The training for intravenous fluid administration was, for example, both an online and practical course. Medical gases training also had theoretical and practical stages.
- Staff completed their training during their work time and all staff we spoke with said they were up-to-date with their training requirements.
- Those staff we met said the training was a good quality. The hospital had an interactive computer-based training system and all staff were provided with access to the system.
- Senior staff said they were able to check on training compliance levels for their staff at a glance. The system allowed senior staff to check on individual records and departmental results. All training compliance was discussed with staff at their annual appraisal. This conversation included asking staff if they found the mandatory training comprehensive and an effective learning tool.

Assessing and responding to patient risk

- The hospital used an early warning score system to respond to deteriorating patients. The hospital protocol followed the guidance of the National Early Warning Score (NEWS) system. All patients were monitored by the nursing staff for a number of clinical and physiological markers. This included for example, patients' blood pressure and temperature levels, and respiratory measures. If any of these triggered concerns, there were different protocols to follow. These ranged from increasing observations and measurements, to contacting the consultant or resident medical officer.
- Emergency resuscitation equipment was available and equipment checks were up-to-date. The hospital had a designated team who attended emergency calls including the resident medical officer (RMO) who was trained in advanced life support.
- For oncology patients, staff had access to the UK Oncology Nursing Society (UKONS) triage tool. This was used to risk assess patients who have had chemotherapy, radiotherapy and other disease-related immunosuppression for their risk of sepsis. The tool was based on a number of questions with each answer rated either 'green', 'amber' or 'red'. Depending on the number of scores, the tool stated the action needed to be taken by staff, and when urgent medical assistance was required.
- A team of staff, supported by a consultant, cared for patients treated in the endoscopy unit. Following the procedure, patients were transferred back to their room on the day unit and were cared for by the staff on this unit. If staff or the patient had any concerns about the patient's condition, the consultant would review them.
- A resident medical officer (RMO) was on duty 24 hours a day and they were trained in advanced life support to assist if a patient became unwell. Patients who became medically unwell could be transferred to the local acute NHS hospital by NHS ambulance if required.

Nursing staffing

- There were safe levels of nursing staffing on the day unit. The hospital was using a planning tool (the BMI Healthcare Nursing Dependency and Skill Mix Planning Tool 2015) to optimise the levels of nursing staffing. This tool was used to safely support the needs of patients being admitted. It was used to plan the appropriate levels of staff five days in advance of each shift. The ratio of nurses to patients was around one nurse to six patients. We went back through the nursing staff rotas for January to March 2016 and, with the exception of a few occasions, all shifts were covered. On the few occasions where there were gaps, these were of no more than six hours without the full complement of staff.

- Staffing levels were adjusted to meet patient needs. The model used provided the senior nursing staff with a baseline. We saw how the staffing levels had been increased at times when a patient had a higher degree of needs or support required than had been anticipated.
- Bank and agency staff supplemented vacant nursing shifts. There was some use of agency staff, although the hospital used predominantly bank staff (its own staff either working additional hours, or with flexible working terms). In 2015, there had been an average of 5% of nurses in the inpatient department engaged from agencies. There were 4% engaged in theatres. The majority of the agency staff were used in the latter part of 2015, including the winter period. There were no agency staff employed as healthcare assistants, and, in the latter part of 2015, an average of 3% of allied health professionals came from agencies. Any other vacancies not covered by agency staff were filled by bank staff.
- There was a good skill mix among the nursing staff. The staffing levels and skill mix supported the safe ratios of nurses and healthcare assistants to patients. The wards used a mixture of a senior nurse manager (matron), sisters, staff nurses and healthcare assistants. They had support from physiotherapists, pharmacy staff, and administration support. The hospital employed 30 nurses (18.1 full-time equivalent (FTE) posts) and 13 healthcare assistants (10 FTE) in the inpatient and day-case wards. There were three operating department practitioners (2.5 FTE), 23 nurses (19.1 FTE) and 11 healthcare assistants (9 FTE) in the operating theatres. The allied health professionals (AHPs) provided support including physiotherapy and pharmacist services. The hospital had 33 AHPs (18.9 FTE) among its clinical staff. Staff worked both full and part time and the nursing team staffed the inpatient ward seven days a week, 24 hours a day. The theatre team worked Monday to Saturday.
- There were low levels of staff turnover, although some vacancies to be filled in nursing care. In 2015, there were just 1%, on average, of nursing and healthcare staff in the wards and theatres leaving. Vacancy rates at the end of 2015 were 7% for ward-based nurses, although the hospital had a fully employed team of healthcare assistants. There were vacancies for 8% of the nursing team and 3% for operating department practitioners in theatre. As the hospital employed relatively low numbers of nursing and healthcare staff when compared with a larger NHS trust, these vacancy rates also represented low numbers of actual staff, and just one or two in most departments. Most of these vacancies had been filled by the time of our inspection.
- Endoscopy staff worked as part of the day unit. The unit was staffed depending on how many patients they had for each list. A senior member of staff told us if a patient was to have an endoscopy in theatre then extra staffing hours were organised, as they had to go into theatre to assist the consultant. Endoscopy staff reported they had sufficient numbers of staff to meet the workflow and patients' needs in a safe manner. They told us staff would cover for each other to make sure there were no gaps in the staff rota.

Medical staffing

- There was a small medical team at the hospital, which enabled the hospital to monitor their working practices. The hospital did not employ medical staff directly, but approved doctors and consultant surgeons operating under practising privileges. Doctors working at the hospital were approved by a medical advisory committee, consisting of consultants representing the main specialties, and chaired by an experienced consultant surgeon. There were 107 doctors granted practising privileges (this covered all specialities and not just medicine). Of these, 30 had not provided any episodes of care in 2015. The chair of the medical advisory committee said any doctors who had not practised for over a year would be reviewed by the committee before they would return to practise at the hospital. Seventy-one doctors had carried out over 10 episodes of care, and 51 of these were working regularly having each delivered over 100 episodes of care.
- The doctors and consultants came to the hospital when they had patients attending for consultations, clinics, or procedures. The hospital was organised with sessional arrangements. The hospital's contract with medical staff required them to be available when they had patients in the hospital. This could be in person or by telephone. The doctor was required to have appropriate alternative named cover arranged if they were to be unavailable at any time when they had a patient admitted to the hospital.
- The hospital had constant medical cover from a resident medical officer (RMO). The hospital did not employ its RMOs, but had a long-standing small team who were contracted from a third-party agency. There was one

doctor on duty at all times. Covering the rota usually involved two doctors (employed by the agency) handing over to each other within an agreed framework. The primary RMO had been at the hospital for 15 years, and the other for about 18 months. The primary doctor undertook the majority of the rota, with the other doctor covering their contracted absences. The contracted agency would provide another RMO if either of the doctors were unable to be at the hospital in a planned or unplanned absence. The RMOs were qualified doctors and required to have advanced life support (ALS) and European paediatric advanced life support (EPALS) training. We checked the files for the RMOs and both had EPALS and ALS training in date.

- The RMO was available throughout the day and the night for any planned or unplanned care or treatment for patients, or guidance to staff. The RMO we met said they had a good working relationship with the consultants, who came to the ward and saw their patients both pre- and post- operatively. The RMO had a handover at the end of their session with their colleague coming on duty.

Major incident awareness and training

- There was limited simulation training and some gaps in the business continuity planning. The business continuity plan did not contain action cards for an outbreak of infection/pandemic (although this was contained in the infection control policies), inaccessibility of the hospital to vehicles, security failures (although the hospital said this had been produced in December 2015), and providing support to the local NHS acute trust. Essential electrical equipment had also not been recognised. This had been escalated to the risk register, but no progress had been made as yet. The hospital had also recognised it was not participating in the simulation programme according to the organisation's policy. The hospital was required to carry out a staff communications exercise every six months, a desktop exercise every year, and full live evacuation every three years. The hospital provided evidence of the last evacuation they carried out in 2014, and the comprehensive report about how the exercise worked. The hospital had not addressed the latter two items on the risk register, but staff said they were scheduling six-monthly simulation exercises.

Are medical care services effective?

Good

We rated effectiveness as good because:

- Medical staff were checked and evaluated for their fitness to practise and all staff employment checks were complete and up-to-date.
- The hospital had access to services it needed over all seven days, and had arrangements with the local NHS hospital for emergency transfers.
- The oncology operational policy had been devised by a senior member of the oncology team and this was to be shared across all BMI hospitals.
- Oncology patients had access to advice and support seven days a week.
- We found staff were competent, skilled and knowledgeable within their clinical area.

However:

- The hospital personnel system was not able to demonstrate that all employed staff had been given an annual review of their performance (appraisal).
- There was no pharmacist advice available out-of-hours.
- Endoscopy did not meet the Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation; however, BMI Healthcare were reviewing their options.

Evidence-based care and treatment

- The endoscopy department had not met the requirements for the Joint Advisory Group (JAG) accreditation for gastrointestinal endoscopy. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited. Staff told us this was due to the environment and BMI were considering options on how to proceed.
- A senior member of staff in the oncology unit had devised an oncology operational policy and this was going to be rolled out across all BMI hospitals. The oncology service was developed in line with a number

of national guidance, for example, Manual for Cancer services-Chemotherapy (2011), Manual for Cancer services –Acute Oncology service (2011) and The Manual for Cancer services-Chemotherapy Version 1.0 (2014).

Pain relief

- Oncology patients brought in and took their own medicines when attending for day case chemotherapy treatments. The pharmacy was able to provide prescribed medicines if any changes were made to patients' medication following review by a consultant.
- Patients undergoing procedures in the endoscopy unit were offered local anaesthetic or sedation depending on the procedure. Patients were monitored throughout the procedure.

Nutrition and hydration

- Patients were screened using the malnutrition universal screening tool (MUST) to identify those who were malnourished or at risk of becoming malnourished. This is a validated national nutritional screening tool and was designed to identify adults at risk of malnutrition and to categorise them as low, medium or high risk. This included patients for day case endoscopy procedures.
- Patients were informed when they needed to stop eating and drinking prior to any procedures, when they needed to take bowel preparation and the dietary requirements following this.

Patient outcomes

- Oncology and endoscopy services monitored patient outcomes via a range of measures, including local audits (such as infection prevention and control), incidents, complaints and compliments. We were told by a senior nurse that oncology patient outcomes were monitored by the consultants and staff through their meetings, for example at weekly chemotherapy pharmacy meetings. Copies of multi-disciplinary reports for all new patients were sent to the local NHS hospital.
- The oncology service had undertaken an audit in March 2016 of central venous access devices (CVAD) following a rise in linograms (this is where dye is injected into the CVAD to check it is unobstructed). Following this audit, recommendations were made on how to manage to CVAD and this included how to 'flush' the CVAD using a specialist fluid and the amount of fluid to use.
- There were no unexpected deaths of medical patients in 2015.
- Only a small number of patients admitted for day-case procedures remained at the hospital overnight. Of 6,798 day-case patients, just 1.2% (84) required an overnight stay. This was generally where the patient was assessed as not being well enough to be discharged on the same day as their procedure.

Competent staff

- We saw records of competency checks on the senior nurse who administered chemotherapy. They told us they were supported by a nurse from another BMI Hospital when they completed their competency assessment.
- Doctors were checked for their fitness to practise. The hospital maintained a register, which included checks on valid medical indemnity insurance, Disclosure and Barring Service (DBS), annual appraisals, and registration with the General Medical Council. We reviewed the register and found:
  - All the DBS disclosures were up-to-date. These were reconfirmed by the hospital every five years.
  - All the medical indemnity insurance certificates were up-to-date.
  - The majority of medical staff had supplied up-to-date appraisals from their employing NHS trust. In 2014, it had become a requirement of doctors' registration to have an annual performance review as part of the 'revalidation' programme (General Medical Council, 2014). Almost all doctors practising at the hospital were employed by the NHS, who were responsible for their revalidation, and subsequently their annual appraisal. Copies of these were to be supplied to The Ridgeway Hospital as part of the practising privileges contract. If any doctors were no longer working in the NHS (there was just one consultant who had recently retired from the NHS), they were responsible for ensuring their appraisal was undertaken each year by an independent reviewer (responsible officer).
  - All the doctors had valid registration with the General Medical Council.

We reviewed five of the consultants' files and found all of the above documentation to be in order. However, one of the consultants did not have their hepatitis status recorded, as was required by the organisation. All of these doctors had signed practising privileges contracts held in their files.

- Appraisal data was not demonstrating all non-medical staff (nurses, healthcare assistants, and other staff) had been given an annual review of their competence and professional development. The hospital had changed to a new employee system. During this process it became apparent there had not been effective reporting of staff appraisals from the previous paper-based system. This had been recognised and escalated to the hospital risk register. All the staff we met said they had been given their annual appraisal and this took place with their manager each year. However, the data was not able to support this, and the hospital was aware and open about the previous shortcomings with the reporting system. The senior management team were confident the new system would improve the ability to report accurate data. The data at the end of 2015 (2014 in brackets) was:
  - There were 32% (30%) of ward-based nurses and 15% (15%) of healthcare assistants reported as having their annual review.
  - There were 24% (2014 not reported) of theatre nurses, 50% (2014 not reported) of healthcare assistants in theatre, but 100% (2014 not reported) of operating-department practitioners reported having their annual review.
  - There were 100% (57%) of allied health professionals reported as having their annual review.
  - There were 93% (72%) of administrative and clerical staff, and 61% (50%) of other staff reported as having their annual review.
- The hospital used a regular employment agency to supply temporary nursing staff. The hospital contract with the nursing agency required the agency to perform all employment checks and confirm these were valid. The hospital provided induction to the agency nurses when they came onto their first shift, or had not been at the hospital for a while. This included orientation with the hospital, equipment used, and introduction to key staff. We reviewed a number of induction forms on the ward and operating theatre for agency staff to sign to say they had received their induction. Not all the forms were signed by the nurse who had supervised the induction, but they were completed by the agency staff.
- Staff employed directly by the hospital had employment checks. This included references, DBS disclosures, proof of identity, and a check of any relevant professional registration. Employees were not permitted to start work at the hospital until all of these checks were satisfactorily completed. The DBS disclosure checks were repeated every three years in accordance with hospital policy. We reviewed the hospital's records and all the employment checks had been completed and were up-to-date.

Multidisciplinary working

- There were arrangements for multidisciplinary support between external agencies. The hospital had service level agreements with other providers. This included emergency transfer arrangements with the local acute NHS hospital (although out of date) and a close working relationship with the local hospice located within a few metres of the hospital. The hospital would also contact and involve a patient's GP or other healthcare or social care professionals where this was required.
- Oncology staff said they worked with the local hospice and, if required once a patient was under the care of the hospice, they could have access to a dietitian. Oncology patients could also be referred to a dietitian at the local NHS hospital by their consultant.
- This was a small independent hospital where many staff had worked together a long time and knew each other well. Staff were therefore aware of different strengths and experience they could draw upon throughout the hospital. Patients' records showed a good range of multidisciplinary input. Most patients had input from their consultant, nursing team, and if required the pharmacist and physiotherapist.
- A daily head of department meeting took place every morning in the executive director's office. This was called the CommCell (communication cell) meeting and gave staff an opportunity to discuss their plans and challenges for the upcoming day. The meeting was also used to update staff on ongoing issues and hospital activity, and to praise individual staff for achievements. Outcomes from the meeting were then fed back to staff in the departments by their head of department. The CommCell meeting we went to during our inspection was well attended with representatives from every department.

Seven-day services

- There was an on-call service offered to all oncology patients at this hospital Monday, Tuesday, Thursday and

Friday from 8:30am to 4:30pm. Outside of these hours, from 4:30pm until 8pm and on a Wednesday and weekends between 7:30am to 8pm, oncology patients could contact another local BMI hospital for advice.
- Patients for the endoscopy unit were booked in advance and this was open Monday to Friday.
- There was 24-hour medical cover, seven days a week from resident medical officers (RMOs). The RMOs were based on the hospital inpatient ward and on-call around the clock. Staff told us they had a good working relationship with the RMOs and they attended patients at any time they were requested to do so.
- Although medicines were available over all seven days, day and night, there was no on-call pharmacist advice service out-of-hours. Nursing staff were able to get advice and guidance for medicines from an approved database. This included information on intravenous fluid administration, and other medicine administration guidance. The British National Formulary was available in printed form or online.
- The pathology services were available through the third-party provider 24-hours a day, seven days a week. If a patient needed an X-ray in an emergency, the diagnostic imaging service provided an on-call service over the weekend.

Access to information

- Senior staff told us about the comprehensive 'your chemotherapy record booklet', which was given to patients and brought in with them at each cycle of treatment. This record booklet included their cycle of chemotherapy treatments and other important information.
- Patients we spoke with told us information relating to their endoscopy procedures and pre-operative/ procedure checklist was provided prior to admission.
- Staff told us that the pre-operative/procedure checklists were reviewed with the patient on admission. At discharge, information was provided appropriate to the outcomes of their procedure.
- GPs were given information about care and treatment provided to their patients. There were letters produced and provided to each patient's GP, which were given to patients to deliver. There was currently no electronic system to deliver this information, so the hospital relied upon patients to deliver the letters. The information provided to the GP was comprehensive and included information on any medicines prescribed, the procedure carried out, test results and other important information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were enabled to give valid informed consent where they were able. Patients assessed as having the mental capacity to make their own decisions were given time and information to make informed consent. The hospital followed the organisation's policy on consent for examination or treatment. Clinical staff taking consent from patients recognised the legal and ethical principles around gaining valid informed consent. We spoke with a range of patients about how their consent was given. They all told us it was given voluntarily, and not before they had been told about the advantages and possible risks of the proposed procedure. Patients said they had been able to ask any questions about the treatment. Those patients we met said they were aware they could change their minds, even after signing their consent form. The hospital performed only planned procedures. However, the hospital policy recognised treatment could be provided to patients unable to give consent due to an emergency. In those circumstances, treatment could be given without consent in order to save life or avoid significant deterioration in a patient's health. The patient was to be told what had taken place as soon as was practically possible.
- Written, verbal or implied consent was gained where this was required by hospital policy. Not all consent needed to be given in writing, but clinical staff followed hospital policy where this was needed. Written consent was required, for example, in all complex and invasive surgical procedures, those involving risks or complications, or may have significant consequences on a patient's employment or personal life. Consent was also needed for any procedure or investigation that involved research. Implied or verbal consent was otherwise sought when it was appropriate. This would include, for example, non-invasive scans or diagnostic tests, blood tests, and physiological observations. Patients were able to give partial consent. The hospital's policy allowed patients to consent to some procedures

and not others. Therefore, patients who objected on religious grounds, for example, to some aspects of medical treatment, were able to complete forms restricting the care or treatment they would accept.

- Consent was documented on appropriate forms and copies provided to patients. There were different forms for patient consent. The hospital used four forms, and the majority of patients used form one. This was consent from a patient or competent child for procedures involving general/regional anaesthesia or sedation. Forms two and three were used for consent from a parent or guardian for a patient who was a child or young person. Form four was to be completed in the event an adult patient was not able to provide valid informed consent. We saw appropriate forms used in patient records, and those patients we met said they had been given copies of their consent forms.
- The hospital acted in the best interests of patients who could not give valid informed consent. The hospital followed the requirements of the Mental Capacity Act 2005 in providing care and treatment only in the best interests of patients with limited or no capacity to decide for themselves. Patients were assessed by consultants or a senior nurse to determine if they had the capacity to make their own decisions. If this were decided not to be the case for the procedure being considered, the patient's consultant would involve other parties in the decision. This may include a person who held the Lasting Power of Attorney for the patient's medical decisions or a court appointed deputy. It usually involved the patient's family and GP, and other healthcare professionals. Before proceeding, the consultant was expected to determine if the patient had previously indicated any wishes around medical treatment through an Advanced Directive. If a decision were taken to proceed in the best interests of the patient, this would involve the least restrictive treatment for the patient.
- Staff had knowledge of Deprivation of Liberty Safeguards, but it was unlikely to apply in this hospital. A person can be deprived of their liberty if they do not have the capacity to make their own decisions, and need treatment, care or safety to protect them. An application to deprive a person of their liberty in order to receive care and treatment was unlikely to be required for a patient treated at The Ridgeway Hospital. However, the hospital described the circumstances in which this might apply and the procedures to follow in the unlikely event it would be deemed appropriate. None of the nursing staff we met could remember it ever being used, but knew of its application.

Are medical care services caring?

Outstanding ☆

We rated caring as outstanding because:

- Feedback from patients who used the service and those who were close to them was continually positive about the way all staff treated patients. The organisation and all its staff highly valued their relationships with their patients and their families.
- There was a strong person-centred culture among all staff. Patients said the care they received exceeded their expectations.
- Patients and their relatives were involved and encouraged to be partners in their care, in making decisions, and with any support they needed. Staff spent time talking with patients and those close to them who staff treated and respected as individuals.
- Patients and their relatives were spoken with in a caring manner and received information in a way that they could understand. Staff were encouraging, empathetic, sensitive and supportive. Patients and relatives were encouraged to ask questions and raise any concerns or worries.
- Patients understood their care, treatment and condition, worked with staff to plan their care, and shared decision-making about their care and treatment. Staff understood and were empathetic about the impact treatment might have on a patient, and found ways to make it as comfortable as possible for the patient.
- All staff responded compassionately when patients needed help and supported them to meet their needs. Staff anticipated patients' needs and maintained their privacy and confidentiality at all times.

Compassionate care

- We observed staff introduce themselves to the patients when they came into the day/endoscopy unit. Staff interactions with patients were friendly and welcoming.

Where patients had built relationships with staff following repeated visits, first names were used. We also observed this friendly approach where staff knew the patient's family.

- All the patients we spoke with told us all the staff treated them very well. All praised the staff for the work they did. This included not just the hospital leadership, nurses and doctors, but also the housekeeping team, the catering staff, and the maintenance team. They told us the staff were compassionate and caring. We were told, "Nothing is too much trouble", and "they [the staff] are wonderful."
- All staff showed empathy, kindness and care towards their patients and their relatives. When patients received treatment, we saw the staff treat them with dignity and respect. During procedures staff made sure patients' dignity was maintained at all times.
- We observed staff treating a patient with compassion when they felt unwell during a procedure. Staff spoke with them to reassure them that what they were feeling was normal during the procedure and the consultant also reassured them. They made sure the patient was comfortable at all times.
- We observed staff using touch with patients and their relatives when it was deemed appropriate. For example, one patient and their relative were dealing with a very difficult time and the member of staff used touch to reassure them and to show their empathy. We observed the patient and their relative receive great comfort from this.
- Staff spoke with patients and their relatives in a respectful manner, taking time to explain what they were doing and the treatment they were receiving.
- The hospital had outstanding results from the NHS Friends and Family Test. In the six months from September 2015 to February 2016 (the most recent data), the hospital had a higher response rate than the NHS average. The hospital had an average response rate of 46% (NHS average 28%). Of those patients who responded, in five of the six months, 100% said they would recommend the hospital to their family and friends. In the other month, the recommendation was from 99% of patients.
- The hospital produced a more in-depth patient satisfaction report with excellent results. There was an outstanding quality of comments made to the hospital by patients completing the in-house questionnaire.
- The patient satisfaction survey (184 responses) results were excellent for privacy, dignity and care. The results for February 2016 were:
  - 100% said they were given privacy and dignity when discussing their condition/treatment.
  - 99% said they were treated with dignity and respect.
  - 98% said they were impressed with the consultant surgeon/physician.

Understanding and involvement of patients and those close to them

- Patients undergoing endoscopy procedures had been provided with information, both verbal and written, to enable them to make an informed decision about their treatment. There had been sufficient time at their outpatient appointment for them to discuss any concerns.
- Patients who were privately funding their treatment told us they had received information about the cost of these prior to treatment starting. One patient told us "I was not worried about the cost as the reassurance I got from being seen quickly and by a consultant was worth every penny".
- All staff talked with patients so they understood their care, treatment and condition. All the patients we spoke with told us staff clearly explained procedures and checked they understood prior to carrying these out. Patient said they were able to ask any questions and staff did not hurry them.
- Staff were able to recognised when patients and their relatives/carers needed additional support to help them understand and be involved in their care and treatment.
- Patients told us they felt actively involved in decision making about their care and treatment. Options were discussed with them and any risks with the treatment to enable them to make an informed decision. Patients told us they worked in "partnership" with the staff when it came to their care and treatment. Relatives we spoke with were also consistently complimentary and said they were encouraged to be involved as well.

Emotional support

- The patient satisfaction survey (184 responses) results were excellent for emotional support to patients. The results from a question about emotional support for February 2016 were:

- 100% said they could talk with someone about their worries/fears.
- A patient and relative described how the staff had helped them through difficult times during the course of their treatments, and they were assured if they needed any support they knew they could contact the staff at any time.
- Oncology patients could be referred to the local hospice for advice and support as well as other support groups, for example the Ridgeway Breast Care Support Group. Staff took the time to make sure patients were aware of any additional support available to them and how to access it.

Are medical care services responsive?

Good

We rated responsiveness as good because:

- Services were planned and delivered to meet people's needs.
- There was equitable access for all people who used the hospital.
- There was timely access to services.
- People were treated as individuals, and care and treatment delivered to meet their different needs.
- There was a good response to complaints and the organisation learned lessons when something went wrong or a patient was not entirely happy with the service.

However:

- There were known but unresolved problems with limited parking spaces for patients and their visitors at all times.

Service planning and delivery to meet the needs of local people

- The hospital met the needs of local people. The hospital was opened originally in 1984 by a group of local consultants in order to provide independent healthcare to the area. Since that time, the hospital had taken on an increasing amount of work for the NHS, commissioned by the local clinical commissioning groups and local NHS hospitals. The work undertaken for the NHS now comprised, in the year to March 2016, of 44% of the service provided by the hospital. In 2015, this had amounted to 15,854 patient spells and around 34% of the services provided. This was therefore helping to meet the needs of the local population. The service enabled NHS patients in the local area to have access to, and a choice of, where to have a range of elective operations or procedures.
- The premises and facilities were appropriate for the services planned and delivered, although there were problems with car parking at some times of the day. The hospital environment was accessible for people with disabilities and they could use services on an equal basis with others. The patient areas of the hospital were spread over two floors. The first floor was accessible by stairs or a lift and the lift was suitable for wheelchair access. The one area of concern from patients about the facilities related to car parking. Some patients we met did not have a problem finding a parking space, but others said it was their only worry about visiting the hospital. The senior management were aware of the concerns of patients and visitors and were looking at possible solutions in the local area.

Access and flow

- Patients had timely access to services. Those patients we met (a mixture of both self-funded, medical insurance-funded, and NHS patients) said they had been given quick appointment, and most in a matter of a few weeks. Patients said they had been asked if there were appointment times that would not suit them, although they were happy to fit in with the hospital and consultant routines.
- Oncology treatments were provided for private patients only and patients were treated at twice-weekly sessions (Monday and Thursday). All admissions were planned to effectively manage access and flow in accordance with the patient's treatment regimes.
- Endoscopy treatments were provided for both NHS and private patients. Admissions were by appointment. Treatment lists and scheduling were managed in conjunction with the consultants to effectively manage access and flow.
- One patient told us they were given their appointment for an endoscopy procedure less than a week after their outpatient appointment, which they felt was excellent.

Meeting people's individual needs

- Oncology patients had information in their chemotherapy record booklet about the signs and

symptoms to look out for following chemotherapy that could indicate an infection. The booklet also included in and out of hours contact details in case patients were concerned.

- Food provision at the hospital met people's individual needs, although this area had received some criticism in the recent past and been improved. Patients we spoke with said they had a choice of food. The food had been served at the right temperature. We were told by several patients that staff said they could ask the hospital catering team to prepare them something else if they did not like anything being offered, or were keen to have something not on the day's menu. Responses from the patient satisfaction survey included:
  - 80% of patients liked the variety/choice of food.
  - 91% said their food order was correct.
  - 89% said the food was prompt.
  - 84% said the quality of the food was good.
  - 93% said the catering staff were friendly and helpful.
- Menu choices and refreshments were available to patients admitted to the day oncology unit and the chef told us they had devised a special menu for them.
- The patients we spoke with were day case patients and they told us they had access to refreshments of sandwiches and drinks (both hot and cold) during their stay.
- Patients and their visitors were provided with regular drinks. Apart from when patients were unable to have fluids due to a procedure, there was water provided and regular tea and coffee.
- There were no barriers to patients on the grounds of equality and diversity. Admission criteria did not discriminate based on age, gender, gender reassignment, pregnancy and maternity status, race, religion or belief, or sexual orientation. Translation services were available and staff were available to chaperone patients if requested.
- There were no barriers to patients on the grounds of their mental health. Patients who were living with dementia were admitted for care and treatment. There was a pre-assessment for patients to screen for dementia. If this was suspected, or already diagnosed for a patient, one of the senior nursing staff or the consultant would assess the patient. This was to determine if they were able to understand what was proposed to help them with a medical problem. If the patient was not able to understand or had a limited ability to retain information, the patient would be treated in their best interests. This involved hospital staff taking into account the views of others who cared for the patient. This could include the patient's GP, the courts, other healthcare professionals, and must include the patient's relative or carers, or an independent mental capacity advocate. The hospital consent policy followed the requirements of the Mental Capacity Act 2005 when it came to taking decisions for people who were unable to make their own.
- The hospital would make specific arrangements if staff were asked to support patients living with a learning disability or living in vulnerable circumstances. However, the hospital was rarely commissioned to treat people living in these circumstances. The nursing staff told us, however, they treated every patient as an individual. They said they would endeavour to admit, accommodate and support any potential patient and provide individualised care. This could be achieved with the advantages the hospital had of using single rooms for patients, flexible visiting times, named nurses, and the relative peace and quiet on the wards.
- We saw a copy of the information leaflets given to patients who were undergoing upper endoscopy procedures. It contained details on the procedure itself, possible complications and recovery. We also saw a leaflet about bowel preparation required before a colonoscopy and dietary limitations needed after this.

Learning from complaints and concerns

- There were small numbers of complaints to the hospital, and they were reported upon and shared among staff and the wider organisation. The hospital produced an annual report for complaints covering October 2014 to September 2015. During this period, there were 52 complaints. In any year, the hospital saw around 45,000 patients. This therefore represented 0.1% of patients making a complaint. In this annual report, the hospital reported 50 of these complaints were resolved by the hospital (called stage one) and the other two were taken to stage two, and managed by the provider organisation, BMI Healthcare. No complaints were reported as being taken to the highest level, stage three, which was to involve the Independent Healthcare Sector Complaints Adjudication Service. The majority of complaints related to consultants, although there was no information as to what aspect of their care. There were six complaints relating to finance.

- There was a system and process for responding to people's complaints and response times had improved. People who complained had an acknowledgement letter within two working days followed by a full response within 20 days. If the investigation took longer than 20 days to complete, the complainant was sent another letter each 20 days until the matter was resolved. During the 12 months from October 2015 to September 2015, there were three months where not all complaints had responses within 20 days. The last time this occurred was May 2015. This was brought to the attention of the senior management team, and after May, all responses were within 20 days.
- There was learning from complaints and comments by patients and their families. The hospital had addressed matters such as the televisions in patients' rooms. These were originally said to be very small, and had now all been replaced with larger screens. The catering had been criticised, and this had been improved with the third-party provider.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a detailed strategic vision for the hospital, although the key risks did not flow through the strategy or the future plans.
- Audit work was not providing effective assurance of safe and quality care. There was insufficient discussion of audit results in clinical governance meetings. The governance work was not picking up some issues, including the lack of assurance of the medical equipment register, and status of staff appraisals. This did not relate to the oncology service where there was a good governance framework.
- The risk register did not show the age of risks, any reduction in the rating of the risk through actions already taken, and how risks were going to be closed or managed to an acceptable level.
- The hospital's action tracker was over-detailed and not referenced at the clinical governance meeting, although it was at the head of department meeting.

However:

- There was a clear structure for governance and various committees of experts providing analysis and review. Incidents were discussed in detail and actions taken when needed.
- There was a regular and reasonably well attended medical advisory committee with an established experienced chair.
- There was benchmarking in relation to patient satisfaction with other hospitals in the BMI Healthcare group.
- There was strong, visible and approachable leadership within surgery services, and the wider hospital, at all levels. There was good engagement with both staff and the public/patients.
- There was innovation and change, and the hospital was aware of potential risks to sustainability and future growth.

Vision and strategy for this core service

- There were a number of strategic documents which highlighted risks and future plans. These were quite detailed. However, the corporate templates for these documents did not describe the risks or issues, only how they were being controlled. Therefore, it was not possible to know if the controls addressed the risks. In addition, there was no strategy to take forward the top key risk in the 2016 business plan, which was the lack of accreditation of the endoscopy suite. The business transformation projects did not address the four key risks identified by the organisation and did not extend beyond 2016 and into future plans. The objectives, however, did relate to the organisation's eight strategic priorities. The business transformation projects for 2016 included the '@work' employee system for managing the payroll, and the ward-labour resource-planning tool, to manage safe staffing levels. There was a project for standardising guidelines and practices in housekeeping. All of these projects had already been completed. The remaining project was for the delivery of an ambulatory care service. This had an objective to provide services for patients who would not need to remain in hospital overnight, whereas this had otherwise been necessary in the past. This was due for completion in September 2016.

Governance, risk management and quality measurement for this core service

- Audit work at the hospital was not assuring the hospital it provided a safe and effective service at all times. Patient health records were shown as 99% compliant in January to March 2016. We found areas that were not complete or were illegible. There had been no audit of the equipment in the hospital to pick up the lack of assurance of planned maintenance being undertaken. Not all hospital staff had a good understanding of the work of audits, and how they contributed to identifying areas for improvement.
- There was poor recording of audit results at some clinical governance meetings. Senior staff told us audits were discussed in detail, but the reporting in the minutes did not always demonstrate this. In the minutes from February 2016, for example, the audit comments were "none for discussion". In the previous month, the comments were "nothing further to discuss." In other sections of the report relating to audit, there were no comments to show anything had been picked up at audit and needed further investigation. This was despite there being a monthly audit programme. There was good detail in the clinical governance meeting minutes for other areas, such as incident reporting, but some topics, including audit, were poorly represented.
- The hospital risk register was complex, and did not separate general corporate business risks from those within the control of the hospital and that affected patients, staff and visitors. The dates the risks were added were not included. This meant it was not possible to see how long the risk had been known about, and how long it was taking to resolve. There was no progress of the risks, so it was not possible to see if or when the score given to the risk (a combination of the impact and likelihood) had been reduced by mitigating actions. There was no indication of how or when the risk would be closed. The register did not state if there was a projected score for the risk, which would be considered acceptable in future (as not all risks could be eliminated in any hospital setting). The risk register included risks to the business, financial risks and government policy risks. There was no progress listed against any of these particular risks.
- The hospital was using an action tracker in relation to reported incidents, repairs or maintenance required, but, and staff agreed, this was becoming too large and somewhat unmanageable. Many of the actions were now completed, which showed good progress in resolving problems. Some were also minor issues, which had quick resolutions. The action tracker, however, did not show the date the action was raised, so there was no evidence of how long it had been open or taken to resolve. We looked at clinical governance meeting minutes and head of department meeting minutes, but the action tracker was not a standing agenda item for assurance. However, it was discussed at the head of department meetings.
- There was a clear structure for governance and risk management. The hospital's senior management team reported to the BMI Healthcare clinical governance board, which, in turn, reported to the chief executive. At hospital level, the medical advisory committee, health and safety committee, and clinical governance committee reported to the senior management team. Within the clinical governance framework were a number of sub-committees, including:
  - Medicines management – this was chaired by the lead pharmacist. There were good sets of minutes covering medicine incidents, controlled drugs, discontinued medicines, clinical guidelines and medicine safety alerts. The hospital however, did not have any key performance indicators (KPIs) for medicines' management. The Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy said that hospitals should work with KPIs and an audit programme to enable continuous professional development and improvement.
  - Hospital transfusion team
  - Oncology governance
  - Resuscitation
  - Radiation protection
  - Quality
  - Infection control
  - Water safety

Appropriate staff had been appointed to these committees, and they were led by senior personnel.

- There was regular input into the governance system from the hospital's medical advisory committee. The committee met at the end of a working day every two months. Four sets of minutes from July 2015 to January 2016 showed between eight and 13 people attended. This included the director of nursing who attended all meetings, and the executive director who attended three of these four meetings. The chair of the committee attended and conducted all these meetings. Discussions were from a standard agenda. They

included consideration of applications from consultants to practise at the hospital and a review of speciality services. There was an update on business conducted, complaints, and clinical incidents, which included patient readmissions and transfers to the local NHS acute hospital. Shared learning from serious incidents was discussed along with new services being offered by the hospital.

- We saw the bi-monthly minutes of the oncology clinical governance meetings for December 2015 and February 2016. They discussed for example, incidents, complaints and audit outcomes. They were due to discuss at their next meeting the audit into the central venous access devices audit, which took place in March 2016. The oncology team met monthly and we saw minutes from the January, February and March 2016 meetings. An example of what they discussed included, audits and patient satisfaction feedback. There were also weekly chemotherapy meetings with the pharmacy where they looked at, for example, patient prescriptions. This was where they identified an error with a patient's chemotherapy prescribing and action was taken to correct this.
- To provide comparison, there was some measure in terms of patient satisfaction against other hospitals within the BMI Healthcare group. There was an extensive patient satisfaction questionnaire produced by the hospital each month. This measured a number of different factors as discussed throughout this report above. The report produced enabled the hospital to see how each response from patients had changed over the last 12 months. It also gave the hospital a ranking alongside other hospitals within the BMI group as a tool to promote improvement.

Leadership and culture of service

- There was support for the senior management team. The hospital worked within a cluster in the BMI Healthcare group and reported to a regional director. The finance manager, business services manager, marketing and maintenance managers reported to the executive director at the hospital, but also worked as part of a cluster team. The executive director had support from other hospital directors in the cluster. The regional director and the chief executive were said to be approachable and supportive.
- Front line staff were very positive about the leadership at departmental and senior management level. They felt the leadership team was visible and approachable and all said they report any concerns they had to any of the managers. Staff said any of the managers at departmental or senior level would listen to their concerns and act on them.
- There was an on-call rota for senior staff out-of-hours. All the senior staff were part of the rota and would be called for advice or to attend the hospital in an emergency, or if there had been or could be a significant incident.

Public and staff engagement

- There was a range of meetings for staff to attend. This included departmental meetings, such as ward meetings or theatre meetings and group meetings, such as the quality committee or health and safety team. The senior management team had a weekly meeting, and heads of department met monthly. Ward staff said their monthly meetings included reports from the senior staff meetings and messages being cascaded down. Incidents and adverse events were discussed, as were audits, training compliance and complaints. Trends from incidents were discussed and suggestions and solutions raised to manage any changes or improvements recognised. There was feedback from any reported incidents, and staff felt confident at these meetings to report anything they felt uncomfortable or unsure about.
- There was good communication with staff. Weekly newsletters were sent by email, although not all staff were on the provider's email system. We asked staff how those without email were made aware of this newsletter, but staff were not sure. Some staff said emails were sent to private email addresses.
- The hospital recognised long service by holding a yearly ceremony where lapel pins were given to staff with a different stone in for every five years of service they had given. The awards were announced throughout the BMI Healthcare organisation. Staff wore their pins with pride and were keen to tell the inspection team of their significance.
- The hospital provided staff to speak at local events. There was a recent GP education event, for example, provided by the hospital and staff attended this event. There was a good link with the local hospice, which was close to the hospital.
- Patients were encouraged to leave feedback about their experience by the use of tell us your experience cards,

local and national patient satisfaction questionnaires and for NHS patients by the Friends and Family Tests. NHS patients were also able to comment upon the hospital through the NHS Choices website. The hospital was now able to respond directly to comments and contact any patients who left their contact details and wanted to pass on their compliments or raise concerns.

- There was a culture of inclusiveness and encouraging staff, including reducing anxiety. The hospital had prepared staff for the CQC inspection with a handbook on many elements of the areas that would be under review. This was designed to update staff on all aspects of what the hospital did, so questions from the CQC team would hopefully not be too daunting. This booklet ran to 33 pages and was given to all staff.

Innovation, improvement and sustainability

- The hospital was aware of possible risks to sustainability and these were included in the strategic plans and risk register.
- The endoscopy unit did not have Joint Advisory Group accreditation and BMI Healthcare were aware of the inadequacies of the service. This included the limited decontamination area, which posed infection control risks in handling the scopes. BMI Healthcare and The Ridgeway Hospital were reviewing all options at the time of our inspection to decide the best way forward.
- There was a recognition and reward system in the hospital for staff going the extra mile.

Requires improvement

Surgery

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

Information about the service

Surgery services at BMI The Ridgeway Hospital included performing elective operations for a range of specialties. This included ear, nose and throat (ENT), general surgery, ophthalmology, orthopaedics (such as total hip and knee replacements), plastic surgery (reconstructive and cosmetic), and urology. The service was supported by consultant surgeons, with operating theatre teams, and ward-based nursing and healthcare staff. Patients were treated as both inpatients and day-case depending upon the procedure and recovery expectations.

The hospital had three operating theatres, two of which were laminar flow (specialised theatres with a system of airflow to reduce the risk of airborne contamination) and all with their own anaesthetic rooms. Theatres operated from 9am to 9pm Monday to Friday and from 9am to 5pm on Saturdays. In 2015, the hospital treated around 1,700 inpatients, and just less than 7,000 day-case patients. Surgery was carried out on privately-funded patients aged 16 years and above, and aged 18 years and above for NHS patients.

We visited all the areas connected to surgery services, including the operating theatres, the inpatient and day-case wards, and the stores and supplies areas, We spoke with members of all the staffing teams, including nurses and doctors. We met and talked with 12 surgical patients who were either pre- or post-operative, and some of their family members.

Summary of findings

We rated surgery services overall as requires improvement because:

- Surgical safety checklists were not being fully completed at all times. This had not been identified by routine audit.
- There was a lack of assurance of the servicing and maintenance of surgical equipment.
- Some patient records, including prescription charts, were not legible or fully completed.
- Some clinical areas of the surgery services were showing signs of wear and tear and not able to be effectively cleaned.
- The hospital employee systems were not able to demonstrate staff were having an annual review of their employment. This had been added to the hospital's risk register and would be addressed with the introduction of a new system just coming on line.
- The governance work did not show how surgical audit work and the risk register were delivering improvements in safe and quality care. The governance work was not picking up some issues, including gaps in the surgical safety checklist, the lack of assurance of the medical equipment register, and the status of staff appraisals.
- There was no pharmacist advice available out-of-hours.

However:

- There was a good culture and process for reporting and acting on adverse incidents.
- There were almost no hospital-acquired infections in 2015.

Requires improvement

Surgery

- There were safe levels of nursing and medical staff in surgery areas, and all were checked for their fitness and suitability to practise.
- There was an effective response to deteriorating patients.
- The hospital was delivering good surgical outcomes to patients and a multidisciplinary approach to care and treatment.
- Pro-active programmes encompassing pain relief, physiotherapy, and fluid and nutrition balances were providing effective recoveries for surgery patients.
- All surgery patients were able to give valid informed consent, or the hospital followed legal principles for people with limited mental capacity.
- In surgery services, patients were treated with outstanding compassion, kindness, care and understanding.
- Care was responsive and met the needs of people who used the service.
- There was strong, visible and approachable leadership throughout the hospital and good engagement with staff and patients.

Are surgery services safe?

Requires improvement

We rated safety as requiring improvement because:

- There was a lack of completion and attention to detail in the recording and audit of the surgical safety checklist.
- The medical equipment asset register did not provide assurance that all equipment had been serviced as required. There was some equipment in the recovery room not showing up-to-date electrical testing.
- Some patient records, including prescription charts, were not legible or fully completed.
- There was some breach of the policy for all staff to be bare below the elbow in clinical areas at all times.
- The hospital was showing signs of wear and tear in some areas of the ward and recovery room, which made them difficult to keep fully clean.
- Inpatient rooms had baths and not showers and baths posed a risk to some post-operative patients. However, replacing the baths with showers was part of the refurbishment programme.
- There were some areas of the operating theatre recovery room that had not been effectively kept free of dust.
- Some hazardous products did not have adequate secure storage.
- There was no reconciliation of patient medicines when patients came into hospital, and there had been no audit of antibiotic prescribing in 2015 or 2016 to date.
- The business continuity plans and simulation exercises had not been completed.

However:

- There was a good culture among staff for reporting and investigating incidents.
- There was 100% harm-free care given to patients over the last 12 months. This meant patients did not acquire pressure ulcers, suffer harm from falls or infections.
- There were no incidences of methicillin-resistant Staphylococcus aureus (MRSA) or clostridium difficile in 2015.
- There were safe levels of nursing and medical staff and a reducing and limited use of agency to cover unfilled shifts.
- There were low levels of surgical site infections.

- Staff were aware of their responsibilities to safeguard vulnerable people.
- The majority of mandatory training was up-to-date.
- There was a good system for responding to patient risks and when a patient's health was deteriorating.

Incidents

- There was a good culture of incident reporting. Incident reports showed a wide-range of incidents reported, including small issues through to more significant concerns. There was an experienced staff group within surgical services and experience extended to recognising and knowing when to report incidents. Staff we met said they recognised what events would constitute an incident and why they should report them. This included issues ranging from patients suffering a slip, trip or fall, medicine errors, delays and cancellations of operations for a variety of different reasons, and if a patient used their emergency call bell.
- There was no barrier to staff reporting incidents, although the system used for the staff to report at was still paper-based and not advanced to a more efficient electronic system. There was no blame culture and staff were encouraged and expected to report any issues or concerns. Staff said they reported incidents to contribute to improving care for patients so procedures could be changed if they were not working at their best, and lessons learned. The system used by the provider remained a paper-based form for staff to complete, and not the more widely-used electronic reporting system. This meant staff had to complete a handwritten form for any incidents to be reported, and these would be entered to a database by a member of the management team. This could delay the reporting process and involved an additional administrative step. A number of staff said it did not particularly discourage them from reporting incidents, but recognised it took more time to complete and could result in delays. A number of staff said they felt there was a risk to some minor incidents not being reported if staff were particularly busy.
- There was learning from and follow-up to incident reports, which included an investigation when necessary and feedback to staff. A nurse manager had come into post in the surgical wards earlier this year and was closely involved with incident investigations. They took forward learning to staff where it was recognised as needed, and provided staff feedback. Learning included providing additional training and support when there were errors, such as there had been infrequently, but occasionally in medicine administration.
- Incidents were discussed and reported at clinical governance meetings. One of the strong areas of the clinical governance meetings were the discussions and reports into investigations into incidents. These included non-clinical and clinical incidents, medicine errors, cancelled operations, any readmissions or returns to theatre. The minutes of the meetings showed explanations of incidents, reported by type, and any actions taken to avoid a recurrence.
- The hospital reported and investigated serious incidents. There had been one serious incident reported in 2015, which related to a patient sustaining a fracture following an unwitnessed fall.
- The rate of incidents had fallen in 2015. The peak was 34 reported in March 2015 and this had fallen to the low point of 18 in December 2015.

Duty of Candour

- There was knowledge among staff of when to apply Duty of Candour and the hospital was open and honest, and apologised to people when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Those staff we spoke with knew about this regulation and training and explanation had been cascaded from the senior management team. Those we spoke with were all aware of the Duty of Candour, but explanations tended to revolve around being open and honest with patients. However, none of those staff we asked described the duty as also being required to apologise to a patient.

World Health Organisation (WHO) surgical safety checklist

- There was a lack of completion in too many surgical safety checklists. The operating theatres used the internationally recognised World Health Organisation

surgical safety checklist ('the checklist') in all surgical procedures. The checklist formed part of a procedure carried out to scrutinise all safety elements of a patient's operation before and after proceeding. This included, for example, checking it was the correct patient, the correct operating site, consent had been given, and all the staff were clear in their roles and responsibilities. The review checked all equipment was present and functioning, and all instruments and swabs used accounted for. We reviewed 18 sets of medical records selected at random for patients undergoing surgical procedures. In these records, 13 checklists were not complete. Some did not have the sign-in procedures recorded, but had the other procedures recorded, some did not have the sign-out procedure completed. Some were missing the name and signature of the responsible consultant and handover to the recovery team. Some had multiple sections not completed, and others had no date, time or signature.

- The lack of completion with the checklists had not been picked up by the monthly audit. The audit reviewed 10 sets of medical notes each month. In January and February 2016, the audits of the checklists (which examined whether the checklist questions had been answered) and patient records (which recorded if the checklist was complete) returned results of 99% to 100%. Although we cannot dispute that the records the hospital staff checked may have been fully complete, we found over 70% from a random selection of records from January to April 2016 to be incomplete.
- We observed good practice among theatre teams in using the checklist and team briefing prior to a session in the operating theatres. The full team attended the briefing. There was a good introduction and all cases were discussed in advance. In the pre-operative checklist read-through, all staff involved were present and included in working through the checklist as required. This included checking the patient's consent had been given, the surgical site was marked, and risks of venous thromboembolism (blood clots) had been anticipated. There were no distractions. We observed the way the checklist was respected and felt staff appeared 'natural', in that it was not being performed for our benefit, but was part of normal embedded practice. We noted how in minutes from the medical advisory committee in July 2015, a consultant "had refused the team brief and WHO checklist." The anaesthetist had raised this as an incident and emailed both the surgeon concerned and the chair of the medical advisory committee. The minutes recorded the chair and executive director were to speak with the surgeon. There was, however, no update on this in the minutes of the next meeting in September 2015.

Safety thermometer or equivalent

- There was 100% harm-free care for patients over the last 12 months. Avoidable patient harm data was collected and reported for all NHS inpatients. The NHS Safety Thermometer was a collection of data submitted by all hospitals treating NHS inpatients. The results were publically available on the Health and Social Care Information Website. Data was a snapshot of inpatients with avoidable harm usually on one day each month. This included harms such as pressure ulcers, falls, and infections. In the most recent published results (from April 2015 to March 2016), the hospital had reported 100% of harm-free care each month. The data covered 87 patients. There were five patients during this time with catheter or urinary tract infections. However, these patients were being treated for this condition on admission, and did not acquire it in the hospital.
- The safety thermometer results were not on public display. It is considered best practice to display this data, but the hospital did not have the data available for patients or their families to see. It had, however, been displayed in staff areas.
- The hospital had assessed almost all appropriate patients for their risk of developing a blood clot (venous thromboembolism or VTE). All patients were treated appropriately for assessed risks. The NHS compliance rate for VTE screening was that a minimum of 95% of adult inpatients were assessed. The hospital audited 20 sets of private and all NHS patients' health records each month and reported the results quarterly. In 2015, the hospital fell just below the target of 95% in the second quarter of the year (reaching 93%) but was at or above the target in the other three quarters. If a patient was assessed as being at risk from developing a VTE, preventative measures would be taken, which were predominantly in the use of anti-embolism stockings. This led to there being no incidents of VTE or pulmonary embolism in 2015.

Cleanliness, infection control and hygiene

- The majority of the surgical areas of the hospital were clean and tidy, but there were some areas with

excessive dust in the recovery area of the operating theatres. The ward areas were clean and well organised. Cleaners were operating throughout the day during our inspections. They cleaned all aspects of the wards, including the harder-to-reach areas at height. Those areas we inspected were clean, dust and debris-free. In the theatre recovery area we found some racking directly outside an operating theatre was dusty, and a noticeboard, which had been removed and placed against a wall, was also dusty at the top edge.

- There were some shortcomings in infection control assurance in the operating theatre recovery room. There was an open sluice hopper in a corner of the room. The hospital were aware this should not have been in an open area within the recovery room. We were told this was due to be boxed-in shortly. The dirty utility area sink and worktops were corroded and in a poor state of repair. This prevented fully effective cleaning.
- There was carpeting in some patient bedrooms, which did not provide complete assurance of optimal infection control procedures. The carpets were being replaced in a refurbishment programme of patient rooms, and the six remaining rooms were due to be completed by June 2016. The head of housekeeping assured us each carpet was deep cleaned every three months or when required, but there was no record of a regular routine. However, records we kept to show when the carpets had been cleaned. There were also carpeted corridors in the ward areas. There was no evidence of stains or significant wear and tear to the carpets, but cleaning was not enhanced as it would by clinical hard floors throughout. The new floors were a good quality hard flooring which swept up the walls to provide sealed skirting. The hard flooring in the operating theatres and recovery room area was in good condition, hardwearing, and easy to keep clean.
- Bedding, mattresses and linen used within the hospital was clean and in good condition. Sheets, duvet covers and pillowcases we saw were laundered, clean and free from ingrained stains or damage to the fabric. The mattresses we saw were clean and in good condition.
- Disposable curtains provided assurance of infection control. The hospital used disposable curtains in the operating theatre and recovery rooms to screen patients and bed spaces. These indicated when they were last changed. All those we saw were in good condition, clean and free from any damage. They were all within their date for being replaced.
- There were cleaning routines and schedules for specific equipment. Non-disposable curtains (those in other areas including patient rooms), were changed or cleaned according to the schedule. Fans used in the wards and other areas, and all radiators were part of a regular cleaning schedule. This was maintained and updated by the head of housekeeping and shared with the nurse manager for continuous review.
- The cleaning staff had good quality and sufficient equipment and consumables. The hospital had purchased and just taken delivery of a new mop system for cleaning hard floors. There had been investigation into the standard and quality of this relatively expensive system, but the housekeeping staff said it was “fantastic, and was going to make a significant difference in time and quality of work.” The cleaning staff otherwise had good supplies of cleaning fluids and other equipment and dedicated areas for storing these safely.
- There were low or zero levels of hospital-acquired infections. There had been no incidences of methicillin-resistant Staphylococcus aureus (MRSA) in 2015 in 3,518 bed days. There had been no clostridium difficile in 2015 in 6,918 bed days. There had been one incidence of e-coli in 3,518 bed days.
- Most staff we met and/or observed followed infection prevention and control protocols, but the rules were not followed at all times. Staff we met followed the rules around wearing minimal jewellery, having short and clean nails, and long hair being tied back. Staff required to wear uniforms (which was all the nursing and operating theatre staff) had clean and well-maintained uniforms. There were, however, some staff working or coming onto the wards not dressed bare below the elbow. Being bare below the elbow was hospital policy, and contributed to effective hand washing. We also observed a few staff enter the ward area without using the hand-gel at the entrance door before doing so.
- All the staff we observed working on the ward washed their hands and used hand gel as required. Staff wore personal protective equipment (aprons and gloves) when required. There was sufficient stock of personal protective equipment and hand-wash sinks, soap, paper towels and hand gel in appropriate places. Patient bedrooms did not have clinical sinks within the room, so staff were required to use the patient bathroom to wash their hands, which was not ideal.
- There were low levels of surgical site infections. Data for the year 2015 showed:

- Of 227 hip replacements, 249 knee replacements, 1,552 head and neck operations, and 296 pelvic operations, no patients developed a surgical site infection.
- In 996 operations carried out on other limbs, two patients developed a surgical site infection. This represented 0.2%.
- In 191 thoracic surgery operations (including breast surgery), two patients developed a surgical site infection. This represented 1%.
- In 3,412 abdominal surgery operations, one patient developed a surgical site infection. This represented less than 0.1%.

- Clinical waste was well managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. None of the waste bins or containers we saw on the wards or within the operating theatre were unacceptably full. Nursing staff said they were emptied or removed and replaced regularly.

Environment and equipment

- The medical equipment asset register did not provide assurance that all items had been serviced when required. There were 388 items on the medical equipment asset register relating to surgical services. This included, for example, surgical equipment, patient beds, patient monitoring equipment, theatre tools, scopes and defibrillators. Of these 388 items, 250 were showing blanks in the column 'last service date'. This included the inpatient ward defibrillator (one of four in the hospital - although the asset register only showed three), 25 deep vein thrombosis pumps, one anaesthetic ventilator, an ultrasound scanner, and eight patient beds. The hospital provided us with a schedule of planned preventative maintenance completed monthly. This table suggested most items required to be serviced were processed each month, but it did not provide assurance for what happened with items that were not serviced. For example, in May 2015, there were 114 items to be serviced. Only 41 (36%) of these requests were completed. In June 2015, there were 21 items to be serviced and 14 were completed. It was therefore unclear from this statement what had happened to the 73 items not serviced in May 2015. Rates for servicing had improved since the middle of 2015 and most items were serviced subsequently after an additional engineer was engaged by the hospital.
- Some of the equipment in the recovery room did not show it had been recently tested for safety (portable appliance test). In a sample of equipment we looked at, four pieces including an ultrasound and gynaecology machine did not have current labels demonstrating up-to-date testing. One of the four items was recognised by theatre staff as now being obsolete, and was removed.
- There was appropriate resuscitation equipment throughout the hospital for use in an emergency. The defibrillator equipment on the trolley was no longer a current model, although in full and safe working order and due to be replaced. The wards and operating theatre recovery room had resuscitation trolleys in visible places. The trolleys were sealed and tagged to show they had not been tampered with since they were last checked. The medicines and fluids were secure within the relevant drawers. The checks of the trolleys were mostly completed each day as required, although there were three days in March 2016 and one in April 2016 when the ward checklist had not been signed. The trolley in recovery had not been checked on one day in April 2016.
- The hospital patient environment was showing signs of wear and tear and age in some areas, but was due for refurbishment in the course of 2016. Some of the bottoms of doors and skirting boards in patient rooms had chips and missing paint. This made them difficult to clean and maintain. Some of the walls were knocked in places and the coating was missing from parts of the switching unit above the beds. Two of the patients we met told us how they did not like carpets in the ward and patient rooms. One of these patients added that carpets did, however, reduce the noise from footfall in the hospital corridors and rooms – something that had been noticeable to the patient in another hospital with hard flooring. Two patients both described their room as "getting a bit shabby now." In the patient questionnaires from February 2016 were comments that included:
  - "It was clean but could do with an update."
  - "Not enough shelf room in the bathroom (toilet articles have to be put on top of the toilet)."
  - "The room is in urgent need of update, some of the chairs in the room were tatty."

- "Room far too hot. Even with the heater turned to the lowest setting, I have still had an electric fan in constant use." (We also noticed at least two of the rooms were particularly hot and the patients said they were slightly uncomfortable).

Equally, other patients did not have problems with the rooms. Comments to us from patients included:

- "Yes, it's fine. Nice and quiet."
- "Really clean and not too warm."
- There was a good provision of emergency oxygen. The hospital did not have piped oxygen into patient rooms, so oxygen cylinders were stored around the wards in appropriate areas. Those we saw were checked, full, and in working order. They were stored in single cylinder trolleys and secured to the wall so they would not fall or be removed unsafely.
- The patient rooms for inpatients had baths and not showers. Baths would pose a risk for some patients, particularly orthopaedic patients, to use. The hospital was aware of the disadvantages and safety issues with patients having baths in their rooms and not showers. There was a refurbishment plan for the hospital, which included, over the coming two years, upgrading of the inpatient rooms to include provision of a shower or wet-room environment. Showers were available in the day-case patient rooms, but these were infrequently used by these short-stay patients. Inpatients were, however, enabled to use the showers in the day-case rooms if they wished. A comment in a patient questionnaire said about the environment: "update facilities, walk-in showers for ease of access."
- Ten of the 34 inpatient bedrooms did not have low-surface-temperature radiators, although this had been recognised and they were due for replacement in 2016.
- There were good arrangements for decontamination and sterilisation of surgical equipment. The hospital had an arrangement with an NHS hospital trust for sending used instruments each day, which were decontaminated, sterilised, wrapped and returned to the hospital. Staff who were responsible for the surgical instruments said the service worked well. They reported they did not encounter problems with damage to the wrapping of the packs (which would make the equipment unusable). The packs were stored on shelving in a room beyond the recovery area. The area was neat, tidy, and well organised.
- Surgical instruments were stored and transported safely. No used or decontaminated surgical instruments or equipment went past or were stored with the sterilised sets. The operating area had a corridor at the rear of each theatre. Used surgical instruments and clinical waste were removed through the rear doors and into this corridor. Clinical waste was disposed of in approved containers, and used surgical instruments were stored in cabinets to be sent for decontamination and processing. None of these items went back through the 'clean' areas of theatre, the stores, or the recovery room.
- Most equipment and consumables were stored safely, although there were some products that needed improved security for public safety. Not all products deemed as potentially hazardous to health were in locked cupboards or stores. There were some products, including chlorhexidine (an antiseptic agent) which needed to be in locked storage as a known irritant or flammable. This product was in a cupboard in an unlocked sluice room (which did not have the facility to be locked), and in the general stores area. The sluice room was in the theatre area, which was not open to the public, but remained without the facility to be locked. The general stores was in a non-patient area and was looked after by a small team of staff. The area was, however, next to a set of fire doors that were open to the outside and not locked during the day. Members of the public could have entered the hospital through these doors at the rear of the premises. Although there was a 'stable door' arrangement in the general stores (the lower half which was shut and locked), it would be feasible to enter the room and gain access to the chemicals stored. The chlorhexidine was stored immediately inside this door.

Medicines

- We saw most medicines stored securely in locked rooms or locked cupboards and access to medicines was controlled appropriately. Medicine trolleys were secure and locked to the wall. Medicine storage in cupboards was neat and tidy with minimal stock carried. There was a system to manage expiring medicines. There were, however, some IV fluids in the operating theatre area that were not locked securely. There was limited access to these fluids, but their storage did not meet best practice and had been a concern for their own pharmacist.

- Controlled drugs were ordered, stored and recorded in accordance with the Misuse of Drugs Act 1971 and associated regulations. The departments had suitable cupboards to store controlled drugs. The pharmacy department audited controlled drug storage and processes once every three months. We saw actions identified from the audits and an action plan to help improve practice. All controlled drugs in the anaesthetic room were prepared for the first case of the session. They were all clearly and individually labelled and under the direct care of the anaesthetist.
- The hospital provided a pharmacy service five days a week. While medicine supply was available over 24 hours, there was not an out-of-hours service for clinical pharmacy advice.
- The hospital had a procedure to ensure a patient with an allergy or intolerance had this indicated on the front of their hospital record. This was done using a red sticker. However, in only one set of the notes we looked at was the actual medicine or product named on the sticker itself. One record did not have a sticker on the front when a patient had an allergy. We did see, however, all the allergies recorded, as they should be, elsewhere in the patient notes, including the prescription charts.
- Medicine reconciliation was not completed when patients were admitted to the hospital. Medicines reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines. The National Institute for Health and Care Excellence (NICE) recommends that all patients have a medicine reconciliation completed within 24 hours of admission to hospital to make sure the correct medicines are prescribed. This lack of reconciliation had been identified by the pharmacist, who was new in post. It was due to be discussed among the pharmacy team to find a workable resolution.
- The pharmacy supplied discharge medicines quickly – within one hour of receiving the prescription. The pharmacy staff routinely dispensed outpatient prescriptions in less than ten minutes. The doctors and nurses could supply medicines directly to patients if discharge medicine was needed out-of-hours, which provided a responsive service for patients.
- The hospital had an organisational structure to manage medicines safely. The hospital staff reported and investigated medicine incidents. The pharmacy manager led the medicine governance meeting where medicine incidents, medicine safety alerts and clinical policies were discussed. There was a programme of medicine related audits including missed dose audit, controlled drug audit and medicines management audit (safe storage and processes).
- The hospital had not carried out an audit of antibiotic prescribing in 2015 or 2016 to date. This was a requirement of the hospital's audit routine. Although we did not see any unusual antibiotic prescribing, the hospital was not able to provide assurance it was following best practice.

Records

- Not all medical records were fully legible or complete. In 18 sets of records relating to surgical patients we found some had the following problems:
  - Five of the prescription charts were not fully legible. This was due primarily to the name of the medicines not written clearly. The hospital policy required the name of the medicine to "be written in ink clearly, legibly, and indelibly so each individual letter can be read." The names of some medicines were written in capital letters, but many others were written in normal script and the writing was not acceptably legible or following policy.
  - Four of the consent forms for patients had illegible writing, particularly in the area relating to explanation of any possible risks from the procedure. Some had pre-printed labels with possible risks, although this did not demonstrate a personalised approach to the patient.
  - The consent forms and other documents required the doctor to print their name alongside their signature so they could be clearly identified. This had not been done in three of the 18 of the forms.
  - As described above, there was poor completion of a number of the surgical safety checklists used in the operating theatres. This included missing dates, times and signatures in 13 records.
- There were well-completed nursing notes in patients' medical records. Observation charts, such as those used to monitor any deterioration in a patient's health, fluid and nutrition charts, and care plans were well completed. The records we saw were timed, dated and signed. There were standard care plans, which we found

to be well completed. These included turn charts (to prevent pressure ulcers), bed rail assessments, venous thromboembolism (blood clots) risk assessments, and falls assessments.

- Pre-operative assessments were well completed and acted upon. Patients coming to the hospital for a procedure were asked to complete a pre-operative questionnaire. If the patient indicated anything in the questionnaire the hospital needed to be aware of, we could see it was taken forward. This either resulted in a specific test being carried out to fully understand possible risks (such as blood tests or other monitoring) or acknowledged in medical notes (such as allergies or reactions). The records showed patients were given advice and guidance about any medicines they were regularly taking (warfarin, for example) that needed to be stopped before their operation.
- Legibility aside, prescription charts were well completed. We checked eight sets and each had any known allergies documented and signed. The prescriber was indicated and the pharmacists had seen and endorsed the chart. Administration was clear and appropriately signed.
- Most, but not all, anaesthetic medicine charts were signed and dated by the anaesthetist. In three of the four anaesthetic charts in the operating theatre on the first day of our visit, it was not clear what time or what dose of medicine had been given. The majority of those we saw in a review of patient records were, however, timed and dated.

Safeguarding

- Staff were aware of their duties and responsibilities to report any suspicions of abuse. There were policies and procedures to help staff with decision making and reporting when they had concerns. Staff were aware of what made a person vulnerable and what could be considered as abuse. This included people exhibiting the more obvious signs such as bruising or injuries, but also the less obvious, such as neglect or financial abuse. One of the nursing team had also escalated concerns in the past when a vulnerable patient had not wanted to leave the hospital.
- Staff were trained by the hospital to recognise and respond in cases of safeguarding, although not all had been trained to the appropriate level for work with children. The hospital did not provide us with the percentages of training among staff, but lists of staff who had completed their training or were overdue. From adding up the numbers we determined:
  - Vulnerable adult safeguarding training
    - 90% of all staff were up-to-date with their training at level one stage (mandatory for all staff).
    - 97% of staff required to do so (senior staff) had updated their training at level two stage.
    - The one member of staff required to do so (the director of nursing) had updated their training at level three stage.
  - Child safeguarding training - see our children and young people's report section.
- The hospital had an appointed named nurse (the director of nursing) responsible for ensuring any suspicions of abuse were reported and monitored. All those staff we met were aware the director of nursing was the appointed lead for safeguarding. The responsibilities of the director of nursing extended from those areas of safeguarding described above, into reporting any concerns around forced slavery, forced marriages or female genital mutilation.

Mandatory training

- Most staff were up-to-date with refreshing their mandatory training, although there were some gaps to be filled. All staff were trained when they joined the hospital, and training was to be updated at various time periods set by the hospital. Most training was updated annually and some every two or three years. The training data here covered all staff in the hospital, as the hospital worked as one unit and did not differentiate for core-service staff. There were low levels of staff in some categories of worker, so just one or two staff not being up-to-date would have a high impact on the results. The information supplied by the hospital did not provide an overall percentage of staff who had completed their training (clinical governance meeting minutes for February 2016 reported 86.7%) but these were the highlights:
  - Between 64% and 100% of staff had completed the 17 different courses listed as mandatory (although not all courses were for all staff).
  - The courses at the lower end of compliance related to medical gases.
  - Medicine management had been completed by 100% of staff.

- Equality and diversity training had been updated by 91% of staff.
- In adult basic life support (mandatory for all staff), 85% of non-clinical staff and 89% of clinical staff had completed their update, and 92% had completed their immediate life support.
- When looking into the detail of one of the courses, we saw 74% of staff (61 from 82) had updated their infection prevention and control aseptic non-touch technique course. Four of those who had not completed the course represented 50% of the theatre practitioner team.

- Those staff we met said the training was a good quality. The hospital had an interactive computer-based training system and all staff were provided with access to the system. There were some elements of practical training supplementing the online system. The training for intravenous fluid administration was, for example, both an online and practical course. Medical gases training also had theoretical and practical stages.
- Senior staff said they were able to check on training compliance levels for their staff at a glance. The system allowed senior staff to check on individual records and departmental results. All training compliance was discussed with staff at their annual appraisal. This conversation included asking staff if they found the mandatory training comprehensive and an effective learning tool.

Assessing and responding to patient risk

- The hospital used an early warning score system to respond to deteriorating patients. The hospital protocol followed the guidance of the National Early Warning Score (NEWS) system. All patients were monitored by the nursing staff for a number of clinical and physiological markers. This included for example, patients' blood pressure and temperature levels, and respiratory measures. If any of these triggered concerns, there were different protocols to follow. These ranged from increasing observations and measurements, to contacting the consultant or resident medical officer.
- There were regular nursing ward-rounds to ensure patients were safe. These regular rounds were called 'intentional rounding'. They checked, for example, if the patient needed any support with personal care, medicines had been given and taken, if the patient needed assistance to use the toilet or wash, if they were comfortable, including in any pain, and their fluid and nutrition balances assessed and managed.
- There were arrangements for transferring patients for emergency care. The hospital had a service level agreement with a nearby NHS acute hospital with an emergency department. This meant patients who might significantly deteriorate at any stage in their treatment would be taken by NHS ambulance to the local emergency department or directly to critical care with authority from the NHS trust. The patient would be accompanied by the anaesthetist and recovery practitioner. The most current agreement was, however, long overdue for renewal and the hospital was endeavouring to obtain an updated version.
- The hospital had a trained resuscitation team available 24-hours a day. All resuscitation staff were trained in immediate life support for both adults and children.

Nursing staffing

- There were safe levels of nursing staffing on the wards and operating theatres. The hospital was using a planning tool (the BMI Healthcare Nursing Dependency and Skill Mix Planning Tool 2015) to optimise the levels of nursing staffing. This tool was used to safely support the needs of patients being admitted. It was used to plan the appropriate levels of staff five days in advance of each shift. The ratio of nurses to patients was around one nurse to every six patients. We went back through the nursing staff rotas for January to March 2016 and, with the exception of a few occasions, all shifts were covered. On the few occasions where there were gaps, these were of no more than six hours without the full complement of staff.
- Staffing levels were adjusted to meet patient needs. The model used provided the senior nursing staff with a baseline. We saw how the staffing levels had been increased at times when a patient had a higher degree of needs or support required than had been anticipated.
- Bank and agency staff supplemented vacant nursing shifts. There was some use of agency staff, although the hospital used predominantly bank staff (its own staff either working additional hours, or with flexible working terms). In 2015, there had been an average of 5% of nurses in the inpatient department engaged from agencies. There were 4% engaged in theatres. The majority of the agency staff were used in the latter part

of 2015, including the winter period. There were no agency staff employed as healthcare assistants, and, in the latter part of 2015, an average of 3% of allied health professionals had come from agencies. Any other vacancies not covered by agency staff were filled by bank staff.

- There was a good skill mix among the nursing staff. The staffing levels and skill mix supported the safe ratios of nurses and healthcare assistants to patients. The wards used a mixture of a nurse manager, sisters, staff nurses and healthcare assistants. They had support from physiotherapists, pharmacy staff, and administration support. The hospital employed 30 nurses (18.1 full-time equivalent (FTE) posts) and 13 healthcare assistants (10 FTE) in the inpatient and day-case wards. There were three operating-department practitioners (2.5 FTE), 23 nurses (19.1 FTE) and 11 healthcare assistants (9 FTE) in the operating theatres. The allied health professionals (AHPs) provided support including physiotherapy and pharmacist services. The hospital had 33 AHPs (18.9 FTE) among its clinical staff. Staff worked both full and part time and the nursing team staffed the inpatient ward seven days a week. The theatre team worked Monday to Saturday.
- There were low levels of staff turnover, although some vacancies to be filled in nursing care. In 2015, there were just 1%, on average, of nursing and healthcare staff in the wards and theatres leaving. Vacancy rates at the end of 2015 were 7% for ward-based nurses, although the hospital had a fully employed team of healthcare assistants. There were vacancies for 8% of the nursing team and 3% for operating-department practitioners in theatre. As the hospital employed relatively low numbers of nursing and healthcare staff when compared with a larger NHS trust, these vacancy rates also represented low numbers of actual staff, and just one or two in most departments. Most of these vacancies had been filled by the time of our inspection.

Surgical staffing

- The service was supported and delivered by a small consultant team. The hospital did not employ medical staff directly, but approved doctors and consultant surgeons operated under practising privileges. Doctors working at the hospital were approved by a medical advisory committee, chaired by one of the small team of experienced consultant surgeons. There were 107 doctors granted practising privileges (this covered all specialities and not just surgery). Of these, 30 had not provided any episodes of care in 2015. The chair of the medical advisory committee said any doctors who had not practised for over a year would be reviewed by the committee before they would return to practise at the hospital. Seventy-one doctors had carried out over 10 episodes of care, and 51 of these were working regularly having each delivered over 100 episodes of care.
- The doctors and consultant surgeons came to the hospital when they had patients attending for consultations, clinics, or for surgical procedures. The hospital was organised with sessional arrangements. Doctors would therefore attend to provide pre-, intra-, and post-operative care to their patients. The hospital's contract with medical staff required them to be available when they had patients in the hospital. This could be in person or by telephone. The doctor was required to have appropriate alternative named cover arranged if they were to be unavailable at any time when they had a patient admitted to the hospital.
- The hospital had constant medical cover from a resident medical officer (RMO). The hospital did not employ its RMOs, but had a long-standing small team who were contracted from a third-party agency. There was one doctor on duty at all times. Covering the rota usually involved two doctors (employed by the agency) handing over to each other within an agreed framework. The primary RMO had been at the hospital for 15 years, and the other for about 18 months. The primary doctor undertook the majority of the rota, with the other doctor covering their contracted absences. The contracted agency would provide another RMO if either of the doctors were unable to be at the hospital in a planned or unplanned absence. The RMOs were qualified doctors and required to have advanced life support (ALS) and European paediatric advanced life support (EPALS) training. We checked the files for the RMOs and both had EPALS and ALS training in date.
- The RMO carried out two ward rounds each day. The morning round included reviewing the patients, writing-up any prescription charts, taking blood samples and supporting the nursing team. There was a further ward round in the late evening to review all patients again. The RMO was then available throughout the day and the night for any planned or unplanned care or treatment for patients or guidance to staff. The RMO we met said they had a good working relationship

with the consultants, who came to the ward and saw their patients both pre- and post-operatively. The RMO had a handover at the end of their session with their colleague coming on duty.

Major incident awareness and training

- There was limited simulation training and some gaps in the business continuity planning. The business continuity plan did not contain action cards for an outbreak of infection/pandemic (although this was contained in the infection control policies), inaccessibility of the hospital to vehicles, security failures (although the hospital said this had been produced in December 2015), and providing support to the local NHS acute trust. Essential electrical equipment had also not been recognised. This had been escalated to the risk register, but no progress had been made as yet. The hospital had also recognised it was not participating in the simulation programme according to the organisation's policy. The hospital was required to carry out a staff communications exercise every six months, a desktop exercise every year, and full live evacuation every three years. The hospital provided evidence of the last evacuation they carried out in 2014, and the comprehensive report about how the exercise worked. The hospital had not addressed the latter two items on the risk register, but staff said they were scheduling six-monthly simulation exercises.
- The operating theatres had good facilities for securing the area and safe evacuation in the event of an emergency. The operating theatres were secure from fire or smoke outside of the theatres for up to 60 minutes. This would provide theatre staff time to safely evacuate the patient. The theatres were on the ground floor and had rear access. At the rear of the theatres was an internal road, which would permit an ambulance to arrive to receive an evacuated patient. There was a transfer kit available in theatres for such emergency use. There was also a major haemorrhage plan and flow chart in the operating theatres.

Are surgery services effective?

Good

We rated effectiveness as good because:

- The hospital was providing an enhanced recovery programme to patients having orthopaedic surgery. This practice was known to improve patient outcomes.
- Pain relief was well managed for patients and there was a good review and management of patients' nutrition and hydration.
- Patients had good outcomes, in line with NHS outcomes, from hip and knee replacement surgery.
- Few patients had to remain in hospital overnight after day-case surgery; there were few unplanned transfers to other hospitals and few unanticipated patient readmissions.
- Medical staff were checked and evaluated for their fitness to practise and all staff employment checks were complete and up-to-date.
- There was a good standard of multidisciplinary work in patient care.
- The hospital had access to services it needed over all seven days, and had arrangements with the local NHS hospital for emergency transfers.
- There was good access to patient records and other information.
- Patients were enabled to give valid informed consent. The hospital was able to provide care to people who did not have the mental capacity to provide their own valid informed consent.
- The hospital participated in national programmes to monitor and research surgical procedures.

However:

- The hospital was not able to clearly demonstrate through its clinical governance how it was assured of the implementation of new or revised professional guidelines. There was evidence this was shared with key staff, but this was not reported to the executive team to provide assurance.
- Although the number of patients was small, the reported outcomes from groin surgery were not as good as the NHS.
- The hospital personnel system was not able to demonstrate that all employed staff had been given an annual review of their performance (appraisal).
- There was no pharmacist advice available out-of-hours.

Evidence-based care and treatment

- The hospital participated in an enhanced recovery programme for patients having orthopaedic surgery. This was a programme designed to improve patient

outcomes, reduce length of stay, and speed up a patient's recovery after surgery. The hospital ensured there was good planning and pre-operative assessment for patients. Patients we met who had orthopaedic surgery said they felt well prepared for their surgery and knew they needed to get up and on their feet as soon as possible. There was increased attention to pain relief and post-operative nausea. Patients were given both pain and nausea relief, if judged appropriate, to anticipate and reduce these possible problems. Following their operation, patients had a minimal use of catheters and drips, and were mobilised as soon as possible. Patients had two physiotherapy sessions each day until they were discharged. One of the patients we met who had a knee replacement less than 24 hours before we met them had already been taking small steps using a walking frame. They had been assessed and treated by a physiotherapist that morning and had been able to stand and walk. They had been told what exercises they needed to do, how often, and how to build up their strength both while they were in the hospital and at home.

- The hospital reported to the National Joint Registry. This was a group set up by the Department of Health in 2002 to collect data on all hip, knee, elbow, and shoulder replacement operations to monitor the performance of replacement implants. The hospital undertook hip and knee replacements and provided regular data on these procedures.
- The hospital participated in the programme of Patient Reported Outcome Measures (PROMs). PROMs was a programme established by NHS England to measure patients' health-gain following four common procedures. The hospital reported for the three of these procedures it performed, namely hip and knee replacement and groin hernia surgery.
- There was good discharge paperwork and advice to patients. The pack given to patients to take home included the 24-hour helpline number for the hospital, a letter for the patient's GP, advice on avoiding the risks from deep vein thrombosis, an exercise letter (if appropriate), a copy of the consent form, and discharge letter.
- The potential for loss of body temperature in patients in the operating theatre had been recognised. The hospital was using warming equipment to maintain patients' normal body temperatures (called normothermia). It has been recognised that maintaining body temperature and preventing hypothermia (caused sometimes by anaesthetics, anxiety, wet skin preparations and skin exposure) helps to reduce post-operative complications. A patient told us specifically how comforting the use of a warming blanket was when they were recovering from an anaesthetic.
- Clinical governance meeting minutes did not demonstrate how the hospital was assured staff were following and up-to-date with new or revised clinical guidance, although there was a register of new guidance being completed. In terms of governance records, in the three months from November 2015 to January 2016, the minutes had the same comment around National Institute for Health and Care Excellence (NICE) guidance – which was for a member of staff to discuss with another and "distribute." The medical advisory committee minutes from July 2015 noted how there was a "CQC requirement to demonstrate how we review and respond to NICE guidance." This was not followed up by any future referrals in the minutes for September or November 2015 or January 2016. Following our review, the hospital provided us with a register of clinical guidance from June 2015 to July 2016. This showed what the new or revised guidance was about, and to whom it was being distributed in the hospital. There was an opportunity for staff to comment on the guidance and how they would be implementing it.

Pain relief

- Patients told us their pain had been well managed. Those patients we met said the nursing staff on the wards and in the theatre, and the consultant looking after them had asked about any pain or discomfort. Where it was needed, patients were prescribed either regular pain relief medication, or it had been prescribed to be given when required. Patients said they had been asked about any pain during the daytime, and during the night when the nurses were carrying out their observations. Those patients who had required pain relief at either time of the day said it was provided quickly. In the patient satisfaction survey for February 2016 (184 responses) patients responded as follows:
  - 90% said the hospital had assessed the level of their pain.
  - 94% said the hospital did everything it could to help control the pain.

- 98% said the possible level of post-operative pain was explained to them.

- Pain relief was appropriate to the condition and type of pain. Patient prescription charts indicated the use of different forms of pain relief. This included different but appropriate strengths, routes of administration (oral or intravenous) and frequency administered to patients. Patients were given prescription or over-the-counter medicines for ongoing pain relief to take home with administration instructions. Alternatively, patients were given advice about taking over-the-counter pain relief at home following their procedure.
- Patients were given advice regarding any pain that continued longer than it should. The hospital had a helpline staffed 24 hours a day for patient advice. Patients were able to talk to one of the nursing team about a range of questions, including ongoing pain, and obtain advice and guidance.

Nutrition and hydration

- Patients were assessed for risks to adequate nutrition and hydration. The hospital was using the widely recognised Malnutrition Universal Screening Tool (MUST) to assess patients against the risks of poor nutrition or hydration. Fluids intake and output were measured to ensure a good fluid balance was maintained. We saw examples of well-completed MUST records for patients, including care plans to help with any risks identified. Nutritional supplements were available and would be prescribed if patients needed them. Food could be prepared in a variety of textures if patients had difficulty with swallowing or digestion.
- Patients undergoing operations or other procedures were given appropriate instructions about limiting or stopping eating and drinking prior to their procedure. Patients were written to as part of their admission procedures with details of when and what they could or could not eat and/or drink prior to their operation or procedure. Those patients we spoke with all confirmed this information had been given to them and was clear to follow. Patients said they were asked when they arrived if they had followed the instructions. Patients also knew why this was important, as it reduced the risks of being or feeling sick before, during or after surgery or a procedure.

Patient outcomes

- There were no unexpected deaths of inpatients or day-case patients in 2015.
- Only a small number of patients admitted for day-case procedures remained at the hospital overnight. Of 6,798 day-case patients, just 1.2% (84) required an overnight stay. This was, generally, where the patient had been assessed as not well enough to be discharged on the same day as their procedure. Some patients had their surgery later than planned, and staff assessed it was better for the patient to remain in their care overnight. The patients had been able to stay at the hospital overnight as the day-case patient rooms were furnished to enable overnight stays if the inpatient rooms were occupied.
- The hospital participated in the Patient Reported Outcome Measures (PROMs) audits for NHS-funded patients undergoing hip and knee replacement and groin hernia surgery. Results for hip and knee replacements were much the same as or slightly better than those in NHS hospitals, although there was an indication of reduced outcomes for groin hernia surgery. The results for the latest published period with ratified data (April 2014 to March 2015) were as follows:
  - Hip replacement
    - The European quality of life five dimensions questionnaire (EQ-5D) index measured responses in five broad areas of mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Out of 84 questionnaires returned, 91% of patients said they had experienced improvements, and 5% said their health had worsened. This was much the same as the results throughout the NHS.
    - The European quality of life visual analogue scale (EQ-VAS) index measured how the patient would describe their general health on the day they completed their questionnaire. Out of 83 questionnaires returned, 63% reported their health as improved and 24% as worsened. This was much the same as the results throughout the NHS.
    - The Oxford Hip Score measured responses to specific questions relating to the joint replaced. Of 91 questionnaires returned, 99% reported improvements. This was slightly better than the results throughout the NHS.
  - Knee replacement

- In the EQ-5D index, 42 patients returned questionnaires. Of these, 91% reported improvements and 2% a worsening in their health. This was slightly better than the results throughout the NHS.
- In the EQ-VAS index, 42 patients returned questionnaires. Of these, 64% reported improvements and 24% a worsening in their health. This was slightly better than the results throughout the NHS.
- In the Oxford Knee Score, 44 patients returned questionnaires. Of these, 98% reported improvements. This was slightly better than the results throughout the NHS.

- Groin hernia surgery
  - In the EQ-5D index, 43 patients returned questionnaires. Of these, 51% reported improvement and 16% a worsening in their health. This was slightly worse than the results throughout the NHS.
  - In the EQ-VAS index, 42 patients returned questionnaires. Of these, 48% reported an improvement and 36% a worsening in their health. This was below the NHS reported health gain.

- There were low levels of unplanned transfers to other hospitals. In 2015, 10 patients were transferred to the local acute hospital emergency department or critical care (with advanced authority to transfer) due to an unexpected and unanticipated deterioration in their condition during their stay. This represented 0.6% of the 1,718 patients treated as inpatients in 2015. The rate of transfers also fell across 2015. Staff at The Ridgeway would contact the local NHS acute hospital in advance of any transfer and notify the staff on duty and handover relevant medical information. The hospital had a service level agreement with the local NHS trust governing how these transfers should be managed. The agreement had not, however, been updated recently. The date of the agreement was not clear, but it appeared to have been established in 2010 and expired a year later.
- There were low levels of unplanned and unanticipated patient readmissions. In 2015, 17 patients were readmitted as an inpatient within 29 days of their treatment at The Ridgeway Hospital. This represented 1% of the 1,718 patients treated as inpatients in 2015. The rate of readmissions also fell across 2015.

Competent staff

- Doctors were checked for their fitness to practise. The hospital maintained a register, which included checks on valid medical indemnity insurance, Disclosure and Barring Service (DBS), annual appraisals, and registration with the General Medical Council. We reviewed the register and found:
  - All the DBS disclosures were up-to-date. These were reconfirmed by the hospital every five years.
  - All the medical indemnity insurance certificates were up-to-date.
  - The majority of medical staff had supplied up-to-date appraisals from their employing NHS trust. In 2014, it had become a requirement of doctors' registration to have an annual performance review as part of the 'revalidation' programme (General Medical Council, 2014). Almost all doctors practising at the hospital were employed by the NHS, who were responsible for their revalidation, and subsequently their annual appraisal. Copies of these were to be supplied to The Ridgeway Hospital as part of the practising privileges contract. If any doctors were no longer working in the NHS, they were responsible for ensuring their appraisal was undertaken each year by an independent reviewer (responsible officer).
  - All the doctors had valid registration with the General Medical Council.

We reviewed five of the consultant's files and found all of the above documentation to be in order. However, one of the consultants did not have their hepatitis status recorded, as was required by the organisation. All of these doctors had signed practising privileges contracts held in their files.

- Appraisal data was not demonstrating all non-medical staff (nurses, healthcare assistants, and other staff) had been given an annual review of their competence and professional development. The hospital had changed to a new employee system. During this process, it became apparent there had not been effective reporting of staff appraisals from the previous paper-based system. This had been recognised and escalated to the hospital risk register. All the staff we met said they had been given their annual appraisal and this took place with their manager each year. However, the data was not able to support this, and the hospital was aware and open

about the previous shortcomings with the reporting system. The senior management team were confident the new system would improve the ability to report accurate data. The data at the end of 2015 (2014 in brackets) was:

- There were 32% (30%) of ward-based nurses and 15% (15%) of healthcare assistants reported as having their annual review.
- There were 24% (2014 not reported) of theatre nurses, 50% (2014 not reported) of healthcare assistants in theatre, but 100% (2014 not reported) of operating-department practitioners reported having their annual review.
- There were 100% (57%) of allied health professionals reported as having their annual review.
- There were 93% (72%) of administrative and clerical staff, and 61% (50%) of other staff reported as having their annual review.

- The hospital used a regular employment agency to supply temporary nursing staff. The hospital contract with the nursing agency required the agency to perform all employment checks and confirm these were valid. The hospital provided induction to the agency nurses when they came onto their first shift, or had not been at the hospital for a while. This included orientation with the hospital, equipment used, and introduction to key staff. We reviewed a number of induction forms on the ward and operating theatre for agency staff to sign to say they had received their induction. Not all the forms were signed by the nurse who had supervised the induction, but they were completed by the agency staff.
- Staff employed directly by the hospital had employment checks. This included references, DBS disclosures, proof of identity, and a check of any relevant professional registration. Employees were not permitted to start work at the hospital until all of these checks were satisfactorily completed. The DBS disclosure checks were repeated every three years in accordance with hospital policy. We reviewed the hospital's records and all the employment checks had been completed and were up-to-date.

Multidisciplinary working

- There was good multidisciplinary working between staff and services. This was a small independent hospital where many staff had worked together a long time and knew each other well. Staff were therefore aware of different strengths and experience they could draw upon throughout the hospital. Patients' records showed a good range of multidisciplinary input. Most patients had input from their consultant, nursing team, the pharmacist, and the physiotherapist. There was also input from a dietitian or other therapist as necessary.
- There were arrangements for multidisciplinary support between external agencies. The hospital had service level agreements with other providers. This included emergency transfer arrangements with the local acute NHS hospital (although out of date) and a close working relationship with the local hospice located within a few metres of the hospital. The hospital would also contact and involve a patient's GP or other healthcare or social care professionals where this was required. Staff said they had worked with adult social care settings, such as nursing homes or care homes, if appropriate. The hospital also communicated with any care provider who delivered support to the patient when they returned to their own home.
- A daily head of department meeting took place every morning in the executive director's office. This was called the CommCell (communication cell) meeting and gave staff an opportunity to discuss their plans and challenges for the upcoming day. The meeting was also used to update staff on ongoing issues and hospital activity, and to praise individual staff for achievements. Outcomes from the meeting were then fed back to staff in the departments by their head of department. The CommCell meeting we went to during our inspection was well attended with representatives from every department.

Seven-day services

- There was access to required services over seven days. The hospital operated on Monday to Saturday, and patients were accommodated across all seven days. There were nursing staff and healthcare assistants on duty across all seven days, which included senior nursing managerial oversight.
- There was access to a consultant seven days a week. Consultants who provided surgery services at the hospital were able to attend the hospital at short notice from an on-call arrangement. Consultants were otherwise available during the daytime, and when they were operating or taking clinics and consultations on Saturdays.
- There was 24-hour medical cover, seven days a week from resident medical officers (RMOs). The RMOs were

based on the hospital inpatient ward and on-call around the clock. Staff told us they had a good working relationship with the RMOs and they attended patients at any time they were requested to do so. The RMO otherwise reviewed all patients twice a day, every day.

- Although medicines were available over all seven days, day and night, there was no on-call pharmacy advice service out-of-hours. Nursing staff were able to get advice and guidance for medicines from an approved database. This included information on intravenous fluid administration, and other medicine administration guidance. The British National Formulary was available in printed form or online.
- The pathology services were available through the third-party provider 24-hours a day, seven days a week. If a patient needed an X-ray in an emergency, the diagnostic imaging service provided an on-call service over the weekend.

Access to information

- There was good access to patients' medical records. There was limited storage on site and medical records were held in their paper form for the current month and previous three months. These were held securely in a medical-records office in an organised and well-designed system. Records could therefore be accessed easily, and there were staff available in medical records to help. Older records were scanned by a professional scanning company and then returned to be held electronically.
- Patient records were in good condition. The patient paper-based records we saw throughout the hospital, either in use or in medical records, were well organised, and pages were secured. Many patients had care plans or procedure plan booklets printed on good quality strong paper. These were in good condition. There were no loose pages in the files we looked at, and a logical order for the records.
- Test results came back in good time. The hospital had a third-party pathology team on site providing results from blood and other agreed tests. There were X-ray and scanning facilities on site within the diagnostics department. The hospital had a third-party agreement with a company providing an open MRI scanner on site.
- GPs were given information about care and treatment provided to their patients. There were letters produced and provided to each patient's GP, which were given to patients to deliver. There was currently no electronic system to deliver this information, so the hospital relied upon patients to deliver the letters. The information provided to the GP was comprehensive and included information on any medicines prescribed, the procedure carried out, test results and other important information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were enabled to give valid informed consent where they were able. Patients assessed as having the mental capacity to make their own decisions were given time and information to make informed consent. The hospital followed the organisation's policy on consent for examination or treatment. This included providing a 'cooling-off' period for patients electing to undergo cosmetic surgery. Clinical staff taking consent from patients recognised the legal and ethical principles around gaining valid informed consent. We spoke with a range of patients about how their consent was given. They all told us it was given voluntarily, and not before they had been told about the advantages and possible risks of the proposed procedure. Patients said they had been able to ask any questions about the treatment. Those patients we met said they were aware they could change their minds, even after signing their consent form. The hospital performed only planned operations, and did not operate on patients in an emergency. However, the hospital policy recognised treatment could be provided to patients unable to give consent due to an emergency situation. In those circumstances, treatment could be given without consent in order to save life or avoid significant deterioration in a patient's health. The patient was to be told what had taken place as soon as was practically possible.
- Written, verbal or implied consent was gained where this was required by hospital policy. Not all consent needed to be given in writing, but clinical staff followed hospital policy where this was needed. Written consent was required, for example, in all complex and invasive surgical procedures, those involving risks or complications, or may have significant consequences on a patient's employment or personal life. Consent was also needed for any procedure or investigation that involved research. Implied or verbal consent was otherwise sought when it was appropriate. This would include, for example, non-invasive scans or diagnostic tests, blood tests, and physiological observations.

Patients were able to give partial consent. The hospital's policy allowed patients to consent to some procedures and not others. Therefore, patients who objected on religious grounds, for example, to some aspects of medical treatment, were able to complete forms restricting the care or treatment they would accept.

- Consent was documented on appropriate forms and copies provided to patients. There were different forms for patient consent. The hospital used four forms, and the majority of patients used form one. This was consent from a patient or competent child for procedures involving general/regional anaesthesia or sedation. Forms two and three were used for consent from a parent or guardian for a patient who was a child or young person. Form four was to be completed in the event an adult patient was not able to provide valid informed consent. We saw appropriate forms used in patient records, and those patients we met said they had been given copies of their consent forms.
- The hospital acted in the best interests of patients who could not give valid informed consent. The hospital followed the requirements of the Mental Capacity Act 2005 in providing care and treatment only in the best interests of patients with limited or no capacity to decide for themselves. Patients were assessed by consultants or a senior nurse to determine if they had the capacity to make their own decisions. If this were decided not to be the case for the procedure being considered, the patient's consultant would involve other parties in the decision. This may include a person who held the Lasting Power of Attorney for the patient's medical decisions or a court appointed deputy. It usually involved the patient's family and GP, and other healthcare professionals. Before proceeding, the consultant was expected to determine if the patient had previously indicated any wishes around medical treatment through an Advanced Directive. If a decision were taken to proceed in the best interests of the patient, this would be the least restrictive treatment for the patient.
- Staff had knowledge of Deprivation of Liberty Safeguards, but it was unlikely to apply in this hospital. A person can be deprived of their liberty if they do not have the capacity to make their own decisions and need treatment, care or safety to protect them. An application to deprive a person of their liberty in order to receive care and treatment was unlikely to be required for a patient treated at The Ridgeway Hospital. However, the hospital described the circumstances in which this might apply and the procedures to follow in the unlikely event it would be deemed appropriate. None of the nursing staff we met could remember it ever being used, but knew of its application.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding because:

- Feedback from patients about the way all staff treated people was continually positive.
- There was a strong person-centred culture. Staff were highly motivated to provide patients with dignity, kindness, compassion and respect. This attitude was found in all staff, not just doctors and nurses, but the team at the reception desk, the housekeeping team, catering services and the maintenance team.
- Staff took the time to interact patiently and empathetically with patients.
- Staff were encouraging, sensitive and supportive.
- Privacy and dignity was respected in all aspects of care and staff respected patients' confidentiality.
- All staff communicated with patients so they understood the care they were receiving and were encouraged to ask questions and raise concerns.
- Staff understood the impact treatment might have on a patient and were sensitive to patients' needs.
- Patients were treated as individuals. Any patient's needs would be considered and the hospital would work hard to overcome any obstacles to provide care and treatment.

Compassionate care

- Patients were treated with kindness and care. All the patients we met said the best thing about their care and treatment at the hospital was the kindness and attentiveness of the staff. We met a number of patients who had been at the hospital before and we were told this had always been their experience, and it was what they would most highly recommend about the service. We observed excellent levels of reassurance given to a patient in the operating theatre prior to the administration of their anaesthetic. Quotes from the patients we met on the wards included:

- "The care you get and the friendliness of the staff is the best. They can't have done anything any better."
- "The staff are wonderful and they are so friendly."
- "I like the atmosphere. It's comfortable and I have been really well cared for."
- "I've been more than happy with the staff I have met and very reassured. Everything was quick and efficient. I can only say it's been very, very good."
- "I just can't fault the care. I have been so very well looked after. The staff couldn't have been kinder – all of them."

- Staff took the time to interact with patients and their families. Patients were met on arrival by staff and accompanied to their room or treatment area. Patients were given time to settle in before staff made sure they were comfortable and if there was anything they wanted to ask or needed.
- Privacy and dignity was respected. Patients were admitted to single rooms on the wards and, unless they requested, the doors were closed for privacy. We observed staff knocked on patients' doors before entering, although one member of staff did not give patients a chance to respond to the knock before they entered. Patients transferring to or from the operating theatre were covered at all times to preserve their dignity. Patients undergoing tests or procedures were admitted to rooms for the tests or obscured by curtains.
- The hospital had outstanding results from the NHS Friends and Family Test. In the six months from September 2015 to February 2016 (the most recent data), the hospital had a higher response rate than the NHS average. The hospital had an average response rate of 46% (NHS average 28%). Of those patients who responded, in five of the six months, 100% said they would recommend the hospital to their family and friends. In the other month, the recommendation was from 99% of patients.
- The hospital produced a more in-depth patient satisfaction report with excellent results. There was an outstanding quality of comments made to the hospital by patients completing the in-house questionnaire. A sample from the list of just under 200 comments made as they related to compassionate care included:
  - "In all my visits to other hospitals I have never been so well looked after as here in Ridgeway. Thank you so very much."
  - "I couldn't fault the treatment and every member of staff was helpful and understanding."
  - "Excellent care from the nursing team."
  - "Extremely caring and friendly staff. I felt completely at ease and comfortable."
  - "Wonderful staff and treatment."
  - "Great care taken by the staff and nothing too trivial to deal with. Care, good advice during stay and made me feel comfortable as an inpatient."
  - "The ward hostess was always so happy; she always cheered me and my family up. She is an asset to your team."
- The patient satisfaction survey (184 responses) results were excellent for privacy, dignity and care. The results for February 2016 were:
  - 100% said they were given privacy and dignity when discussing their condition/treatment.
  - 99% said they were treated with dignity and respect.
  - 97% said they were impressed with the consultant anaesthetist.
  - 98% said they were impressed with the consultant surgeon/physician.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so they understood how their care and treatment was going to be provided. We observed, for example, both support but also good explanations given to a patient in the operating theatre before they were given their anaesthetic. All the patients we met on the ward said communication with them had been good. They had been able to ask questions at any time, and the staff explanations had been straightforward and clear.
- Patients had individualised support. Each patient was given a named nurse during his or her stay at the hospital. Patients told us this was something they appreciated, as the named nurse took time to find out more about the patient, and knew all the details of their care and treatment. Staff took time to contact the partner of a patient. The patient was concerned about their partner, and staff took the time to contact them and reassure the patient.
- Individualised support extended to a patient's religious, cultural, social and personal needs. Patients were asked to provide details on any specific needs they might have and the hospital would endeavour to meet these where it was possible. This included providing chaperones,

gender-specific nursing, and planning appointments, care and treatment to fit in with any religious or cultural needs. Staff were able to talk to us about some of the specifics of certain religions and cultures they had experience of and how they met certain needs for patients and their relatives.

- There was an outstanding quality of comments made to the hospital by patients completing the in-house questionnaire. A sample from the list of just under 200 comments made as they related to people understanding and being involved with their care included:
  - "The entire team were very friendly and supportive. Everything was explained clearly and genuinely. I was well taken care of."
  - "Everyone very professional and caring. Thorough and detailed explanations. Very attentive consultant. Feel lucky to have The Ridgeway on my doorstep."
  - "Attentive staff. Fully informed of the procedures."
  - "Caring, understanding and manage expectations with what is going to happen, ensure comfortable at all times."
- The patient satisfaction survey results (184 responses) were excellent for communication with patients and their families. The results from questions about understanding and involvement of patients and those close to them for February 2016 were:
  - 100% said they were involved in decisions about care and treatment.
  - 96% said their family or someone close to them was able to talk to a doctor.
  - 95% said they had individual attention from the nurses.
  - 95% said they felt confidence in the staff.

Emotional support

- The patient satisfaction survey (184 responses) results were excellent for emotional support to patients. The results from a question about emotional support for February 2016 were:
  - 100% said they could talk with someone about their worries/fears.
- Staff understood the impact care and treatment would have on a patient and provided them with emotional support. Staff described how some patients would be anxious, and they would ensure they spent time with them before their procedure and went with them to theatre. Patients we met confirmed this had happened. One patient described staff as "incredibly perceptive as I was trying to be brave, but clearly not doing terribly well. They were incredibly reassuring. I did not feel like just another patient but someone they cared about getting through this." Another patient said how the anaesthetist had recognised they were anxious and had "really taken my mind off what was happening."
- Patients had their psychological and psychosocial needs met. This included ensuring people had their pain addressed, adequate nutrition and hydration, and their personal hygiene needs met. Staff took time to talk with patients who were anxious and looked for medical support when it was recognised as needed. Patients told us they had not been made to feel embarrassed about asking for help with personal needs or requests. They said staff had respected their privacy and dignity, but not without ensuring they were safe and able to manage first.
- Nursing staff said they would not proceed with a patient's treatment if they were concerned about them in any way. Staff we met said any emotional needs of a patient would be taken into account before any procedure took place. This would be the case even if any of these concerns had not been flagged by the patient prior to the procedure, or were new worries for the patient. Staff were not under any pressure to continue with any non-essential treatment if it was not felt to be in the best interests of the patient's emotional wellbeing at the time. Any proposed changes to plans would be considered with multidisciplinary input to any discussions or decisions.

Are surgery services responsive?

Good

We rated responsiveness as good because:

- Services were planned and delivered to meet people's needs.
- There was equitable access for all people who used the hospital.
- There was timely access to services.
- Planned operations were cancelled infrequently for non-clinical reasons.
- Most patients were treated within 18 weeks of their referral.

- People were treated as individuals, and care and treatment delivered to meet their different needs.
- There was a good response to complaints and the organisation learned lessons when something went wrong or a patient was not entirely happy with the service.

However:

- There were known but unresolved problems with not enough parking spaces for patients and their visitors at all times.
- There was some increase in patients' concerns about noise disturbing them at night.

Service planning and delivery to meet the needs of local people

- The hospital met the needs of local people. The hospital was opened originally in 1984 by a group of local consultants in order to provide independent healthcare to the area. Since that time, the hospital had taken on an increasing amount of work for the NHS, commissioned by the local clinical commissioning groups and local NHS hospitals. The work undertaken for the NHS now comprised, in mid-2016, of just below 50% of the service provided by the hospital. In 2015, this had amounted to 15,854 patient spells and around 34% of the services provided. This was therefore helping to meet the needs of the local population. The service enabled NHS patients in the local area to have access to, and a choice of where to, have a range of elective operations or procedures.
- The premises and facilities were appropriate for the services planned and delivered, although there were problems with car parking at some times of the day. The hospital environment was accessible for people with disabilities and they could use services on an equal basis with others. The patient areas of the hospital were spread over two floors. The first floor was accessible by stairs or a lift and the lift was suitable for wheelchair access. The one area of concern from patients about the facilities related to car parking. Some patients we met did not have a problem finding a parking space, but others said it was their only worry about visiting the hospital. The senior management were aware of the concerns of patients and visitors and were looking at possible solutions in the local area.

Access and flow

- Patients had timely access to services. Those patients we met (a mixture of both self-funded, medical insurance-funded, and NHS patients) said they had been given a relatively quick appointment and most in a matter of a few weeks at most. Patients said they had been asked if there were appointment times that would not suit them, although they were happy to fit in with the hospital and consultant routines.
- There were arrangements for patients to return to surgery for unplanned reasons. The service was flexible to allow for patients to be booked in as soon as possible if they needed a further procedure. The hospital had an on-call theatre team seven days a week, which would be used if medically appropriate to do so. Any emergency readmissions which needed a higher level of care to be available would be handed over to the local NHS acute hospital.
- The hospital was treating most NHS-funded patients within 18 weeks of their referral for treatment. The hospital reported on information about treatment times as required for its NHS patients. In the most recent data available (February 2016) the percentage of patients being treated within 18 weeks of referral for the major surgical specialities (figures in brackets are to compare against South of England Commissioning area in February 2016) were:
  - General surgery – of 150 patients, 97.3% (87.4%) were treated within 18 weeks. The average waiting time was 5.1 weeks (6.6).
  - Urology – of 89 patients, 85.4% (90.7%) were treated within 18 weeks. The average waiting time was 5.8 weeks (6.5).
  - Trauma and orthopaedic – of 271 patients, 93.7% (88%) were treated within 18 weeks. The average waiting time was 7.2 weeks (6.8).
  - Ear, nose and throat – of 53 patients, 92.5% (90.1%) were treated within 18 weeks. The average waiting time was 6.7 weeks (6.0).
  - Ophthalmology – of 70 patients, 95.7% (93.1%) were treated within 18 weeks. The average waiting time was 2.6 weeks (6.0).
- There was limited cancellation of surgery. Clinical governance notes showed patients were spoken with when surgery was cancelled. Some cancellations were for clinical reasons. This included the patient having made good progress without surgery, and it being decided between the patient and the consultant to not proceed at this time. Some patients had not followed

advice or not had medicine management prior to their surgery explained sufficiently, and surgery had to be postponed. There were some procedures cancelled due to a session starting late and there not being enough time to safely complete the whole list.
  - In November 2015, there were seven cancellations. Most of these were for clinical reasons, although two patients were cancelled due to the late start of a theatre list.
  - In December 2015, there were five cancellations. Two of these were for clinical reasons, one due to an implant not being available, and two due to the late start of a theatre list.
  - In January 2016, there were two cancellations. One of these was due to the late start of a theatre list and the other due to an overrun of a theatre session.
  - Cancellations were not reported at the clinical governance meeting for February 2016, but the clinical incident report showed there were two cancellations in that month. This was due to a patient with a pre-existing condition and another due to the ill health of the patient.
- The hospital's bed-status and patient management was examined each day. There was a communication meeting between senior staff each morning to review the whole hospital. We attended one of these meetings as an observer. There was a strong attendance from all areas of the hospital. Issues were raised, including any incidents, risks, potential for cancellations of operations, bed management and staff issues. Solutions to any anticipated or actual concerns were proposed and taken forward. These were reviewed the following day for their success or otherwise.

Meeting people's individual needs

- Food provision at the hospital met people's individual needs, although this area had received some criticism in the recent past and been improved. Patients we spoke with said they had a choice of food. The food had been served at the right temperature. We were told by several patients that staff said they could ask the hospital catering team to prepare them something else if they did not like anything being offered, or were keen to have something not on the day's menu. The patient satisfaction survey for February 2016 (184 responses) included the following comments about the food:
  - "The quality of food could not be better."
  - "Lunch time often too early and clashed with nursing duties."
  - "General level of food is ordinary."
  - "Not enough variety."
  - "Porridge excellent as well as soups."
  - "Need much more choice."
  - "Lighter hot meal options wanted."

Responses from the patient satisfaction survey included:

- 80% of patients liked the variety/choice of food.
- 91% said their food order was correct.
- 89% said the food was prompt.
- 84% said the quality of the food was good.
- 93% said the catering staff were friendly and helpful.

- Patients and their visitors were provided with regular drinks. Apart from when patients were unable to have fluids due to a pending operation or procedure, there was water provided and regular tea and coffee.
- The majority of patients felt the hospital was quiet and calm, although this was not always the case for some. Most of those patients we spoke with who had been staying overnight said they were able to sleep and it had been quiet at night. One patient had been disturbed by another patient, but staff had apologised to them. In the latest patient satisfaction survey, just fewer than 30% of patients said they had been bothered by noise at some point. This issue had been on the increase over the last 12 months. There was an equal split between the noise being from staff, other patients or something else. Of those patients who were disturbed by noise, most (70%) said it was at night. The great majority of disturbance from noise over the last 12 months had been at night.
- There were no barriers to patients on the grounds of equality and diversity. Admission criteria did not discriminate because of age (although the hospital elected not to operate on children under the age of 16), gender, gender reassignment, pregnancy and maternity status, race, religion or belief, or sexual orientation. Translation services were available and staff were available to chaperone patients if requested.
- There were no barriers to patients on the grounds of their mental health. Patients who were living with dementia were admitted for care and treatment. There was a pre-assessment for patients to screen for dementia. If this was suspected, or already diagnosed for a patient, one of the senior nursing staff or the consultant would assess the patient. This was to

determine if they were able to understand what was proposed to help them with a medical problem. If the patient was not able to understand or had a limited ability to retain information, the patient would be treated in their best interests. This involved hospital staff taking into the account the views of others who cared for the patient. This could include the patient's GP, the courts, other healthcare professionals, and must include the patient's relative or carers, or an independent mental capacity advocate. The hospital consent policy followed the requirements of the Mental Capacity Act 2005 when it came to taking decisions for people who were unable to make their own.

- The hospital would make specific arrangements if staff were asked to support patients with a learning disability or living in vulnerable circumstances. However, the hospital was rarely commissioned to treat people living in these circumstances. The nursing staff told us, however, they treated every patient as an individual. They said they would endeavour to admit, accommodate and support any potential patient and provide individualised care. This could be achieved with the advantages the hospital had of using single rooms for patients, flexible visiting times, named nurses, and the relative peace and quiet on the wards.

Learning from complaints and concerns

- There were small numbers of complaints to the hospital, and they were reported upon and shared among staff and the wider organisation. The hospital produced an annual report for complaints covering October 2014 to September 2015. During this period, there were 52 complaints. In any year, the hospital saw around 45,000 patients. This therefore represented 0.1% of patients making a complaint. In this annual report, the hospital reported 50 of these complaints were resolved by the hospital (called stage one) and the other two were taken to stage two, and managed by the provider organisation, BMI Healthcare. No complaints were reported as being taken to the highest level, stage three, which was to involve the Independent Healthcare Sector Complaints Adjudication Service. The majority of complaints related to consultants, although there was no information as to what aspect of their care. There were six complaints relating to finance.
- There was a system and process for responding to people's complaints and response times had improved. People who complained had an acknowledgement letter within two working days followed by a full response within 20 days. If the investigation took longer than 20 days to complete, the complainant was sent another letter each 20 days until the matter was resolved. During the 12 months from October 2015 to September 2015, there were three months where not all complaints had responses within 20 days. The last time this occurred was May 2015. This was brought to the attention of the senior management team, and after May, all responses were within 20 days.
- There was learning from complaints and comments by patients and their families. The hospital had addressed matters such as the televisions in patients' rooms. These were originally said to be very small, and had now all been replaced with larger screens. The catering had been criticised, and this had been improved with the third-party provider.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a detailed strategic vision for the hospital, although the key risks did not flow through the strategy or the future plans.
- Audit work was not providing effective assurance of safe and quality care. There was insufficient discussion of audit results in clinical governance meetings. The governance work was not picking up some issues, including gaps in the surgical safety checklist, the lack of assurance of the medical equipment register, and the status of staff appraisals.
- The risk register did not show the age of risks, any reduction in the rating of the risk through actions already taken, and how risks were going to be closed or managed to an acceptable level.
- The hospital's action tracker was over-detailed and not referenced at the clinical governance meeting, although it was at the head of department meeting.

However:

- There was a clear structure for governance and various committees of experts providing analysis and review. Incidents were discussed in detail and actions taken when needed.

- There was a regular and reasonably well attended medical advisory committee with an established experienced chair.
- There was benchmarking in relation to patient satisfaction with other hospitals in the BMI Healthcare group.
- There was strong, visible and approachable leadership within surgery services, and the wider hospital, at all levels. There was good engagement with both staff and the public/patients.
- There was innovation and change, and the hospital was aware of potential risks to sustainability and future growth.

Vision and strategy for this core service

- There were a number of strategic documents which highlighted risks and future plans. These were quite detailed. However, the corporate templates for these documents did not describe the risks or issues, only how they were being controlled. Therefore, it was not possible to know if the controls addressed the risks. In addition, there was no strategy to take forward the top key risk in the 2016 business plan, which was the lack of accreditation of the endoscopy suite. The business transformation projects did not address the four key risks identified by the organisation and did not extend beyond 2016 and into future plans. The objectives, however, did relate to the organisation's eight strategic priorities. The business transformation projects for 2016 included the '@work' employee system for managing the payroll, and the ward-labour resource-planning tool, to manage safe staffing levels. There was a project for standardising guidelines and practices in housekeeping. All of these projects had already been completed. The remaining project was for the delivery of an ambulatory care service. This had an objective to provide services for patients who would not need to remain in hospital overnight, whereas this had otherwise been necessary in the past. This was due for completion in September 2016.

Governance, risk management and quality measurement for this core service

- Audit work was not assuring the hospital it provided a safe and effective service at all times. The audit of the surgical safety checklist, for example, showed 100% compliance in January and February 2016 (March was not done). However, this was looking at only 10 records per month. We looked at 18 records selected at random from patients treated in January to March 2016, and 70% were not complete. Patient health records were shown as 99% compliant in January to March 2016. We found areas that were not complete or were illegible. Infection control was 100% compliant in January to March, but there were a few areas of the recovery room that had excessive dust, and others were in an unsatisfactory state of repair. There had been no audit of the equipment in the hospital to pick up the lack of assurance of planned maintenance being undertaken. Not all hospital staff had a good understanding of the work of audits, and how they contributed to identifying areas for improvement. This was particularly evident within the operating theatres, and this had been identified by the senior management team prior to our visit.
- There was poor recording of audit results at clinical governance meetings. Senior staff told us audits were discussed in detail, but the reporting in the minutes did not demonstrate this. In the minutes from February 2016, for example, the audit comments were "none for discussion". In the previous month, the comments were "nothing further to discuss." In other sections of the report relating to audit, there were no comments to show anything had been picked up at audit and needed further investigation. This was despite there being a monthly audit programme. There was good detail in the clinical governance meeting minutes for other areas, such as incident reporting, but some topics, including audit, were poorly represented.
- The hospital risk register was complex, and did not separate general corporate business risks from those within the control of the hospital and that affected patients, staff and visitors. The dates the risks were added were not included. This meant it was not possible to see how long the risk had been known about, and how long it was taking to resolve. There was no progress of the risks, so it was not possible to see if or when the score given to the risk (a combination of the impact and likelihood) had been reduced by mitigating actions. There was no indication of how or when the risk would be closed. The register did not state if there was a projected score for the risk, which would be considered acceptable in future (as not all risks could be eliminated

in any hospital setting). The risk register included risks to the business, financial risks and government policy risks. There was no progress listed against any of these particular risks.

- The hospital was using an action tracker in relation to reported incidents, repairs or maintenance required, but, and staff agreed, this was becoming too large and somewhat unmanageable. Many of the actions were now completed, which showed good progress in resolving problems. Some were also minor issues, which had quick resolutions. The action tracker, however, did not show the date the action was raised, so there was no evidence of how long it had been open or taken to resolve. We looked at clinical governance meeting minutes and head of department meeting minutes, but the action tracker was not a standing agenda item for assurance. However, it was discussed at the head of department meetings.
- There was a clear structure for governance and risk management. The hospital's senior management team reported to the BMI Healthcare clinical governance board, which, in turn, reported to the chief executive. At hospital level, the medical advisory committee, health and safety committee, and clinical governance committee reported to the senior management team. Within the clinical governance framework were a number of sub-committees, including:
  - Medicines management – this was chaired by the lead pharmacist. There were good sets of minutes covering medicine incidents, controlled drugs, discontinued medicines, clinical guidelines and medicine safety alerts. The hospital, however, did not have any key performance indicators (KPIs) for medicines' management. The Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy said that hospitals should work with KPIs and an audit programme to enable continuous professional development and improvement.
  - Hospital transfusion team
  - Oncology governance
  - Resuscitation
  - Radiation protection
  - Quality
  - Infection control
  - Water safety

Appropriate staff had been appointed to these committees, and they were led by senior personnel.

- There was regular input into the governance system from the hospital's medical advisory committee. The committee met at the end of a working day every two months. Four sets of minutes from July 2015 to January 2016 showed that between eight and 13 people attended. This included the director of nursing who attended all meetings, and the executive director who attended three of these four meetings. The chair of the committee attended and conducted all these meetings. Discussions were from a standard agenda. They included consideration of applications from consultants to practise at the hospital and a review of speciality services. There was an update on business conducted, complaints, and clinical incidents, which included patient readmissions and transfers to the local NHS acute hospital. Shared learning from serious incidents was discussed along with new services being offered by the hospital.
- To provide comparison, there was some measure in terms of patient satisfaction against other hospitals within the BMI Healthcare group. There was an extensive patient satisfaction questionnaire produced by the hospital each month. This measured a number of different factors as discussed throughout this report above. The report produced enabled the hospital to see how each response from patients had changed over the last 12 months. It also gave the hospital a ranking alongside other hospitals within the BMI group as a tool to promote improvement.

Leadership and culture of this core service

- There was support for the senior management team. The hospital worked within a cluster in the BMI Healthcare group and reported to a regional director. The finance manager, business services manager, marketing and maintenance managers reported to the executive director at the hospital, but also worked as part of a cluster team. The executive director had support from other hospital directors in the cluster. The regional director and the chief executive were said to be approachable and supportive.
- There was a good culture among the staff at the hospital. The staff we met spoke highly of the senior management team. They said the communication from the executive director and director of nursing was excellent. They were approachable and visible at all times. We were told the senior staff went out of their way for staff and patients. They were caring and

supportive. The senior nursing staff were also complimented by the nursing team for their support, visibility and care for staff. Staff told us they did not consider anyone in the senior management team to be defensive. They said the hospital was open and honest about any mistakes, errors or accidents. These included any accidents concerning staff, as well as patients and visitors. The senior management staff understood the value of staff raising concerns and we found no barriers to staff taking their concerns to any level of seniority.

- There was an on-call rota for senior staff out-of-hours. All the senior staff were part of the rota and would be called for advice or to attend the hospital, or if there had been or could be a significant incident.

Public and staff engagement

- There were a range of meetings for staff to attend. This included departmental meetings, such as ward meetings or theatre meetings and group meetings, such as the quality committee or health and safety team. The senior management team had a weekly meeting, and heads of department met monthly. Ward staff said their monthly meetings included reports from the senior staff meetings and messages being cascaded down. Incidents and adverse events were discussed, as were audits, training compliance and complaints. Trends from incidents were discussed, and suggestions and solutions proposed to manage any changes or improvements recognised. There was feedback from any reported incidents, and staff felt confident at these meetings to report anything they felt uncomfortable or unsure about.
- There was good communication with staff, although not all staff were on the provider's email system. There was a weekly newsletter sent by email, but not all staff were on email. We asked staff how those staff not on email were made aware of this newsletter, but staff were not sure. Some staff said emails were sent to private email addresses.
- The hospital recognised long service by holding a yearly ceremony where lapel pins were given to staff with a different stone in for every five years of service they had given. The awards were announced throughout the BMI Healthcare organisation. Staff wore their pins with pride and were keen to tell the inspection team of their significance.
- The hospital provided staff to speak at local events. There was a recent GP education event, for example, provided by the hospital and staff attended this event. There was a good link with the local hospice, which was close to the hospital.
- The hospital had an extensive patient satisfaction questionnaire, which provided an opportunity for patients to comment in specific areas. The hospital also participated in the NHS Friends and Family Test. There was information for the public and staff on notice and information boards throughout the hospital. This included patient satisfaction survey information, minutes of recent meetings, audit results, and general announcements.
- NHS patients were able to comment upon the hospital through the NHS Choices website. The hospital was now able to respond directly to comments and contact any patients who left their contact details and wanted to pass on their compliments or raise concerns.
- There was a culture of inclusiveness and encouraging staff, including reducing anxiety. The hospital had prepared staff for the CQC inspection with a handbook on many elements of the areas that would be under review. This was designed to update staff on all aspects of what the hospital did, so questions from the CQC team would (hopefully) not be too daunting. This booklet ran to 33 pages and was provided to all staff.

Innovation, improvement and sustainability

- The hospital was aware of possible risks to sustainability and these were included in the strategic plans and risk register.
- The hospital had recognised advances in medical equipment. The hospital had recently procured and put into service a piece of specialist scanning equipment. This equipment was called an 'O arm' and was designed for use with spinal and orthopaedic surgery. The multi-dimensional scanner provided perioperative images as the surgeon was operating. The equipment reduced radiation exposure to patients and staff compared with standard fluoroscopy procedures. The hospital had also recently replaced the equipment for performing cataract surgery with one of the latest types of this equipment available.
- The hospital had developed a simple but effective system to locate the ward keys. These keys were for a number of locks, but included the controlled drugs cupboards. It is not untypical in hospitals for nursing

staff to often be searching for the person holding the keys. The ward now had a small bell on the nurses' station, which could be rung if the keys were needed. This simple and effective system was working well.

Requires improvement

Services for children and young people

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

Information about the service

The children and young people's service at BMI The Ridgeway Hospital provided outpatient consultations and surgical procedures. Children aged three to 15 years were provided with advice as outpatients, but did not receive treatment. Young people aged 16 or 17 years were also seen in outpatients and were eligible for surgical treatment as an inpatient or as a day case. This was subject to a risk assessment to ensure suitability for care using the adult care and treatment pathway. Children and young people would also be seen in the imaging and physiotherapy departments as part of their care plan.

In 2015, 1,350 children and young people were seen in the hospital, of which around half were return appointments. Most were private patients, with one NHS-funded. The majority of children and young people (1,321) were seen in the outpatients department. Four 16 or 17 year olds were treated as inpatients and 25 received treatment as a day case.

During the inspection, we spoke with the lead children's nurse, paediatric consultant and the lead clinician for children's safeguarding. We spoke with staff throughout the hospital about their interactions with children and their paediatric competencies. We observed one child being cared for and were provided with feedback from a second child, both in the physiotherapy department. There were no other children on site at the time of our visit.

This report predominantly concentrates on the outpatient paediatric clinic and touches on other departments a child may have accessed as a patient.

Summary of findings

We rated children and young people's services overall as requires improvement because:

- Not all clinical staff who had some degree of contact with children were trained in level two safeguarding children.
- Staff involved in assessing and planning children and young people's care were not trained in level three safeguarding children.
- Although the hospital were following their corporate policy, there were no set paediatric care skills to which staff had to be assessed as competent to work with children and young people.
- There were inconsistencies in documentation guidelines for the admission weight criteria for young people undergoing surgical procedures.
- Feedback from children and parents was not actively sought to help improve the service.
- There was no vision or strategy for the children's service.
- The governance arrangements for the children's service were not clear.
- There were no quality measures to assess the performance or outcomes of the children's service.
- There were no risks identified for the children's service on the hospital's risk register.

However:

- The hospital had appropriate resuscitation equipment for children and staff were trained in paediatric resuscitation.

Requires improvement

Services for children and young people

- The lead children's nurse and paediatric consultant had appropriate competencies to work with children. They were both contactable to provide advice to their colleagues.
- We observed good care provided to one child in the physiotherapy department, where both the parent and child were appropriately informed and involved in the care.
- The paediatric consultant represented children on the medical advisory committee and the service was discussed at this committee as required.
- Where possible the hospital aimed to be responsive to children and young people's individual needs.

Are services for children and young people safe?

Requires improvement

We rated safety as requires improvement because:

- The training records showed not all clinical staff received level two safeguarding children training, despite having a degree of contact with children.
- Safeguarding children level three training had not been considered for staff involved in assessing and planning care for children and young people.
- Young people were risk assessed for care on the adult pathway by adult nurses.
- There was no process to ensure registered adult nurses were competent to work with children and young people by assessing nurse paediatric care skills.
- The young people's weight criteria for admission as a surgical patient were different in the hospital's risk assessment document and care of children procedure.
- The physiotherapy department was not aware of processes or documents used in other areas of the hospital.
- Some of the business continuity plans and simulation exercises had not been completed.

However:

- Incidents relating to children and young people had been appropriately reviewed, with learning identified and shared with staff.
- A children environment risk assessment was completed in departments every day, which showed the safety of children was being considered.
- Safe and appropriate paediatric resuscitation equipment was available. Staff received paediatric resuscitation training and the hospital completed paediatric resuscitation scenarios.
- There were in-date children's policies and procedures. Staff were aware of these policies and those directly involved with children had an understanding of the content.
- The paediatric outpatient clinic was appropriately staffed by the lead children's nurse supporting the paediatric consultant.
- Staff were aware of the correct processes to follow if there was a safeguarding concern.

Requires improvement

Services for children and young people

Incidents

- Two incidents relating to children and young people were reported between April 2015 and March 2016, this included incorrect imaging and grazing of soft tissue when removing a plaster cast. Both incidents were reported and investigated in a timely way, and where required learning was identified and shared.
- We spoke with staff who demonstrated they understood what type of issues should be reported as an incident and the processes to follow. One staff member said they received feedback from incidents, and following any incidents the hospital was receptive to suggestions to how improvements can be made to the service.

Duty of Candour

- There was knowledge among staff of when to apply Duty of Candour and the hospital was open and honest, and apologised to people when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Those staff we spoke with knew about this regulation and training and explanation had been cascaded from the senior management team. Those we spoke with were all aware of the Duty of Candour, but explanations tended to revolve around being open and honest with patients. However, none of those staff we asked described the duty as also being required to apologise to a patient.

Cleanliness, infection control and hygiene

- Overall, the hospital was clean. Areas where children and young people would be seated or consulted appeared unsoiled and tidy.
- The hospital had no incidence of hospital infections in the reporting period January to December 2015.
- At the main entrance to the hospital hand gel was available at a height suitable for children's use. However, we observed patients and visitors were not encouraged to use the hand gel.
- In the outpatient waiting area, a small section was assigned for children. This included an abacus for children's play and a few child friendly magazines. We were informed the abacus was cleaned every evening with medical wipes as part of the reception duties and this was included on the cleaning schedule. The area appeared clean; however, when asked staff did not produce signed daily records to evidence this cleaning.
- In the physiotherapy waiting area there was a small box of toys for children's play. Staff told us these were cleaned every day; however, there were no records available to confirm this.
- The heads of department were responsible for ensuring cleaning of toys was completed, but there were no records to confirm this was audited regularly. On the annual children's services audit the hospital stated toys were cleaned and this was audited. However, there was no evidence to confirm this audit being undertaken.

Environment and equipment

- A daily children environment risk assessment (checklist) was completed in the outpatients and imaging departments. The physiotherapy department had used their own risk assessment and had only recently been made aware of an alternative assessment being used throughout the hospital. The checklist incorporated generic requirements and prompts for a safe environment.
- A paediatric risk assessment form for the environment had been completed in the physiotherapy department, which highlighted potential hazards and safety controls. We were not made aware of risk assessments being completed for other areas of the hospital.
- In the outpatients department, a small children's waiting area was identifiable by a sign. This was separate from the main waiting area. It was appropriately in the line of sight from reception so staff could observe the children in the area. Notices were displayed to advise parents to supervise children at all times. Automatic doors opened to the car park, which could have presented a risk to children. However, children would have been required to pass through a reception area that was staffed at all times.
- The children's waiting area in outpatients had been moved to ensure children were separated from the hot drinks machine. There were no children in the waiting area during our inspection. We observed adults using the children's area with hot drinks on the table. Staff told us during children's clinics they were vigilant in asking patients not to sit in the area with hot drinks.

- In the physiotherapy department, there was no separation between the adult and children's waiting areas. The hot drinks machine was not separate from the waiting area and presented a risk that children have access to hot liquid, which could result in them burning themselves. A sign informed parents that children should not operate the machine themselves.
- The outpatient consulting room used for paediatric clinics presented no apparent health and safety risks to children. For example; the sharps bin was placed out of reach of children and closed when not in use. Records showed every day the environment had been risk assessed for potential hazards to children.
- Safe and appropriate resuscitation equipment for children was available in clinical areas. A new paediatric resuscitation trolley had been provided in the outpatients department and two paediatric grab bags were present on the ward and in the physiotherapy department. Both the trolley and grab bags were clearly identifiable for child resuscitation with security maintained using a tag. Copies of resuscitation guidance and procedures to manage other emergencies, for example, severe allergy and choking, were available with the equipment.
- The paediatric resuscitation trolley in outpatients was stored in the ultrasound waiting area along with adult resuscitation trolleys. This area was cramped when patients were seated and staff told us this made access to them difficult and could cause delays in emergencies. The hospital had an annual resuscitation review and regular scenarios undertaken in outpatients and this had not been identified as an issue.
- The new paediatric trolley and grab bags had been introduced five days before our inspection. We confirmed the record of daily checks for the paediatric resuscitation equipment were completed on the ward and in the outpatients department; however, the previous two working days had not been completed in physiotherapy. We reviewed archived records of the formerly used bags, which contained equipment for paediatric resuscitation, and found the checks were mostly completed each day as required.
- There was no specific paediatric equipment in the outpatients or physiotherapy departments. In physiotherapy, small crutches were available, but no other child-friendly equipment. Equipment could be ordered on an individual patient basis.

Medicines

- Appropriate paediatric medicines used for emergencies were available and in date. These were held in an emergency drugs box, which was checked and sealed by the pharmacy department.
- We reviewed five patient records for young people undergoing a surgical procedure. We saw prescription charts were completed and legible, with known allergies documented. The prescriber was indicated and the pharmacists had seen and endorsed the chart. Administration was clear and appropriately signed for.

Records

- Patient medical records were paper-based. Outpatient records were maintained and kept by the consultant. In line with the organisation's policy it was the consultant's responsibility to keep the records secure in an appropriate location. If a patient was admitted to the hospital, the records were stored safely but accessible on site.
- We reviewed five surgical notes for young people aged 16 or 17 years. All five patients had been assessed by a registered adults nurse for suitability of the adult pathway. Part of this assessment documented whether or not the patients required a paediatric nurse, of which none of the five patients did.
- We observed the records were accurate, complete and legible with the exception of one, which had minor shortcomings in its completion. There were appropriate care plans and risk assessments. The World Health Organisation safer surgery checklist was completed appropriately in three records. Two records had missing signatures.
- Outpatient notes were stored securely in a locked or supervised office.
- Children and young people's medical records were not specifically targeted in monthly patient health record audits. However, they may have been subject to audit if selected at random during the hospital audit programme.

Safeguarding

- Safeguarding training was provided to all staff. This included training on female genital mutilation. The training was a combination of examples, scenarios, and relevant legislation.

Requires improvement

Services for children and young people

- The director of nursing was the safeguarding lead clinician for the hospital and was supported by the head of nursing for the organisation. This person was the designated lead for safeguarding and was available for advice 24 hours a day, seven days a week. The director of nursing said they had a good relationship with their clinical commissioning group.
- Staff demonstrated understanding of the safeguarding policy and processes to follow if they had any concern.
- There are different levels of safeguarding training required dependent on staff roles. The director of nursing was trained in level three safeguarding children. One resident medical officer also had valid certification for level three safeguarding training. The lead children's nurse was in the process of completing level three training. This person held a valid level three safeguarding certification from a different organisation. The paediatric consultant showed all relevant safeguarding training was complete and in date through their annual appraisal.
- The intercollegiate document, Safeguarding children and young people: roles and competencies for health care staff (Royal College of Paediatrics and Child Health, 2014) had not been adequately considered. Young people are defined in this document as those who have not reached their 18th birthday. Staff who had an involvement in assessing and planning care for children and young people, to include staff in outpatients and imaging, physiotherapy, pre-admission team, inpatient and theatre department were not trained in level three safeguarding children.
- The training records showed 94% of staff were compliant with level two safeguarding children. This was based on 34 staff who were shown on the report as requiring the training. Staff were mostly management and senior level. However, the hospital had 34 additional clinical staff, including nurses, health care assistants and allied health professionals working in consulting rooms, pre-admission, physiotherapy and diagnostic imaging who only had level one safeguarding children training. Nursing staff told us level two safeguarding children training did not appear as on option for training and they were therefore only trained to level one. This was not consistent with the intercollegiate document Safeguarding children and young people: roles and competencies for health care staff (Royal College of Paediatrics and Child Health, 2014). This states level two safeguarding children training is the minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people. This was also part of the provider's safeguarding children policy.
- In compliance with national guidelines (Royal College of Paediatrics and Child Health, 2014) all non-clinical and clinical staff should have received as a minimum, level one safeguarding children training. Records showed 92% of staff were compliant.
- The paediatric consultant had been asked to be the on-call paediatrician for advice concerning paediatric patients who may have been abused. This would comply with the organisation's safeguarding policy should they agree this role.
- Safeguarding flow charts with contact information were displayed in areas of the hospital, including outpatients, imaging and ward areas. We noted one flowchart did not include contact numbers on display in the physiotherapy department.
- We were informed the clinical governance bulletin was used to disseminate to staff any national or internal safeguarding updates and learning. Staff were aware of this bulletin.
- The staff we spoke with had not raised any safeguarding children concerns but demonstrated an understanding of the policy, flow charts and how to contact the safeguarding lead.
- There was an organisation chaperoning policy which applied to both adults and children, in line with the organisation's safeguarding adults and children policies.

Mandatory training

- Both resident medical officers had evidence of valid European paediatric life support training on their personnel file.
- There were 16 clinical staff trained in paediatric immediate life support, including the lead children's nurse and staff working in outpatients and the ward. This level of training was a requirement for the emergency response team and for those staff who worked with children under the age of 12 years. A further four staff members required training, which was in the process of being arranged. Compliance at the time of our inspection was therefore at 80%.
- Gaps with basic life support were identified and discussed at the resuscitation committee in March 2016. Dates for training were being made available to staff to increase compliance. At the time of our inspection, 27

clinical staff members across diagnostic imaging, physiotherapy, pre-admission and the ward had been identified as requiring paediatric basic life support training. A training report showed 20 staff had completed paediatric basic life support; seven required training therefore compliance was at 74%.

- Emergency resuscitation scenarios were practiced throughout the year, and included two paediatric scenarios every six months. We reviewed the simulation reports for the paediatric scenarios in June and December 2015. In June, the resuscitation trainer recorded: "the whole team were fully engaged and worked hard under clear leadership", the report was complimentary about staff who "remained calm and confident." In December, the scenario was "not well managed by a team. Lack of structure." It was recommended some staff attended update training sessions, which has since been actioned.
- Staff said the standard and quality of training provided by the organisation was good and found the IT system easy to access and use. They said internal IT systems would alert them of any expiring or expired training. Staff felt supported with their training needs.

Assessing and responding to patient risk

- The hospital had policies and procedures in place to care for children safely. Staff in all departments were aware of these policies and procedures.
- A pre-admission risk assessment for young people document was used to assess young people's suitability for care under adult services. Criteria included the patient being 16 years of age or over, with no existing additional health conditions, patients had to be over 1.45m in height and over 40kgs in weight. The pre-admission team would contact the lead children's nurse and anaesthetist for advice regarding the young person's suitability for treatment.
- Nursing staff we spoke with on the ward and day care unit said, in their opinion, that those young people seen were appropriate for the adult pathway. They commented how they were always mindful of patient weight, which is significant to calculate correct and safe drug dosage.
- The care of children and the pre-admission risk assessment guidelines had different information relating to the criteria for young people's body weight. The pre-admission risk assessment criteria stated over 40kgs, however the care of children procedure stated over 50kgs for drug administration. Staff in pre-admission confirmed they abide by the over 40kgs criteria.
- Although the hospital followed its corporate policy, there was no competency framework to ensure registered adults nurses and other clinical staff had appropriate skills to work with children and young people. Registered adult nurses were responsible for pre-assessing young people for suitability for surgery on the adult pathway; if this is not completed by a paediatric nurse then the registered adult nurse should have their paediatric competencies assessed. Staff in outpatients, diagnostic imaging and physiotherapy had some degree of contact with children; however, they did not have their competencies to work with children assessed.
- On review of five surgical patient records for 16 or 17 year olds, National Early Warning Score (NEWS) charts were only used in two instances. It is recommended by the Royal College of Physicians that NEWS charts are used for all patients in hospitals to track their clinical condition so any deterioration can be identified and treated immediately. There was no requirement for a paediatric early warning score chart as patients had been assessed as appropriate for the adult pathway.
- There was a service level agreement with the local NHS acute trust for arrangements for paediatric facilities and emergency transfer of patients. Albeit this agreement was long overdue for renewal due to its formation in 2010/11 and the hospital was endeavouring to obtain an updated version. The hospital's Emergency Transfer policy was currently for adults but we were informed when the policy is updated the transfer of children will be specifically added. A transfer of a deteriorating child had not been required.
- 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
  - 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.

Nursing staffing

- The lead children's nurse was available for paediatric clinics, which occurred weekly on a Wednesday afternoon. In the event they were not available, a registered nurse would chaperone the paediatric consultant. However, these nurses were not assessed as competent to work with children.
- Paediatric nurses were not part of the pre-admission team and therefore did not have a direct involvement in risk assessing young people as suitable for the adult pathway.
- The Ridgeway had a contract in place for the use of agency staff. Appropriate employment and registration checks were included in the contract at the responsibility of the agency. This was an unlikely occurrence for a children's nurse, however the agency could be contacted if a children's nurse was required. We saw evidence of agency checklists completed to induct new agency staff and confirm that they were safe to work. Staff said the agency staff used were regular.

Medical staffing

- At the time of our inspection, one paediatric consultant with practising privileges provided outpatient clinics to children and young people. The month before our inspection a second paediatric consultant had retired from private practice. This person had been responsible for approximately one quarter of the previous years' workload and therefore there was a chance that the number of children seen in outpatients would decrease in 2016.
- Resident medical officers did not require paediatric competencies as no children were seen under the age of three years. One resident medical officer was always on site should they be required to assist with care and treatment of children and young people.

Major incident awareness and training

- There was limited simulation training and some gaps in the business continuity planning. The business continuity plan did not contain action cards for an outbreak of infection/pandemic (although this was contained in the infection control policies), inaccessibility of the hospital to vehicles, security failures (although the hospital said this had been produced in December 2015), and providing support to the local NHS acute trust. Essential electrical equipment had also not been recognised. This had been escalated to the risk register, but no progress had been made as yet. The hospital had also recognised it was not participating in the simulation programme according to the organisation's policy. The hospital was required to carry out a staff communications exercise every six months, a desktop exercise every year, and full live evacuation every three years. The hospital provided evidence of the last evacuation they carried out in 2014, and the comprehensive report about how the exercise worked. The hospital had not addressed the latter two items on the risk register, but staff said they were scheduling six-monthly simulation exercises.

Are services for children and young people effective?

Not sufficient evidence to rate

We inspected but did not rate the effectiveness of the children and young people's service. Numbers of young people seen in surgery were small. Larger numbers of children and young people were seen in outpatients, there is insufficient data available to rate effectiveness nationally in outpatients. We did confirm:

- The lead children's nurse and paediatric consultant were competent to work with children.
- The paediatric consultant was evaluated for their fitness to practise.
- Staff were able to contact the lead children's nurse if they needed advice.
- Staff had a good level of understanding of how to consent children and young people.

Evidence-based care and treatment

- An annual children's service audit was completed by the lead children's nurse and director of nursing. This was to ensure compliance with the organisation's care of children policy. Requirements included; appropriate resuscitation and safeguarding training for staff, available paediatric resuscitation equipment, health and safety of areas children visit, a lead children's nurse,

paediatric consultant as a member of the medical advisory committee, regional links being maintained, formal transfer agreements in place, working to the organisation's consent and medical records policies, toys marked and cleaned, named person for safeguarding, enhanced disclosure and barring service checks for staff working with children, and admissions pre-planned and facilities for parents to stay available.
- Any evidence based care or treatment would be discussed at management meetings or at the medical advisory committee. This information was likely to be communicated to the hospital through the paediatric consultant and their link to the local NHS acute trust.

Pain relief

- We reviewed five patient notes for 16 or 17 year olds undergoing surgical procedures. Pain relief was assessed and records showed actions had been taken to minimise pain in a timely way. Patient prescription charts indicated the use of different forms of pain relief. This included different but appropriate strengths, routes of administration (oral or intravenous) and frequency administered to patients.

Nutrition and hydration

- We reviewed five patient notes for 16 or 17 year olds undergoing surgical procedures. Intake of food and fluid was recorded post-surgery so staff could monitor and assess the patients nutritional and hydration needs.

Competent staff

- There were processes and policies in place to confirm consultants were competent to work. Consultant applications to work under practising privileges were approved by the medical advisory committee. We saw these in meeting minutes in July 2015, September 2015 and January 2016 whereby a total of 10 consultants were approved.
- There was suitable control to confirm consultants were appropriate to work, in line with the practising privileges policy. Disclosure and barring service, indemnity and registration were checked in line with expiry and a record held. We reviewed the personnel file for the paediatric consultant and verified appropriate on-going checks, including in-date professional registration and medical indemnity. An annual appraisal had been completed by their employing organisation, which confirmed training and paediatric competencies were appropriate. The executive director met with the consultant as part of a two yearly review. The consultant database recorded the disclosure and barring service check was in date, which confirmed the consultant was safe to work with children.
- The paediatric consultant was competent to work with children. This person worked at the local acute NHS trust and was therefore experienced and skilled with working with children.
- The lead children's nurse was a registered children's nurse and was competent to work with children. This person had a background in a local NHS acute trust as a paediatric nurse and reassured us they currently maintained their paediatric competencies whilst working in general practice.
- The resident medical officers did not require paediatric competencies as no children aged under three years were seen in the hospital.
- In the imaging department radiographers said their paediatric skills and ability to communicate with children was transferrable from their main work at the local NHS acute trust.
- Employed registered nurses not directly involved with children said they had become de-skilled, as the small number of children seen in the hospital were predominantly seen by the lead children's nurse as a requirement. They did not maintain any paediatric skills or competencies.
- Appraisal data was not demonstrating all non-medical staff (nurses, healthcare assistants, and other staff) had been given an annual review of their competence and professional development. All the staff we met said they had been given their annual appraisal and this took place with their manager each year. However, the data was not able to support this due to an ineffective reporting system formerly used. The hospital was aware and open about the previous shortcomings with the reporting system. The senior management team were confident a recently implemented system would improve the ability to report accurate data.

Multidisciplinary working

- The staff we spoke with said they were able to contact the lead children's nurse for advice or support regarding the care of children or young people.
- All staff said they worked well as a team. The paediatric consultant was complimentary of the team working with him and other staff support for the paediatric clinics.

Requires improvement

Services for children and young people

- In pre-admissions, staff said they were able to access all staff from the multi-disciplinary team to gather information required. This included contact with the lead children's nurse for advice, theatre staff, and the booking teams to ensure the individual needs of a young person were met.
- For young people admitted for surgical procedures records were held within the hospital. Of the five young people's records we reviewed, discharge documentation sent to the GP was only seen in two files.

Seven-day services

- Seven-day services were not required for the children's service as children and young people were seen during weekday clinic times. Services including diagnostic imaging, physiotherapy, psychology and pharmacy were available at request or referral.

Access to information

- There was good access to patients' medical records. Staff said they had access to information required to treat children and young people.
- Outpatient records were held by the consultant and therefore were available for paediatric clinics. We reviewed three records, which included the initial referral letter from the GP and detailed letters sent from the paediatric consultant to both the parent and GP. This demonstrated information had been shared appropriately with other healthcare professionals.

Consent

- Consent was documented on appropriate forms and copies provided to patients. There were different forms for patient consent. The hospital used four forms, and the majority of patients used form one. This was consent from a patient or competent child for procedures involving general/regional anaesthesia or sedation. Forms two and three were used for consent from a parent or guardian for a patient who was a child or young person. Form four was to be completed in the event an adult patient was not able to provide valid informed consent. We saw appropriate forms used in patient records, and those patients we met said they had been given copies of their consent forms.
- On review of five medical records for 16 or 17 year olds, all five had completed consent forms, which were appropriate for their age group. In four cases, there was no documented evidence of the views of parents and the young person. However, these young people had been assessed for the adult pathway and the ability for the young person to consent had been confirmed at pre-admission.
- Staff could explain how they would consent children and young people. Consent for children below the age of 16 years was obtained from a parent or guardian and followed national guidance (Royal College of Nursing: Caring for children and young people: Guidance for nurses working in the independent sector, 2014). Children over the age of 16 years were asked if they would like to consent for themselves. Staff understood the requirement to assess the maturity of a child to make their own decisions and to understand implications of those decisions, in line with Gillick competency and Fraser guidelines.
- We spoke with one 12-year-old patient and their mother who were attending a physiotherapy appointment. The child had previously seen an orthopaedic consultant in the hospital. The mother felt she had been appropriately asked for consent throughout the treatment, and the child had been included in consenting.
- The young person should be able to make informed decisions about available care options and understand the consent process. This was discussed with the child and carer during the pre-admission process.
- Children and young people's consent was not specifically targeted in quarterly consent audits. However, they may have been subject to audit if selected at random during the hospital audit programme.

Are services for children and young people caring?

Not sufficient evidence to rate

Due to the low numbers of children or young people receiving care or treatment at the hospital during our inspection, we were unable to rate how caring the service was. We observed good care for one child in the physiotherapy department and spoke with one child and their parent who were happy with the care provided in outpatients and physiotherapy.

Compassionate care

Requires improvement

Services for children and young people

- Staff could explain to us ways in which they would provide compassionate care to children and young people. For example, being kind to children so they felt comfortable in the hospital environment and being considerate that for some young people it might be their first time in hospital. The care would be targeted to meet each child and young person's individual needs.

Understanding and involvement of patients and those close to them

- We observed good care provided by a physiotherapist to a 10-year-old patient. The child was spoken with in an appropriate way for their age and ability. There was a child friendly approach and the child and parent were involved in the treatment. Future treatments were discussed with the agreement of the child and parent. The parent told us they were pleased with the communication from the hospital and the treatment their child had received so far.
- We spoke with a child and their mother who were attending a physiotherapy appointment and had previously seen an orthopaedic consultant in the outpatient department. They were both happy with the care provided during their hospital visits. It was mentioned the physiotherapists could relate well to the child, and despite seeing different physiotherapists, they were all aware of the care needed. The mother was present during appointments and was able to enter treatment areas with their child.

Emotional support

- We were informed parents were invited to attend the anaesthetic room prior to surgery to provide emotional support to their child.
- If bad news needed to be given to a child and their parents, the paediatric consultant and lead children's nurse said they would offer initial emotional support. If required the family could be referred to an external outreach team.

Are services for children and young people responsive?

Good

We rated responsiveness as good because:

- When children and young people were seen in the hospital, the staff aimed to meet their individual needs. For example; keeping waiting times to a minimum for children in outpatients and placing young people at the start of a theatre list to limit nil by mouth times.
- Continuity of care was achieved as children in outpatient paediatric clinics saw the same paediatric consultant and lead children's nurse on each visit.
- The two parents we spoke with said appointments were easy to book and they were able to get appointment times to suit their needs.

However:

- Views of children and parents were not sought in order to help develop the service responsively.

Service planning and delivery to meet the needs of local people

- Services were planned dependent on corporate direction. The children and young people's service was a very small percentage of the hospital's business and therefore there was a limited service plan.
- One mother and 12-year-old we spoke with had attended appointments in outpatients and physiotherapy. They said it was easy to book appointments and could normally book outside of school time.
- All patients were asked to complete a feedback card following their visit to the hospital. These were not aimed at gathering the views of children and young people. This would have enabled their views and experiences to be used to improve services.

Access and flow

- Children were seen during Wednesday afternoon paediatric outpatient clinics. Access for patients was therefore arranged around the availability of the paediatric consultant and lead children's nurse. The 2 to 8pm clinic time provided the opportunity for children to be seen outside of their schooling.
- The booking team said they allocated adequate times for appointments, to ensure children and young people waiting times were kept to a minimum. There was no audit of waiting times for children and young people.
- Young people were pre-assessed for suitability for treatment on the adult pathway. The pre-admission team informed us they worked closely with the bookings

team and the theatre team to accommodate young people. For example, where possible surgical procedures for young people were undertaken first on a surgical list. This was done to limit nil by mouth times.
- Patients and their parents could contact the paediatric consultant through the medical secretary outside of clinic hours.

Meeting people's individual needs

- There were limited toys available in outpatient paediatric clinics. An abacus was fixed to one table and a few children's magazines were available. We were told a supply of toys was not provided due to health and safety, and the requirement to regularly clean the items.
- We were informed children tended to bring in their own toys or IT devices and were provided access to the hospital internet.
- In the outpatients department, the paediatric consultant said they involved the child and parent in treatment, dictating any letters in the presence of the parents and providing them with a copy.
- Child friendly leaflets were not available at the hospital. Within the outpatients department, the paediatric consultant brought information leaflets from the local NHS hospital's paediatric department.
- A radiographer explained how recently a child came in to the imaging department for an X-ray and was very unsettled. Staff understood the importance of trying to make children feel as relaxed as possible in a non-paediatric environment. They told us they settled the child by providing a tour of the department and by explaining how things work. The appointment was then rescheduled for a later date when the child was prepared and able to have their tests.
- Young people were able to have a tour of the theatre prior to their surgical admission, particularly if they were anxious.
- If a young person required an overnight stay, they could request a parent or guardian to stay overnight and a double room would be booked to accommodate them.
- If a child had a learning disability, this was noted on the booking form. This enabled all staff to be aware of any specific or individual needs of the child.
- The paediatric consultant explained how they encouraged children to use diaries with stickers to document and demonstrate their pain.
- One mother commented how it was good towels were provided when using the physiotherapy department's hydrotherapy suite.
- A child spoken with said they enjoyed the hot chocolate available in the waiting area.

Learning from complaints and concerns

- One complaint was received in November 2015 from a child's mother regarding appointment cancellation and an unhelpful staff member. An investigation was undertaken in line with the complaints policy and evidence was gathered from the staff member involved and witnesses. We observed a timely response was sent by the executive director to the complainant both acknowledging and responding to the complaint.

Are services for children and young people well-led?

Requires improvement

We judged well-led as requires improvement because:

- There was no vision or strategy for the children's service.
- The governance arrangement for the children's service was not clear.
- Audits were not undertaken to measure the quality of the children's service, although the annual audit covered issues around safety of children's services.
- There was no consideration of the risk to the children's service as a result of the lack of paediatric working.

However:

- The paediatric consultant represented children and young people on the medical advisory committee and provided a paediatric link to the local NHS acute trust.
- Staff said they worked well together throughout the hospital and were able to contact the lead children's nurse if they needed advice.

Vision and strategy for this core service

- There was no vision or strategy for the children's service.

Governance, risk management and quality measurement for this core service

Requires improvement

Services for children and young people

- There were no clear governance structures or quality measures in place for children and young people services.
- Children were not specifically targeted in the hospital's audit plan and therefore quality measures for the service were not monitored. Additionally, audit work throughout the hospital was not providing effective assurance of safe and quality care. There was insufficient discussion of audit results in clinical governance meetings.
- The medical advisory committee met every two months and was responsible for advising the hospital on clinical matters. They also approved new consultants under practising privileges. The paediatric consultant sat on the medical advisory committee to represent children and young people. We saw evidence of their attendance in meeting minutes between July 2015 and January 2016. On review of the meeting minutes, children did not appear as a standard item on the agenda; however, we saw evidence of discussion and decision surrounding introducing consultations for children three years and under. The paediatric consultant confirmed the children service was discussed at the medical advisory committee as needed.
- The paediatric consultant worked for the local NHS acute trust and therefore provided a link to other paediatric services. This enabled the hospital to keep informed of changes locally and nationally to children's services.
- There was a hospital risk register, however there were no entries relating to the children's service. Consideration was not given to the risk surrounding the lack of paediatric working due to the low numbers of children and young people treated at the hospital. This was not acknowledged as a risk area during our conversations with management.

Leadership and culture of service

- The lead children's nurse was happy to raise concerns to the management team with regards to the children's service and felt supported in their role.
- Staff in all areas of the hospital said they could contact the lead children's nurse if they needed advice. This was generally an occurrence for the pre-admission team.
- Staff said there was a good team spirit in the children's outpatients' service.
- A number of staff said they loved working at the hospital. Comments included: "nice friendly atmosphere'', ''staff are the biggest asset, everyone works hard to ensure the patient journey is as smooth as possible'' and ''always people to go to and really good support from the top down, management to colleagues.''

Public and staff engagement

- There was no opportunity specifically for children to contribute their opinions on the care they received. Any feedback forms used in the hospital were designed for adults.

Good

Outpatients and diagnostic imaging

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

Information about the service

BMI The Ridgeway Hospital is an independent hospital, which formed part of the group BMI Healthcare Limited. The hospital provided outpatient and diagnostic imaging services to NHS and privately funded patients at its facility, which opened in 1984.

In the outpatient department there were 12 consulting rooms, including a dedicated ophthalmic room, ear nose and throat room and a treatment room for minor procedures. Clinics were held from 8am to 8pm Monday to Friday in audiology, cardiology, dermatology, dietetics, ear, nose and throat (ENT), gastroenterology, general medicine, general surgery, gynaecology, haematology, neurology, oncology, ophthalmology, orthopaedic, paediatric medicine, pain management, pathology, psychiatry, cosmetic plastic surgery, reconstructive plastic surgery, podiatry, psychology, radiology, rheumatology, sports and exercise medicine and urology. In 2000, the hospital was extended and physiotherapy and hydrotherapy were added to the outpatient services.

The diagnostic imaging department comprised of a main X-ray room, a small screening X-ray room, a room for mammography and an ultrasound room located in the outpatient department. Clinics were held from 8am to 6pm Monday to Friday and an on call service was provided at weekends. Procedures carried out in the department were X-rays and fluoroscopy, mammography and ultrasound. Computerised tomography (CT) scanning and magnetic resonance imaging (MRI) were delivered on site by third party providers.

The physiotherapy department was part of the outpatients' department and it consisted of six treatment rooms, two consulting rooms, a hydrotherapy pool and a gymnasium. Sessions were held from 8am to 7pm Monday to Friday with the ability to provide a service on Saturdays if required.

In January to December 2015, there were 37,745 outpatients seen of which 11,819 (31%) were NHS funded and 25,926 (69%) were self-funded or insured. In January to December 2015, there were 14,438 new attendances in the outpatient department, and 23,307 (62%) follow up appointments.

During our inspection, we visited the outpatients' department where clinics in audiology, dermatology, ENT, general medicine, general surgery, gynaecology, ophthalmology, orthopaedics and urology were being held. We also visited the physiotherapy outpatient department and the diagnostic imaging department including ultrasound, mammography and x-ray. We did not visit the MRI or CT scanning areas as these services were delivered by third party providers.

We spoke with 22 patients and 23 members of staff, including managers, doctors, radiographers, nurses, allied health care professionals, health care assistants and non-clinical staff.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated outpatient and diagnostic imaging overall as good because:

- Staff were aware of their responsibility to report incidents and had a good understanding of the Duty of Candour.
- Departments were visibly clean and well organised with completed cleaning schedules in place.
- Medicines were stored and managed safely in accordance with national guidelines.
- Patient records were accessible when required, they were stored and managed safely in the departments ensuring confidentiality was maintained.
- Staff were able to identify their responsibilities in respect of safeguarding patients and had received appropriate training.
- Staffing levels and skills were reviewed by the head of department to ensure people were safe and services were efficient.
- Staff followed national and local guidelines to ensure patients received effective care. They had a good understanding of their role in protecting people from unnecessary radiation exposure.
- We observed effective, patient centred, multidisciplinary team working and there were good relationships between all members of the team.
- All patients were extremely positive and complimentary about the care they received at the hospital. They said they were kept informed with verbal and written information, which was easy to understand. They received telephone calls from their doctor following treatment to ensure they had no complications or concerns.
- Staff were passionate and proud of the care they provided and worked hard to improve patient experiences.
- Targets for referral to treatment times for NHS patients at the hospital had always been met in the reporting period and extra clinics were provided in departments if required.
- The length of appointments were monitored and adjusted to avoid long waiting times for patients and all patients we spoke with reported being seen quickly and sometimes ahead of their appointment time.
- A multidisciplinary team approach was taken to resolve complaints and staff were involved in this process.
- Staff said the senior management team were very visible and approachable.
- The heads of department were supportive and knowledgeable and kept staff up to date with developments and changes.
- Patient and staff opinions were sought and service improvements were made because of these.
- All staff said they felt valued and were proud to work at the hospital.

However,

- Staff reported they did not always receive feedback from reported incidents.
- There was a lack of assurance regarding the servicing and maintenance of equipment.
- The temporary closure of a treatment room had caused some delays in the outpatient department.
- The governance work did not show how audit work and the risk register were delivering improvements in safe and quality care.
- Some patients we spoke with commented there was insufficient parking at the hospital.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safety as good because:

- Staff were aware of their responsibilities in reporting incidents.
- Areas in the outpatient and diagnostic imaging departments were visibly clean and well organised. Complete and up to date cleaning schedules were in place. Staff used approved handwashing techniques.
- Medicines were managed safely.
- Patient records were stored appropriately both outside and in the hospital, and staff were aware of their responsibilities in respect of security of patient records.
- There was a good understanding of safeguarding from the staff we spoke with.
- The heads of departments regularly reviewed staffing levels based on the hospital activity and sizes of clinics.

However

- Staff did not always receive feedback from incidents they reported.
- Bins for disposing of clinical waste were not easily accessible and staff did not always use personal protective equipment when handling clinical waste.

Incidents

- Staff we spoke with understood their responsibilities to raise concerns internally and externally and to record safety incidents, concerns and near misses. Staff told us there was an open reporting culture in the departments. Between January and December 2015, the hospital reported 295 clinical incidents. Between April 2015 and March 2016, 28 incidents were reported in the outpatients and diagnostic imaging departments. Examples of incidents reported included incorrect patient details on samples and requests, medication errors and adverse drug reactions.
- Staff we spoke with were able to describe the reporting procedure for all incidents. If a patient was involved in an incident, they were informed of what had happened and given an apology. Staff informed the head of department and completed an incident reporting form.
- The system for reporting incidents used by the provider remained a paper-based form for staff to complete, and not the more widely-used electronic reporting system. This meant staff had to complete a handwritten form for any incidents to be reported, and these would be entered onto a database by a member of the management team. This could delay the reporting process and involved an additional administrative step. Staff said it did not particularly discourage them from reporting incidents, but recognised it took more time to complete and could result in delays.
- Incident reviews and investigations were always carried out in the departments. In its incident reporting policy, the hospital said every incident report was seen as a learning and quality improvement opportunity. Heads of departments reported they updated staff on incidents at staff meetings. Solutions to prevent incidents recurring were discussed and for those unable to attend, minutes from the meetings were available to read. A member of staff in the diagnostic imaging department gave an example of a change in practice following incidents where there had been mistakes in entering patient details onto images. Because of this, the process had been divided and had not occurred again.
- Staff reported people who used services were told when they were affected by an incident. They were always given an apology either verbally or in writing and informed of any actions taken as a result. However, some staff reported they were not always involved in investigating incidents and the investigation was usually completed by the head of department. Some staff also said they did not always receive feedback following investigation of the incidents they reported.

Duty of candour

- There was knowledge among staff of when to apply duty of candour and the hospital was open and honest, and apologised to people when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the hospital to be open and transparent when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.

Cleanliness, infection control and hygiene

Good

Outpatients and diagnostic imaging

- Cleanliness in the outpatient and diagnostic imaging departments was of a good standard. In a Patient Led Assessment of the Care Environment (PLACE) audit carried out in March 2015, cleanliness in the departments was rated at 99%, which was above the England average score of 98%.
- Good standards of cleanliness and hygiene were maintained by all staff. Some patients we spoke with said the departments always looked clean and tidy. We were shown completed room and equipment cleaning logs in the areas we visited. Staff described the daily cleaning they carried out in preparation for clinics and the cleaning completed between patient consultations. Although staff reassured us equipment and rooms were cleaned between patients, there was no written evidence this had been carried out.
- We observed good hand washing practices from doctors and nursing staff during our visit. Staff we saw mostly adhered to the hospital infection prevention and control policy, and were bare below the elbow. Staff could explain the importance of effective hand decontamination and when it was appropriate to wash their hands instead of using alcohol gel.
- Personal protective equipment (PPE) was available for staff in outpatients and diagnostic imaging. Despite this, we observed a member of staff carrying clinical waste for disposal through the department to the dirty utility area who was not using PPE, such as an apron and gloves.
- Clinical waste was disposed of in the appropriate bins. In the outpatients' department, the clinical waste bin was kept in the sluice area. There were, however, no clinical waste bins in consulting rooms and staff had to take clinical waste through the department to the sluice area. This meant there was a risk it may come into contact with other staff, visitors and patients while being transported
- The outpatients' department was carpeted in both non-clinical and clinical areas. It did not have chairs made of a wipe-clean material, which reduced effective cleaning. The carpets and chairs were, however, all visibly clean with no signs of staining. In the diagnostic imaging department, clinical areas had wipe clean seats and floors were not carpeted. We were informed there was a maintenance programme in place to remove carpets in clinical areas and change the chairs for those that could be wiped clean. However, staff we spoke with were not aware of the timescale for this to be completed.
- There were infection control measures for patients requiring isolation due to infection or diarrhoea and vomiting. However, staff reported infected or unwell patients did not visit the outpatient and diagnostic imaging departments and had their appointments rearranged.
- The hospital had no incidences of clostridium difficile or methicillin-resistant Staphylococcus aureus (MRSA) from January to December 2015.
- Not all the sinks in the departments conformed to current handwashing regulations and had two separate taps instead of the recommended one mixer tap. The head of department reassured us there was an ongoing refurbishment programme to replace the sinks and taps but was unsure of the timescale for this to be completed.
- There was a small dirty utility area in the outpatients' department. This was used for disposing of clinical waste and decontaminating equipment. It was clean and tidy but due to the size some staff commented it was difficult to carry out tasks effectively. The sink did not conform to current standards for effective handwashing or decontamination of equipment and replacement of this was part of the ongoing refurbishment programme.
- Chemicals were stored securely. Cleaning chemicals were stored in the dirty utility area and the door to this area was kept locked at all times preventing patient access.

Environment and equipment

- The main reception waiting area was bright and clean with newspapers, magazines, refreshments and toilet facilities. There was also a play area for children. Reception staff had a clear view of the entire area.
- Storerooms in the departments were clean and tidy without any excess stock. Equipment was checked daily and trolleys used for clinics in the department were checked, restocked and cleaned daily. We saw written evidence of this, and when we checked the trolleys, they were clean, well-stocked and all the equipment was in date.
- There were systems for the use and maintenance of equipment but the hospital asset register for

outpatients and diagnostic imaging had equipment listed which did not have a planned service date. Equipment we saw was well maintained and tested for electrical safety. Portable appliance testing (PAT) had been undertaken and stickers on each piece of equipment showed when it had been tested and when it was due to be retested. We saw up-to-date maintenance stickers for most of the equipment we looked at except in the physiotherapy department. Some equipment in this department did not have an up-to-date service or safety test. This was mentioned to staff as it could put patients at risk. There was a piece of electrical equipment in the outpatient department store room which we were informed was no longer in use and awaiting disposal. However, it was not labelled and patients could have been put at risk if it had been used.

- Resuscitation and emergency equipment was available to the departments. Staff we spoke with could identify where their nearest emergency equipment and resuscitation trolley was located. The equipment and trolleys were tamper evident and were checked on a daily basis. We saw evidence to confirm these checks. Each emergency trolley had an emergency drugs box, which was checked and sealed by the pharmacy department. If the seal had broken, staff would return the box to pharmacy and receive a replacement. The equipment in the outpatients' department was located in a small waiting room. We observed, and staff confirmed, the location of the equipment was restricted by the space and layout of the area, and not ideal.
- The diagnostic imaging department carried out risk assessments for the use of radiation. These assessed risks to staff, patients and visitors. The results of the risk assessments were held in the department and reviewed annually. We were shown the report following an Ionising Radiation (Medical Exposure) Regulation audit in March 2015, which showed all radiation equipment was within acceptable testing limits. Although the equipment used calculated the correct amount of radiation required to examine different parts of the body, local rules were displayed in each treatment room. The local rules provided information for radiology staff to confirm radiation levels were correct and restrict exposure to it.
- The diagnostic imaging service ensured the premises had arrangements to control the area and restrict access. Visitors were greeted on arrival at the department by a member of staff and the reception staff had a clear view of the entrance doors to the department. They also had a clear view of the waiting area.

Medicines

- Medicines were stored appropriately in the departments in locked cupboards and fridges. The cupboards and fridges were located in a locked room only staff had access to. The pharmacy department checked the medicines, stock levels, fridge and cupboard temperatures on a daily basis to ensure medicines were stored safely and as the manufacturers instructed. We saw the checklists during our inspection and they were completed and up to date. All the medicines we checked were in date and stored appropriately. Controlled drugs were not stored in the departments but there were suitable cupboards to store these.
- In the diagnostic imaging department, there were additional checklists in place for some medicines (contrast). The system for recording batch numbers of contrast had been reviewed and updated. Following this, batch numbers were recorded electronically on each patient record and a paper record was kept. We were shown examples of both systems.
- The hospital had an organisational structure to manage medicines safely. The hospital staff reported and investigated medicine incidents. The pharmacy manager led the medicine governance meeting where medicine incidents, medicine safety alerts and clinical policies were discussed. There was a programme of medicine related audits.
- There was safe management of prescriptions. The prescription pad was stored in a locked cupboard in the office ensuring only authorised staff had access to it.
- The pharmacy department dispensed medicines quickly within one hour of receiving the prescription and routinely dispensed medicines to the outpatient department within ten minutes.
- The hospital provided a pharmacy service five days a week. Medicine supplies were available 24 hours a day but there was not an out-of-hours service for pharmacy advice on medicines.
- The pharmacy department informed us there was only one Patient Group Directive (PGD) in use in the hospital for staff to dispense or administer medicines without prescription. This PGD was for preoperative carbohydrate drinks. However, in the outpatient

ophthalmology clinic we were shown two further PGDs. One was for administering an eye preparation to reduce irritation caused by eye drops given to patients prior to investigations; the other was for the administration of eye drops. One did not have a review date and the other was past the review date. We informed the pharmacy department of the PGDs in the outpatient department and we were informed these were no longer in use.

Records

- In the outpatient department, individual patient care records were in paper format. The ones we saw were up-to-date, accurate, complete, legible and stored securely. We observed locked filing cupboards in the outpatient department office and the door to the office was locked if unattended. Records were only taken from the cupboard when required. We did not see unattended care records.
- In the diagnostic imaging department records were scanned and kept electronically; the hard copies were kept by the doctors. The electronic system was password protected and could only be accessed by staff. We observed five sets of scanned electronic patient records in the department and found some difficult to read. Shorthand had also been used, for example 'L' and 'R' instead of 'left' and 'right', which was not good practice. Staff reported they sometimes had to check the information with doctors to care for patients safely.
- When doctors arrived in the department with patient care records, we observed these being stored securely in the filing cabinets in the office. Doctors we spoke with knew their responsibilities regarding securely storing patient care records if they were kept outside of the hospital premises. They told us patient care records kept outside of the hospital premises were stored securely in a locked cabinet.
- The patients we spoke with confirmed their records were always available at the time of their appointment. Patients also said they did not have any concerns about the safekeeping of their records as they had never seen any unattended in the department.

Safeguarding

- There were policies, systems and processes for safeguarding. Safeguarding concern levels were low. From January to December 2015, only two safeguarding concerns had been raised. There had been no safeguarding concerns from January to March 2016.
- Safeguarding training was mandatory. All staff were trained to safeguarding level one and 90% of staff were up-to-date with this training. However, most staff in the departments had contact with children and not all of them were trained to level two. Senior staff were trained to level two and the heads of the outpatient and diagnostic imaging departments were trained to this level. The director of nursing was the lead for safeguarding and all staff we spoke with were aware of this. The director of nursing was trained to level three for safeguarding.
- All staff we spoke with were aware of when and how to raise a safeguarding concern. They knew who the safeguarding lead was and how to contact them. One member of staff gave an example of how a safeguarding concern had been raised, and the action which had been taken.
- There was an up-to-date hospital safeguarding policy. This had a staff signature sheet attached to it which staff signed when they had read the policy. One of the signature sheets we saw was incomplete but the head of department told us some of the missing signatures were for staff who had either left the department or only worked there occasionally. The head of department reviewed this regularly and reminded staff to read the policy and sign the sheet at staff handover.

Mandatory training

- Most staff were up-to-date with their mandatory training updates. All staff were trained when they joined the hospital and most training was to be updated annually. The training data provided was for all staff in the hospital and did not provide an overall percentage for compliance. However, in the clinical governance meeting minutes from February 2016 the mandatory training compliance was reported as 86.7%.
- Staff said they received regular mandatory training. Some sessions were practical and others were on line via an e-learning package. Sessions included infection prevention and control, equality and diversity, fire safety, basic and immediate life support and manual handling. Heads of department regularly monitored mandatory training compliance and assisted staff to attend sessions.

- Staff we spoke with informed us the training was of a good standard and most did not have problems with finding time to complete it. Training for clinical and non-clinical staff was offered and tailored to meet their different needs.
- During our inspection, a member of the inspection team observed part of a manual handling session being run by a physiotherapist from the hospital. They reported the training was interactive and appeared to be of a good standard.

Assessing and responding to patient risk

- The radiation protection advisor (RPA) was provided by an NHS trust. Staff reported the RPA was easily accessible by telephone or email. A senior radiographer in the imaging department was a radiation protection supervisor (RPS) and was trained to ensure the safety of individuals who may be exposed to radiation. An RPA is employed to advise the hospital on compliance with radiation rules and regulations in work situations, including radiation protection. An RPS is more closely involved in the work being done in the department than the RPA and ensures compliance with the rules and regulations in the department.
- Signs and information in the diagnostic imaging department kept people safe. Doors to the department were kept closed and visitors were always greeted by a member of staff. There were signs on doors where radiation exposure occurred. Staff had a good, clear view of the department, and could prevent visitors from entering radiation areas.
- The diagnostic imaging department ensured women who were, or may have been, pregnant always informed a member of staff. There were posters reminding women to inform a member of staff of this in the waiting room and in the treatment rooms. Staff always asked women if there was a possibility they may be pregnant and they signed a form stating they were not pregnant; this was also recorded in their notes. If a woman was pregnant, staff sought further advice before performing any radiation exposure procedures.
- The diagnostic imaging department used a six-point checklist prior to carrying out any procedures. We saw five copies of these and they were complete. The World Health Organisation (WHO) safety checks were also carried out in the department prior to any interventional procedures.
- There was always a resident medical officer (RMO) on duty trained in advanced life support. Staff reported the RMO always attended promptly when required.
- There were arrangements for transferring patients for emergency care. The hospital had a service level agreement with an NHS ambulance service to transport patients to a nearby NHS acute hospital with an emergency department. This meant patients who significantly deteriorated at any stage in their treatment would be taken by an NHS ambulance to the local NHS hospital. However, the agreement we were provided with was overdue for renewal having expired in March 2011 and the hospital was endeavouring to obtain an updated version.

Nursing and allied health care staffing

- There were adequate nursing staff levels to safely meet the needs of patients. Staffing was planned by the head of department according to their skills and the level of activity in the departments. In the outpatients' department, an electronic system was used which ensured the right number of staff with the right skills were available. In the diagnostic imaging department, the head of department organised staffing using a paper-based record, as there was not an electronic system in use. Staff reported staffing levels were good. At the time of our inspection, there was only one staff vacancy in the departments due to a member of staff leaving to work in another department in the hospital. The post had been advertised.
- The departments reported no use of agency staff from January to December 2015. Departments did sometimes use bank staff to cover shifts. The bank staff were regular members of staff already employed in the departments so they were familiar with systems and processes.
- Staff handovers kept people safe. There was a staff handover at the beginning of each shift and we attended a handover in the outpatient department. Clinical activity for the upcoming shift and designation of staff to each area was discussed to ensure people received safe care and treatment.

Medical staffing

- A resident medical officer (RMO) was available 24 hours a day, seven days a week. An agency supplied the RMO

Good

Outpatients and diagnostic imaging

service, and the hospital had strict criteria for the skills the RMO should have. Wherever possible, the agency provided the same two RMOs to the hospital at different times to ensure continuity of services.

- There were 107 doctors working under practising privileges in the hospital. Part of the practising privileges agreement was that doctors had to be available 24 hours a day, seven days a week to provide emergency care or advice for their patients in the hospital. There were good processes to confirm doctors were competent to work in line with the BMI Healthcare Practising Privileges Policy.
- All doctors working under practising privileges in the hospital had registration with a professional body, indemnity insurance, and an up-to-date Disclosure and Barring Service (DBS) check. The schedule for these requirements being current was checked at the time of our inspection and up-to-date. The hospital was assured doctors were skilled in the treatments as the majority of them were employed in NHS trusts carrying out similar procedures.
- There were no concerns raised in respect of medical staffing during our inspection.

Major incident awareness and training

- There were arrangements to respond to emergencies and major incidents. There was a dedicated team for responding to emergencies. We spoke with some members of the team and they were able to fully describe their responsibilities and the actions they would be required to take. Emergency procedure practice sessions were carried out regularly and we saw audits of response times to emergency team calls, which were carried out on a daily basis. The members of the emergency response team we spoke with took their role very seriously and we observed their efficiency in ensuring the system was fit for purpose and regularly tested.
- Staff informed us there was an emergency back-up generator in place and this was tested regularly.
- There were arrangements in case of a radiation or radioactive incident. The hospital had access to a radiation protection advisor at all times and a radiation protection supervisor was on site at the hospital.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic services was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

We found:

- Staff followed national and local guidelines to ensure patients received effective care.
- Staff had a good understanding of their role in protecting people from the risks of unnecessary exposure to radiation.
- We observed effective multidisciplinary team working.
- Staff reported training to be accessible and of a good standard.
- The hospital provided evening appointments and diagnostic imaging was available seven days a week.

However:

- The outpatient and diagnostic imaging departments routinely collected information on patient outcomes but this was not always analysed to improve care.
- Telephone calls to the 24-hour helpline were not formally monitored for themes.

Evidence-based care and treatment

- The service had local policies and guidelines. The policies we read were written according to national evidence based guidance from organisations such as the Department of Health (DoH), the Chartered Society of Physiotherapy (CSP) and the National Institute for Heath and Care Excellence (NICE). Although audits were carried out against the guidelines, results were not always analysed to guide and improve practice. The diagnostic imaging department used diagnostic reference levels and audited these to ensure exposure was carried out according to DoH guidance.
- Staff were kept up-to-date with changes in policies. We saw evidence staff had read updated policies in all areas. Changes and updates to policies were highlighted to staff by heads of departments at handover. They were reminded to read the updated policies and sign to show they had read them.
- Clinical care pathways were in use. Patients had their needs assessed prior to treatment, and care pathways that reflected best practice were in use. Examples of

these were seen in the physiotherapy department for patients requiring aquatic therapy and hand therapy. Patients were assessed at their first appointment and a treatment and exercise plan was started. This was reviewed and updated at each appointment with the patient.

Pain relief

- Pain relief was available in all departments. Staff informed us if a patient required pain relief they would be assessed by the resident medical officer (RMO) who would then write a prescription for them. This would be dispensed by the hospital pharmacy. Staff informed us this rarely happened, as most patients attending the departments were well.
- Complementary pain relief therapies were available via the physiotherapists. The physiotherapy department had transcutaneous electrical nerve stimulation (TENS) machines available for patients who were able to take them home to use.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored, but the results were not always used to guide and improve practice. However, a patient satisfaction survey was carried out monthly and the results were compared with other hospitals within the BMI Healthcare group to improve care and services.
- The physiotherapy department routinely collected information on patient outcomes. They had protocols for monitoring outpatient progression and timescales for post-operative recovery. Although the information was collected, it was not analysed so patient outcomes were not always compared to guide future practice.
- The outpatient department ran a 24-hour helpline to provide patients with advice out of hours. Staff reported they routinely received calls from patients who had been discharged and were confused about their post-operative care. Although staff were aware this happened frequently, they had not audited it or escalated to managers so changes in discharge advice had not been made.

Competent staff

- The hospital checked doctors were fit to practise. We saw a register, which included checks for valid indemnity insurance, Disclosure and Barring Service, annual appraisals and registration with the General Medical Council. All the information provided was up-to-date.
- Patients had confidence in the staff. One patient said whenever they had asked staff questions they always knew the answer straightaway.
- All staff administering radiation were appropriately trained to do so. The staff in the diagnostic imaging department had worked there for a number of years and were always supervised in accordance with legislation set out under the Ionising Radiation (Medical Exposure) Regulations 2000.
- All staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment or when they took on new responsibilities. Staff reported they were positively encouraged and given opportunities to develop and their heads of department were keen for them to learn and improve. For example, a member of staff had undertaken a work related course and their head of department arranged for time off and funding. Throughout the outpatient and diagnostic imaging departments staff said they were positively encouraged to learn and improve.
- Staff regularly discussed their training needs with their managers. A nurse in the outpatient department had been funded by the hospital to attend a course to learn new skills. This had assisted in developing a service in the outpatients' department.
- In the physiotherapy department, regular staff-led training sessions took place. This enabled staff to share good practice about matters that were important to them and ensure the department was safe.
- The appraisal information provided did not demonstrate that non-medical staff such as nurses, healthcare assistants and allied health professionals had received an annual appraisal. The hospital had recently changed to a new system and this had highlighted problems with the previous paper-based system. This meant some of the data prior to the new system was not accurate. Senior managers were aware of this and confident the new system was more effective. All staff we spoke with said their annual appraisal was up-to-date and they were working toward their next review as the dates had already been planned.

Good

Outpatients and diagnostic imaging

- There were arrangements in place for supporting and managing staff. We saw study sessions for nurses to help them with their revalidation advertised in the outpatients' department.
- Sub-speciality clinics were run in the outpatient department. There were specialist nurses who had received extra training employed by the hospital. They carried out clinics in the outpatient department as part of their role. These included gynaecology, gastroenterology and breast care.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. Care was delivered in a coordinated way between different teams. The outpatient department received a form for each patient discharged from the ward detailing the treatment they had received and any follow-up required. Staff reported they always received these forms enabling them to provide seamless care between departments. This was particularly helpful if a patient contacted the 24-hour helpline as they had direct access to patient information and were able to advise them quickly and appropriately. As the outpatient department was not staffed at night, calls to the 24-hour helpline were answered by staff on the ward in the hospital. The ward contacted the outpatient department to inform them of telephone calls they had received overnight.
- The hospital provided one-stop clinics. There was a one-stop clinic for breast care where patients were able to attend to have a consultation with a doctor, a mammogram and scan in one visit. The results were interpreted and given during the appointment. Staff reported this worked well and patients said it was a good service. A similar clinic was provided in the outpatient department for gynaecology patients but this had been more difficult to coordinate due to the variety of treatments and investigations required. Staff in the outpatient department said they were hoping to introduce more one-stop clinics.
- A daily head of department meeting took place every morning in the executive director's office. This was called the CommCell (communication cell) meeting and gave staff an opportunity to discuss their plans and challenges for the upcoming day. The meeting was also used to update staff on ongoing issues and hospital activity, and to praise individual staff for achievements. Outcomes from the meeting were then fed back to staff in the departments by their head of department. The CommCell meeting we went to during our inspection was well attended with representatives from every department.
- Communication with other departments was good. In the outpatient department, staff completed a referral form for patients requiring physiotherapy treatment and reported this system worked well. Staff reported they could also telephone the department and access an on call physiotherapist if their services were required at short notice.
- There was good communication between medical and nursing staff. We observed doctors discussing patients and clinics with the nursing team. Communication was open and we observed effective multidisciplinary teamwork.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday from 8am to 8pm. The outpatient department held clinics on a Saturday when required, but this was usually at the request of the doctors or when demand was high.
- The diagnostic imaging department provided services Monday to Friday 8am to 6pm. There was also an on-call radiologist available at weekends and there was a rota for this service.
- The physiotherapy department provided services from Monday to Friday 8am to 7pm. There was also a pool session on Saturday morning and an osteopath clinic. The head of department reported when demand was high they would run an extra clinic on a Saturday. This regularly occurred and a clinic had been held on the Saturday before our inspection.

Access to information

- The information needed to deliver effective care and treatment was always available to staff. Records for NHS patients were requested before a consultation. When the records arrived, they were filed and transferred to a locked cabinet in the department the day before the clinic. Records were kept both on site and by doctors for non-NHS patients. In the event records were unavailable, staff would use a temporary set of records and these would be filed in the main care record when it was available.

Good

Outpatients and diagnostic imaging

- In the diagnostic imaging department, records were scanned and stored electronically as doctors kept the original paper records. All staff had access to the patient care records, which were kept on a password-protected system. Staff did not report any problems with accessing information.
- When patients were discharged from the ward, the outpatient department was sent a copy of their discharge paperwork. This enabled the outpatient department to provide effective ongoing care. The discharge paperwork was kept in the department for at least two weeks before being filed in the patient care record.
- The hospital contacted GPs by letter to inform them of the treatment patients had received. Patients reported they received a copy of the letter to their GP and this usually arrived one to two weeks following their discharge from the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the rights of people subject to the Mental Capacity Act 2005 (MCA). The hospital did not have a high incidence of patients with mental health problems. Staff showed a good understanding of the MCA Code of Practice. A member of staff gave an example of how they had used the MCA Code of Practice when a patient was unable to give consent to treatment, as they could not retain sufficient information. The patient was referred back to their GP.
- Staff reported they always obtained verbal and written consent from patients prior to any treatment. They showed us a completed consent form where all information had been entered which was filed in the patient notes. If a patient was unable to give consent this was discussed with the head of department and senior management team.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

We rated caring as outstanding because:

- All patients and those close to them we spoke with were consistently positive about the treatment and care they had received at the hospital.
- Some patients told us staff were "fantastic" and "very responsive" to their needs. They felt valued and involved in decisions regarding their care and treatment.
- There was a strong culture of person-centred care. Staff were highly motivated to provide care to patients treating them with dignity, kindness, compassion and respect.
- All staff we spoke with were passionate about the care they provided and were proud of the difference this made to the patients.

Compassionate care

- All patients were consistently positive about the care they received in the departments. They reported care was focused on their needs and preferences. They said staff were able to meet their physical and mental needs and respected their personal preferences including addressing them with their preferred name.
- All patients were treated equally. We spoke with both NHS and privately funded patients and found there was no difference in the care they had received.
- All patients we spoke with were extremely complimentary about the care they received. They did not make any negative comments regarding their care. Some of the comments made to our inspection team included:
  - "Welcoming, helpful and brilliant staff. I feel lucky to be being treated at the hospital."
  - "Staff are lovely."
  - "Staff are friendly and efficient."
  - "A fantastic service, wonderful staff who are kind, helpful and polite."
  - "Staff are attentive, pleasant and professional. I have confidence in the hospital."
  - "I have nothing but praise for the staff. I am very happy with the hospital."
  - "Staff are polite, kind, compassionate and considerate."
- The hospital had outstanding results from the NHS Friends and Family Test. In the six months from September 2015 to February 2016 (the most recent data), the hospital had a higher response rate than the NHS average. The hospital had an average response rate of 46% (NHS average 28%). Of those patients who

responded, in five of the six months, 100% said they would recommend the hospital to their family and friends. In the other month, the recommendation was from 99% of patients.

- Staff took their time interacting with patients. We observed them behaving respectfully towards patients in an unhurried manner. They gave patients and their relatives time to ask questions and all the staff we observed were polite, kind and caring. We also observed them being considerate and supportive to patients and their relatives.
- Confidentiality was maintained at the hospital. The reception desk was far enough away from the waiting area so conversations between the receptionist and patients could not be easily overheard. Patients reported they felt confidentiality was maintained and their privacy and dignity was always respected.
- Chaperones were available at all times. All staff had received chaperone training and said the quality of the training was excellent and they were confident to chaperone in clinics.

Understanding and involvement of patients and those close to them

- Staff always communicated with patients so they understood their care, treatment and condition. All patients we spoke with told us staff clearly explained procedures and checked they understood prior to carrying these out. We observed a member of staff explaining how to store medication to a patient. They checked the patient understood the information they were given and had an opportunity to ask questions.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment. A member of staff described helping a patient who was extremely anxious about coming in for an operation. The staff member took time with the patient to explain everything and telephoned the patient the next day to ensure there were no further concerns.
- Patients reported they felt actively involved in decision making about their care and treatment. Options were discussed with them and they said care was individualised for them. Relatives we spoke with were also consistently complimentary and said they were encouraged to be involved as well. Patients said they always received a telephone call from the consultant after any treatment or care at the hospital. They reported being very pleased to receive the follow-up call as it gave them an opportunity to discuss any concerns they had and ask further questions.

Emotional support

- The patient satisfaction survey (184 responses) results were excellent for emotional support to patients. The results from a question about emotional support for February 2016 were:
  - 100% said they could talk with someone about their worries/fears.
- Staff clearly demonstrated their understanding of the impact a person's care, treatment or condition might have on their wellbeing. They explained how different treatment options were discussed with patients and their relatives. Patients were helped and supported by staff to make their own decisions regarding their treatment.
- Staff had time to provide patients with emotional support and information. One member of staff reported the best thing about working for the hospital was being able to "spend time with patients and not feel as though appointments were rushed."

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsiveness as good because:

- Targets for referral to treatment times for NHS patients at the hospital were always met in the period from January to December 2015.
- Extra clinics were put on in the departments if demand required them.
- Staff monitored the length of appointments and adjusted these lengths as required to avoid long waiting times for patients.
- All patients we spoke with reported being seen quickly, sometimes ahead of their appointment time.
- Patients who had complex needs were identified and extra support was provided.

- The hospital had a policy regarding complaints. Staff reported they were involved in investigations and were given feedback. Staff took a multidisciplinary approach to resolving complaints and concerns.

However:

- The temporary closure of a treatment room had caused delays in the outpatient department.
- Some patients reported difficulty with parking at the hospital.

Service planning and delivery to meet the needs of local people

- Most of the facilities and premises were appropriate for the services offered. Patients reported the waiting areas were comfortable and inviting. There were a variety of refreshments, magazines and newspapers in the waiting area. Wi-Fi was available for patients to use and there was a television. A play area was provided for children, which was easily visible from all areas in the waiting room.
- A treatment room in the outpatient department was not in use during our inspection due to an insufficient air filtration system. This had been identified recently during an infection prevention and control audit. The temporary closure of the room meant some clinics were delayed as this had reduced the rooms available to treat patients. There were plans to upgrade the air-change system and this was being dealt with as a priority.
- Car parking at the hospital was free of charge but sometimes difficult. Some patients we spoke with commented that car parking spaces at the hospital were insufficient. Alternative car parks were available close to the main hospital site but transport from them to the hospital was not provided.
- All patients we spoke with reported they did not have any problems in finding departments in the hospital, as they were clearly signposted. In outpatients and diagnostic imaging, members of staff escorted patients from the waiting area to their appointment. Patients requiring an ultrasound scan, computerised tomography (CT) scan or magnetic resonance imaging (MRI) were escorted to these by a member of staff who also accompanied them back to the department.
- Patients received detailed information prior to their appointment. A member of staff would initially telephone them with their appointment details and they received written information in the post following this. Patients we spoke with said the information they were given was of a good standard and they felt able to contact the hospital if they had any questions.
- In response to local needs, the hospital had been extended in 2000 and 2011/12. The first extension provided a gymnasium and pool for the physiotherapy service, which enabled them to carry out more clinics and provide hydrotherapy. The outpatient department had been extended in 2011/12 and four consulting rooms had been added enabling them to offer a wider range of clinics.

Access and flow

- People had timely access to initial assessment, diagnosis or treatment. The referral to treatment waiting times for NHS patients at the hospital were consistently below (better than) the England target. From January to December 2015, NHS patients in the outpatient and diagnostic imaging departments received treatment within the target of 18 weeks. The physiotherapy department saw patients within one week of referral. The physiotherapy manager monitored all incoming referrals and arranged urgent appointments when required.
- Appointments were offered in the outpatient and diagnostic imaging departments from Monday to Friday. Saturday appointments were offered when there was a demand on the service. Clinics were held up until 8pm in outpatients and 6pm in diagnostic imaging. Staff reported most patients were able to book appointments within the times offered. Most patients we spoke with said they were not offered a choice of appointments but if their appointment time was inconvenient, they did not have any problems rearranging it.
- The diagnostic imaging department offered one-stop clinics for breast care patients. Patients attending this clinic had a consultation with their doctor, followed by a mammogram and ultrasound. They were given the results of the investigations in the same appointment.
- Clinics ran on time and we observed this during our inspection. Patients we spoke with said they did not experience long waits from clinics running late and many reported being taken straight through to their appointment on arrival at the hospital. When there were delays, patients we spoke with said they were kept informed and offered an alternative appointment if they were unable to wait. One patient was “very impressed”

and said: “My doctor escorted me to my appointment because he wanted to apologise for keeping me waiting.” Staff said they monitored waiting times in the outpatient department. If patients were regularly delayed due to appointments running over they discussed this with the doctors and extended appointment times to prevent it from happening. This made clinics longer but helped to ensure patients did not experience delays.

- The temporary closure of the treatment room in the outpatients’ department in response to an audit had caused delays to some patients. Alternatives had been looked into but none were identified as a suitable long-term solution. The hospital had prioritised replacing the air filtration system.
- There was a culture of flexibility, willingness and shared responsibility among all the teams and staff we met. For example, on one occasion, a department in the hospital had experienced a staff shortage meaning they would have to cancel some services at short notice. A member of staff in the outpatient department volunteered to work there and stayed on beyond their shift so the service could continue as planned.

Meeting people’s individual needs

- The hospital planned services and delivered them to take account of the needs of different people. For example, in the outpatients’ department new patient appointments for gastroenterology patients were 40 minutes long and follow-up appointments were 20 minutes long. Surgical patients’ initial appointments were 20 minutes long and follow-up appointments were 10 minutes. In the physiotherapy department, initial appointments were 45 minutes long and follow-up appointments were 30 minutes in duration. This was monitored regularly and if patients required more time, appointments were extended.
- The hospital planned services and delivered them to take account of people with complex needs. Staff told us they were informed by the doctors if a patient with complex needs was attending and additional requirements for them were identified. In the Patient Led Assessment of the Care Environment (PLACE) audit carried out in March 2015, dementia services at the hospital scored 83%. This was above the England average of 81% for independent sector acute hospitals but the hospital was devising a plan to provide more dementia-friendly facilities.
- The physiotherapy department were informed in advance if they had patients attending with complex needs and were able to plan for this.
- The hospital had good disabled access but a patient we spoke with reported they were unable to park in a disabled spaces at times, as there were not enough available. During busy times, the main hospital waiting area was crowded which could cause access issues for patients with walking aids or wheelchairs.
- Staff had access to interpreter services. Staff explained how they would access an interpreter if required using an online system and a conference telephone during the consultation. They reported an incident when a patient attended the hospital where English was not their first language. They had quickly recognised the patient did not understand what they were being told, and not engaging in the conversation. A member of staff spoke the same language as the patient and it was arranged for their duties to be covered by another member of staff so they could attend the consultation as an interpreter. Consent was obtained from the patient prior to this being carried out.
- Patients were encouraged to bring a relative or their carer with them to appointments. The consulting rooms in the outpatient department were large enough to accommodate extra people.
- Staff made sure patients and their relatives were given further information and time to ask questions about their care and treatment. Patients reported they were given as much time as they needed during the consultation and they were given leaflets, which staff explained to them. Contact numbers for the hospital, doctors and their secretaries were given including a 24-hour helpline number where they could discuss any concerns with a member of staff at any time.
- Patients reported they received information in a timely manner following their appointment. They were informed when and how they would receive results, when their next appointment was and knew whom to contact if they had any concerns. They also received a copy of any letters sent to their GP.

Learning from complaints and concerns

- Patients told us they knew how to make a complaint or raise concerns. They said they felt confident to speak up about concerns if they needed to. There were leaflets available explaining how they could make a complaint and they reported feeling confident to raise any

concerns with staff. In the period from January to December 2015, the hospital received 56 complaints – although these were for the overall hospital and not just for outpatients.

- The hospital followed its corporate policy when handling complaints and aimed to acknowledge complaints within two working days of their receipt. They sent a full response within 20 working days if it was available; if not, a further holding letter was sent every 20 days until the full response could be sent. However, in the reporting period, two complaints were regarding the lack of response from the complaints department. The number and type of complaints received were benchmarked against other BMI Healthcare hospitals.
- Staff we spoke with said they received information about complaints in their team meetings from their head of department. They reported working together to try to address concerns and issues. They said a multidisciplinary team approach was taken when trying to resolve issues and concerns.
- Following complaints about treatment costs, notices had been displayed in all consulting rooms advising of the charges made for procedures.
- In the outpatient department staff we spoke with said they had been involved in investigations following complaints and their opinions and views had been valued and listened to.
- In the diagnostic imaging department, a patient had complained about treatment they had received. Because of this, the department had carried out an investigation and changed the care pathway for patients receiving similar treatments. They had updated the patient information leaflet and changed the way the procedure was carried out to protect the privacy and dignity of the patients.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a detailed strategic vision for the hospital, although the key risks did not flow through the strategy or the future plans.
- Audit work was not providing effective assurance of safe and quality care. The governance work was not picking up some issues, including the lack of assurance of the medical equipment register and the status of staff appraisals.
- The risk register did not show the age of risks, any reduction in the rating of the risk through actions taken, and how risks were going to be closed or managed to an acceptable level.
- The hospital's action tracker was over-detailed and not referenced at the clinical governance meeting, although it was at the head of department meeting.

However:

- There was a clear structure for governance and committees of experts provided analysis and review. Incidents were discussed and actions taken when needed.
- Staff said the senior management team were very visible and approachable.
- Heads of departments were supportive and knowledgeable. They kept staff up to date with developments and changes.
- Patient and staff opinions were sought. Service improvements were made because of these.
- Staff felt valued and engaged.

Vision and strategy for this core service

- There were a number of strategic documents which highlighted risks and future plans. These were quite detailed. However, the corporate templates for these documents did not describe the risks or issues, only how they were being controlled. Therefore, it was not possible to know if the controls addressed the risks. In addition, there was no strategy to take forward the top key risk in the 2016 business plan, which was the lack of accreditation of the endoscopy suite. The business transformation projects did not address the four key risks identified by the organisation and did not extend beyond 2016 and into future plans. The objectives, however, did relate to the organisation's eight strategic priorities. The business transformation projects for 2016 included the '@work' employee system for managing the payroll, and the ward-labour resource-planning tool, to manage safe staffing levels. There was a project for standardising guidelines and practices in housekeeping. All of these projects had already been completed. The remaining project was for the delivery of an ambulatory

care service. This had an objective to provide services for patients who would not need to remain in hospital overnight, whereas this had otherwise been necessary in the past. This was due for completion in September 2016.

Governance, risk management and quality measurement for this core service

- Staff we spoke with understood their roles around governance and risk management. They were able to explain what they were accountable for in the hospital and their department. Governance meetings were held monthly and attended by the senior management team and all heads of departments. Subjects discussed included clinical incidents and investigations, safeguarding, patient satisfaction including complaints and staff training. Relevant items from the governance meetings were discussed by heads of departments with ward staff. There were also governance sub-committees within the clinical governance framework including radiation protection, resuscitation and infection control. Appropriate staff were allocated to these committees.
- The departments recognised and reported their risks. The hospital had a risk register but it was complex, long and did not separate risks into individual areas. The dates risks were added were not entered and progress made in reducing or resolving the risks were not included.
- The hospital was using an action tracker in relation to reported incidents, repairs or maintenance required, but, and staff agreed, this was becoming too large and somewhat unmanageable. Many of the actions were now completed, which showed good progress in resolving problems. Some were also minor issues, which had quick resolutions. The action tracker, however, did not show the date the action was raised, so there was no evidence of how long it had been open or taken to resolve. We looked at clinical governance meeting minutes and head of department meeting minutes, but the action tracker was not a standing agenda item for assurance. However, it was discussed at the head of department meetings.
- The departments had an audit schedule. In the period from January to December 2015, the schedule showed the audits had all been completed. There was an audit schedule for the period from January to December 2016. All audits in January and February 2016 had been completed, except for in February where the results of the hand hygiene audit and an audit on the completion of patient risk for venous thromboembolism were not available. We were informed that audit schedules and results were discussed at the monthly governance meeting. However, there was little evidence of audit results being discussed in the four governance meeting minutes we were provided with.

Leadership and culture of service

- All staff we met spoke highly of the leadership within their departments. They reported their heads of department had the skills, knowledge and experience to lead the team effectively. The heads of department were friendly and approachable and staff said they were always available to help or advise them.
- All staff we met spoke positively about the senior management team and reported they were accessible and approachable. They said the executive director and senior management teams were seen most days in their departments, and if they raised concerns to them, they were able and willing to deal with them. One member of staff had made a comment to a member of the senior management team about an aspect of the service the hospital provided. The senior manager immediately visited the department to raise the concern and returned to inform the member of staff the action that had been taken. The member of staff said there had been no further issues following this.
- In outpatients and diagnostic imaging, the heads of department had a positive and friendly attitude. They were aware of the challenges in their department and took steps to resolve these. For example, the treatment room in the outpatient department had been temporarily taken out of use. The head of department had explored other options, so the clinics that usually took place in that room could continue. There were plans to resolve the issue in the room so it could be put back into use as soon as possible.
- Some staff we spoke with reported improvements and developments in the hospital were discussed with them to explore their impact. This gave them an opportunity to be involved in service improvement. When staff were involved in discussions, they reported feeling valued and said the opinions they gave were used to develop service provision.

Public and staff engagement

Good

Outpatients and diagnostic imaging

- All patients were given a feedback card at the end of their consultation to complete. There were also feedback cards in the main reception. The card had been designed so it would be quick and easy to complete and there was a section for patients to explain their answers or put comments. Changes that had been made because of patient feedback were clearly displayed in the waiting area on a poster titled “You said, we did”. For example, patients commented there were limited menu choices and the internet connection required improving. In response to these complaints, the hospital extended their menu options and introduced new dishes. They asked staff not to use the hospital guest internet login and this had improved the speed of the internet service for patients.
- The hospital participated in the NHS Friends and Family Test (FFT). This survey asks whether patients would recommend the service they had received to friends and family. From July to December 2015, the hospital response rate for this test was above the national England average for five out of six months. In the same period, the FFT score for NHS patients was 100% except for one month where the score was 99%. This meant 99 to 100% of NHS patients from July to December 2015 would recommend the service to friends and family.
- The departments held regular staff meetings, which were advertised in advance to give staff an opportunity to attend. Incidents and adverse events were discussed, along with training compliance and complaints. In the outpatient and diagnostic imaging departments, minutes from the meetings were available to all staff. However, in the physiotherapy department, no up-to-date minutes were available, despite meetings having taken place. This meant staff that had been unable to attend were not always aware of updates and discussions.
- There was a weekly newsletter sent by email but not all staff were on the provider’s email system. We asked how those staff not on the system were made aware of the newsletter but staff were unsure. Some staff received the newsletter through their private email.
- The hospital recognised long service by holding a yearly ceremony where lapel pins were given to staff with a different stone in for every five years of service they had given. The awards were announced throughout the BMI Healthcare organisation. Staff wore their pins with pride and were keen to tell the inspection team of their significance.
- In the staff canteen, a poster was on display with staff names on it. Some of the names were written in large fonts and others in smaller fonts. A member of staff explained that if they were specifically named by a patient giving positive feedback, their name was put onto the poster. Each time they were mentioned positively their name was made bigger. Staff we spoke with reported this gave them pride in achieving compliments from patients.
- Staff were encouraged to recognise achievements by others. At any time, they could nominate an individual for an 'Above and Beyond' award. Nominated staff received recognition at the daily head of department CommCell meeting, a personal “thank you” from the senior management team and acknowledgement at department level. Staff we spoke with had nominated colleagues for this award, showing a mutual respect for each other.
- Staff we met said the recognition systems in place at the hospital focused them to continually improve the quality of the care they gave.

Innovation, improvement and sustainability

- The departments had some improvement strategies in place. For example, the hospital was in the process of purchasing a magnetic resonance imaging (MRI) scanner so this service could be provided by the hospital instead of being outsourced to another company.
- The hospital was making plans to become more dementia friendly following an audit which showed there was room for improvement.
- The hospital had improved the services it provided in the outpatient department. An extension had been built to enlarge the facilities in the physiotherapy department and incorporate a hydrotherapy pool. The outpatient department had also been extended to provide more clinics.
- The diagnostic imaging department provided a one-stop clinic appointment for patients requiring breast care. The outpatient department reported they were looking into providing a similar one-stop service for some of their patients.
- Staff we spoke with in the outpatient department could not give any examples of where financial pressures had

Good

Outpatients and diagnostic imaging

comprised patient care. Where issues such as the closure of the treatment room in the outpatient department were identified, resolutions were sought and action plans developed quickly.

Outstanding practice and areas for improvement

Outstanding practice

- There was outstanding care provided to surgical and medical inpatients and day-case patients, including oncology patients, and outpatients. Patients told us they could not fault the kindness, compassion and sensitivity of staff.
- There was an outstanding service to patients from the pharmacy team when medicines were prescribed to take home. Patients were given their medicines within an hour, and this therefore meant they were not delayed in going home.
- The senior management team were visible, approachable and supportive to both staff and patients. Engagement with staff and patients was welcomed in a positive and constructive manner.
- The organisation had an extensive and detailed patient satisfaction questionnaire. This provided useful information for the hospital and the wider provider organisation. It enabled the hospital to look for, and implement, improvements to patient care.
- The oncology operational policy had been devised by a member of the oncology team at The Ridgeway Hospital and was to be shared across the organisation.
- The provider had various staff recognition schemes, which made staff feel proud, valued and encouraged them to improve services for patients.

Areas for improvement

Action the provider MUST take to improve

- Ensure all surgical safety checklists are fully completed, and audit routines are able to provide full assurance.
- Review the medical equipment asset register to be able to provide assurance that all medical equipment is serviced and maintained as required.
- Ensure all surgical patient records are legible and complete.
- Ensure all audit work, the risk register and action tracker provide assurance that the governance systems are delivering safe, effective, and quality care and treatment.
- Ensure all staff who have some degree of contact with children are appropriately trained in level two safeguarding.
- Ensure all staff who are involved in assessing and planning care for children and young people are appropriately trained in level three safeguarding.
- Develop a competency framework to assess the paediatric skills and training competencies for registered adult nurses and other clinical staff who may be required to work with children and young people. Young people must be risk assessed for care on the adult pathway by either a paediatric nurse or an adult nurse with paediatric competencies.
- Ensure the children and young people's service is being assessed and monitored through audit work, the risk register and patient experience, to provide assurance that the governance systems are delivering safe, effective and quality care and treatment.

Action the provider SHOULD take to improve

- Continue the programme of refurbishment, replacement, and remedial works to ensure all areas of the hospital and its equipment are safe, compliant with clinical requirements, and able to be cleaned effectively.
- Ensure all staff are bare below the elbow when in clinical areas.
- Review the storage of IV fluids in the operating theatre to ensure they are stored securely.
- Ensure all areas within the operating theatre recovery room are free of dust at all times.

Outstanding practice and areas for improvement

- Review the storage and security of chemicals and products that should be locked away.
- Arrange for a regular review of antibiotic prescribing and key performance indicators for pharmacy staff to achieve.
- Ensure the business continuity plans are satisfactory for the services provided and there are simulation exercises at the required intervals.
- Display the excellent harm-free care (NHS safety thermometer) results on the ward, as is best practice.
- Review the electrical testing of all surgical equipment to ensure the records are accurate and all equipment has been tested as and when required.
- Make sure the service level agreement with the local NHS acute hospital trust for emergency transfers of patient is updated and current.
- Ensure all staff have had their annual performance review and there are systems to demonstrate this.
- Look to provide pharmacist advice for staff out-of-hours.
- Allow patients to respond to staff knocking on doors before entering.
- Continue to investigate how to deliver improved parking facilities.
- Ensure patients are not disturbed by unnecessary noise at night.
- Confirm the correct weight criteria for young people's suitability for surgical treatment on the adult pathway.
- Ensure inactive patient group directives in the outpatients' department are not available and archived.
- Review and improve clinical waste management systems in the outpatients' department.
- Make sure that consent forms contain more details about the risks involved rather than one word.
- To review all medical records written by consultants to make sure they can be read by staff.
- Ensure patient consent forms are fully completed and contain sufficient detail in line with hospital policy.

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 12(1) Care and treatment must be provided in a safe way for service users. 12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Young people were not risk assessed for their care on the adult surgical pathway by staff with paediatric skill competencies.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users. The intercollegiate document, Safeguarding children and young people: roles and competencies for healthcare staff had not been adequately considered. Training records did not demonstrate that all staff that had some degree of contact with children were appropriately trained in level two safeguarding children or staff involved in assessing and planning care for children and young people were level three trained.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15(1) All premises and equipment used by the service provider must be- (e) properly maintained The medical equipment asset register did not provide assurance that all medical equipment had been serviced and maintained as required.

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 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17(2) 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 and experience of service users in receiving those services); and (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of services users and others who may be at risk which arise from the carrying on of the regulated activity, and (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The surgery services were not able to demonstrate from the patient records or the audit work that all surgical safety checklists were fully completed at all times. Not all patient records were fully legible or completed.

This section is primarily information for the provider

Requirement notices

Within the hospital's governance framework, audit work, the risk register, and action tracker (where not dates were being recorded) were not able to provide assurance of how these processes were delivering safe, effective and quality care and treatment.

The hospital was not able to demonstrate how services for children and young people were being considered within the strategy, the governance framework, audit work, or the risk register.

Children's experiences were not being sought.