BMI The Park Hospital

Quality Report

BMI The Park Hospital
Sherwood Lodge Drive
Burntstump Country Park
Arnold
Nottinghamshire
NG5 8RX
Tel: 0115 9662008
Website: www.bmihealthcare.co.uk/thepark

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

This was an announced comprehensive inspection of BMI The Park Hospital, which was part of the CQC's ongoing programme of comprehensive, independent healthcare acute hospital inspections. We carried out the announced inspection of BMI The Park Hospital on 6 and 7 September 2016. Following this inspection an unannounced inspection took place on 17 September 2016.

The inspection team inspected the core services of medicine, surgery and outpatients and diagnostic imaging services.

Overall, we have rated BMI The Park Hospital as good. Medicine services were good in safe, effective, caring, responsive and well-led. Surgery services were requires improvement in safe and good relating to caring, effective, responsive and well-led. Outpatients and diagnostic imaging services were good in the key questions relating to caring and responsive, and requires improvement for safe and well-led. We inspected but did not rate the key question of effective in outpatient and diagnostic services.

Are services safe at this hospital

We found services provided at BMI The Park Hospital required improvement for safe.

- Staffing in outpatients was dependent on bank staff who did not complete the hospital's mandatory training if they worked less than 80 hours per month in line with BMI policy, which was a risk to the quality of patient care.
- There were no dedicated areas in outpatients for children and their safety was not fully risk assessed.
- A children's nurse could not always be present in outpatients if a child came in for a short notice appointment.
- Equipment was not tested systematically in diagnostic imaging, which meant that checks for cardiac monitoring equipment were overdue.
- At the time of our inspection clinical areas were carpeted and a refurbishment plan was being implemented.
- Staff did not always adhere to theatre protocols as we observed staff did not always change into appropriate clothing within the theatre environment.
- Medical records documentation was not always legible.
- Daily reviews by consultants for surgical inpatients were not documented within the medical records which meant patients may not receive the care planned by the surgeons. There was no separate systematic daily review sheet for patients within critical care.
- The critical care unit did not meet the requirements of the Core Standard for Intensive Care Units (2013) which state care must be led by a consultant in intensive care medicine. There was no resident anaesthetist overnight for critical care patients.
- There was a good incident reporting culture throughout the hospital, staff understood and were supported to raise concerns and report incidents and near misses.
- Staff were encouraged to be open and honest and were aware of the duty of candour regulation. This regulation requires providers to be open and transparent with people about the care they receive in particular circumstances and especially where things go wrong.
- Incidents were investigated; learning identified was shared throughout the hospital and with other hospitals within the organisation.
- The hospital had a safeguarding lead and staff were supported to take a proactive approach to safeguarding. All staff knew who the safeguarding lead was and told us they would always approach them for guidance.
- Staff assessed and responded appropriately to potential risks to patients. The hospital had appropriate processes and agreements in place to transfer patients to a nearby NHS acute hospital if their condition deteriorated.
- There were effective arrangements and processes in place to support the handover of appropriate patient information between the resident medical officers (RMOs), consultants and other clinical staff such as nurses and allied healthcare professionals at the hospital.

Summary of findings

Are services effective at this hospital

We found services provided at BMI The Park Hospital were effective.

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Local policies and procedures, alongside National Institute for Health and Care Excellence (NICE) guidelines, were discussed at the Medical Advisory Committee (MAC) meetings.
- Patients received care and treatment in line with national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals.
- The hospital participated in a number of national audits and responded to findings to improve services.
- Staff told us they understood the principle of assessing mental capacity and best interest decisions but that they had not had to apply this knowledge.

Are services caring at this hospital

We found services provided at BMI The Park Hospital were caring.

- The patients we spoke with told us staff were kind, caring and they were likely or extremely likely to recommend the service.
- Patients were followed up after they were discharged home.
- Emotional support was provided by staff at the hospital. We saw staff providing reassurance for patients throughout their treatment and care.
- Patients received clear information prior to their appointment and were able to ask questions and get clear responses during their appointment.

Are services responsive at this hospital

We found services provided at BMI The Park Hospital were responsive.

- Patients' needs were met through the way services were organised and delivered. Patients accessed services provided by the hospital via a NHS referral, via self-referral and self-funding or via their health care insurer.
- Services were flexible and choice and continuity of care was reflected throughout the service. The needs of all patients were taken into account throughout the planning and delivery of services.
- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- Occupancy rates on the ward meant that any day case patients who needed to stay overnight because they were not fit to go home could do so.
- The hospital had a policy, which outlined the inclusion and exclusion criteria for patients.
- All patients were screened pre-operatively to determine whether the hospital could meet their needs.
- In line with BMI policy, all complaints were responded to in a timely manner. Lessons identified were shared with staff.

Are services well led at this hospital

We found services provided at BMI The Park Hospital were well led.

- There was a clear governance structure in place which enabled heads of department to feed into the medical advisory committee (MAC) and the hospital executive management team.
- The leadership, governance and culture promoted the delivery of high quality person-centred care.
- Whilst there was a clear corporate vision and strategic priorities, the strategy for services for children was still being formulated and not all of the service leads were clear about the vision and strategy for the service.

Summary of findings

- The Fit and Proper Persons Requirement (FPPR) intends to make sure senior directors are of good character and have the right qualifications and experience. We reviewed that these requirements had been fulfilled.
- Without exception, staff we spoke with were consistently positive about leadership across all areas.

Our key findings were as follows:

- The senior leadership team displayed the skills, knowledge and experience required to lead. This was demonstrated through their attitude, values and commitment to ensure staff felt valued and involved in decision making throughout the hospital.
- Senior staff provided clear leadership and motivation to their teams and held regular staff forums to update staff. The leadership team were known to staff and were visible throughout the hospital.
- Staff morale was good and staff enjoyed working at BMI The Park Hospital. There was very good, effective multidisciplinary team-working.
- There was a positive, open culture in which staff were able to raise concerns and make suggestions.
- All the areas we visited were visibly clean and uncluttered. Staff wore protective clothing when necessary and were aware of current infection prevention and control guidelines. There were defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- The hospital had reported no incidence of methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. difficile) or methicillin-sensitive staphylococcus aureus (MSSA) between March 2015 and April 2016.
- Patient-led assessments of the care environment (PLACE) audits for 2016 showed the hospital had achieved 100% for cleanliness.
- The hospital had an infection control nurse who provided training and provided support to staff so patients who acquired infections could be identified and treated promptly.
- A resident medical officer (RMO) provided 24-hour cover for all patients. Consultants and anaesthetists could be contacted 24 hours a day.
- There were no unexpected inpatient deaths in the hospital in the 12 months preceding our inspection. Deaths would be reviewed and discussed at the clinical governance and medical advisory committee (MAC) meetings.
- Patient records included an assessment of risks.
- Staff followed guidance on fasting prior to surgery which was based on best practice. For healthy patients requiring a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- Some areas we inspected had to rely on bank staff to enable an appropriate skills mix to meet patients' needs.
- Medical staff did not meet the hospital target for safeguarding adults and children training.
- Patient's daily reviews by medical staff were not always documented in the patient's medical records.

We saw areas of outstanding practice including:

- Award from the Macmillan Quality Environment Mark (MQEM); a quality framework for assessing whether cancer care environments meet the standards required by people living with cancer.

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

Action the hospital MUST take to improve

- The hospital must ensure that all staff have an appropriate level of adult safeguarding training.

In addition the provider should:

Action the hospital SHOULD take to improve

- The hospital should consider displaying NHS safety thermometer data so that it can be seen by patients and staff.
- The hospital should ensure that daily consultant reviews are documented in the patient medical records.
- The hospital should consider providing a child friendly environment.

Summary of findings

- The hospital should ensure national early warning score documentation is consistently completed.
- The integrated governance committee should include staff from all levels within the hospital.
- The hospital should display leaflets and information for patients on how to complain.
- The hospital should provide information for patients in different languages.
- The hospital should ensure seating is washable in patient areas.
- The hospital should audit the imaging reporting turnaround times.
- The hospital should review the risk register regarding the risks posed to children in the outpatients waiting area.
- The hospital should define their vision for the provision of children's services.
- The hospital should formally monitor how responsive the service was for outpatients.
- The hospital should produce specific leaflets for children.
- The hospital should have a clear system for allocating rooms to ensure that sufficient nursing staff are able support booked clinics.
- The hospital should have an induction pack and mandatory training for bank staff to complete.
- The hospital should have equipment tested systematically in diagnostic imaging.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	We rated this service as good because: Staff were encouraged to report incidents. Incidents and lessons learned were discussed at integrated governance meetings and shared with all staff. There was good multi-disciplinary working and relationships throughout the department, with the rest of the hospital and local NHS acute trusts. Nursing, medical and allied healthcare professionals were caring and patients were positive about their care and experiences. Patients were treated with dignity and respect. Care and treatment was provided in line with national guidelines and the service contributed data to relevant national audits. Without exception, staff we spoke with were consistently positive about local leadership across all areas in medical care services at this hospital. The culture of the ward, endoscopy (theatre team) and oncology team was nurturing and staff were professionally supportive of each other. Some of the patient rooms and corridors did not comply with the requirements of regulations for infection control as they were carpeted. Medical record documentation did not always meet satisfactory standards. The handwriting was not always legible. Daily reviews by consultants for inpatients were not documented within the medical records which meant patients may not receive the planned care.
Surgery	Good 	We rated this service as good because: Staff were encouraged to report incidents. Incidents and lessons learned were discussed at integrated governance meetings and shared with all staff. Nursing, medical and allied healthcare professionals were caring and patients were positive about their care and experiences. Patients were treated with dignity and respect.

Summary of findings

There were effective systems in place to ensure patients received adequate pain relief following their operation. Patients also received a follow-up phone call within 48 hours of discharge to ensure they were coping at home.
Care and treatment was provided in line with national guidelines and the service contributed data to relevant national audits. Patient outcomes were generally in line with national data.
Safeguarding training was not given enough priority. There was no evidence that the majority of consultants had received safeguarding training and staff were unclear about their responsibilities relating to female genital mutilation (FGM).
Planned level three children's safeguarding was e-learning which is not in line with intercollegiate guidance.
The critical care unit did not meet the requirements of the Core Standard for Intensive Care Units (2013) which state care must be led by a consultant in intensive care medicine. There was no resident anaesthetist overnight for critical care patients.
Some of the patient rooms and corridors did not comply with the requirements of regulations for infection control as they were carpeted.
Staff did not always observe theatre protocols by changing into appropriate clothing within the theatre environment.
Medical record documentation did not always meet satisfactory standards. The handwriting was not always legible. Daily reviews by consultants for surgical inpatients were not always documented within the medical records which meant patients may not receive the care planned by the surgeons. There was no separate systematic daily review sheet for patients within critical care.

Outpatients and diagnostic imaging

Requires improvement

We rated this service as requires improvement because:
The hospital depended on bank staff who did not all receive mandatory training, and who were not always available if a child had an appointment at short notice. This posed a risk to patient safety.
The hospital did not have a clear system for allocating sufficient nursing staff to support clinics or for booking clinic rooms.

Summary of findings

Equipment checks were not robust to keep people safe. Checks for cardiac monitoring equipment were overdue in diagnostic imaging.
The hospital had not defined its vision for outpatients or for children's services. Its risk register and risk assessment approach did not include the risks to children, and there were no dedicated areas for children in outpatients.
The services did not use data and performance monitoring to improve quality. Participation in national and clinical audits and benchmarking was poor. There was a lack of formal monitoring of how responsive the service was for outpatients and no quality and performance dashboard reported publicly.
Public engagement and learning from patient comments in outpatients was limited. Although there was a corporate range of informative leaflets, there were no specific leaflets for outpatients who were children, or leaflets in alternative formats.
Staff learnt from safety and quality incidents and shared learning across the hospital, and governance arrangements supported this well.
There was an effective process for investigating serious incidents. Staff had a good understanding of safeguarding and how to react to concerns.
The patients we spoke with told us staff were kind, caring and they were likely or extremely likely to recommend the service. Patients received clear information prior to their appointment and were able to ask questions and get clear responses during their appointment. Nurses, doctors and imaging staff obtained consent to care and treatment in line with legislation and guidance.
Staff considered the individualised needs of patients when planning care. Services coordinated appointments to enable patients to see a number of services in one day. Nurses, doctors and imaging staff combined their skills well in a good multidisciplinary team approach to meeting the needs of patients using the service.
The hospital had a clear vision for its imaging services and imaging staff contributed to strategic decisions. Outpatient staff had strong leadership at service level with the ability to problem solve.
Waiting times for outpatient appointments were within the national guidelines Patient care and

Summary of findings

treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.

Summary of findings

Contents

Good

BMI The Park Hospital

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

Summary of this inspection

Background to BMI The Park Hospital

BMI The Park Hospital is part of BMI Healthcare Ltd, a provider of independent healthcare with a nationwide network of hospitals.

The hospital has an executive director, who is also the registered manager.

BMI The Park Hospital is registered to provide the following Regulated Activities:

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

Healthcare is provided by staff at the hospital to patients with private medical insurance, those who self-pay and through National Health Service (NHS) contracts.

The BMI The Park Hospital has practising privilege arrangements for over 227 doctors and dentists. The hospital offers treatment over a range of 28 specialties. These specialties include ophthalmology (cataract), orthopaedics (hip, knee, shoulder, elbow, spine, foot and ankle, hand and wrist), gynaecology, hernia repair, urology (male and female urology, including prostate surgery), colorectal, oral surgery, podiatric surgery, and gastrointestinal/liver outpatient consultations. NHS patients account for approximately 26% of the activity undertaken at BMI The Park Hospital, the majority access the services through the choose and book NHS contract. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

The hospital provides outpatients, inpatient and day case care and treatments. The service is registered to provide adult inpatient care and children's inpatient care to 68 patients at any time.

There are five operating theatres including an eight bedded recovery area. All of the single bedrooms have en-suite facilities, Wi-Fi, television and telephone. The outpatient department comprises of 15 consulting rooms, a pre-assessment room and ambulatory care room, two treatment rooms for minor procedures and cardiology and an eye clinic. The outpatient department offers appointments from 8am to 9pm Monday to Friday with some additional clinics on Sundays.

The senior team told us that the intensive care unit is available to stabilise inpatients whilst awaiting emergency service to transfer the patient to a local NHS trust and post-surgical patients, requiring level two critical care facilities. The hospital was in the process of developing the service to offer level three care in the forthcoming months.

The outpatient consultations were being held in available consulting rooms along one of the outpatient corridors and in temporary consulting rooms on the ward upstairs. The physiotherapy department has a gymnasium area with fitness equipment and exercise classes. The diagnostic and imaging department carries out magnetic resonance imaging (MRI), computerised tomography (CT), x-rays, ultrasound scans and full field digital mammography (FFDM).

We inspected the core services of medicine, surgery and outpatients and diagnostic imaging services at BMI The Park Hospital as part of our ongoing comprehensive inspection programme of independent healthcare hospitals.

Our inspection team

Our inspection team was led by:

Inspection lead: Martine Pringle, Inspector, Care Quality Commission

Oversight from: Bridgette Hill, Inspection Manager, Care Quality Commission

Summary of this inspection

The team included three CQC inspectors, three specialist advisors, a children's nurse, consultant anaesthetist and a consultant physician.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection on 6 and 7 September 2016 and an unannounced inspection on 17 September 2016. We spoke with a range of staff in the hospital, including nurses, consultants, and administrative, ancillary and clerical staff. During our inspection we reviewed services provided by BMI The Park Hospital in the ward, the operating theatre and outpatients department.

During our inspection we spoke with 39 members of staff, including nurses, medical staff, allied health professionals, support workers and consultants who were not directly employed by the hospital, 18 patients and three relatives from all areas of the hospital, including the ward, operating theatre and outpatient department. We observed how patients were being cared for and talked with patients. We reviewed the personal care or treatment records of 10 patients in surgery, five patients in medicine and 10 patients in outpatients and diagnostic imaging. We also reviewed five medication administration charts in surgery.

Information about BMI The Park Hospital

The BMI The Park Hospital has practising privilege arrangements for over 227 doctors and dentists. The hospital offers treatment under a range of 28 specialties.

There were 43,278 outpatient attendances at BMI The Park between April 2015 and March 2016. Most were adults and 1380 (3.1%) were children and young people under 18 years. During this period, 122 children and babies up to the age of two, 877 children aged from three to 15 years and 381 young people aged 16 and 17 attended the outpatient clinics.

In the reporting period April 2015 to March 2016 there were 7,839 surgical inpatients and day case patients and the majority of these were non-NHS funded (74%). The hospital does not perform surgical procedures for NHS patients under the age of 18, but does undertake a small number of procedures for children aged 12 and upwards, including minor foot and knee surgery, tonsillectomies, circumcisions and cruciate ligament reconstructions.

Between April 2015 and March 2016, the hospital performed 16 day case or inpatient procedures for children aged 12 to 15, and 26 day case or inpatient procedures for young people aged 16 and 17 years.

The five most common procedures performed were eye surgery (474), vasectomy reversal (450), diagnostic bowel surgery (340), primary total hip replacement (258) and replacement of knee joint (247).

The cardiac catheterisation laboratory was closed for refurbishment during our inspection. During this work, procedures were undertaken in a mobile laboratory, which was on site on Mondays.

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

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.

Good

Medical care

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

Information about the service

BMI The Park Hospital in Nottingham is part of BMI Healthcare. The hospital provides medical services to patients who pay for themselves, are insured, or are funded under National Health Service (NHS) contracts.

Medical services are those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Endoscopy or chemotherapy treatments undertaken as a day case are also included within medical care.

BMI The Park Hospital medical service consists of three separate components; oncology chemotherapy treatment, a diagnostic endoscopy service and a cardiac catheterisation laboratory.

The largest service is oncology; between September 2015 and August 2016 there were 1036 day case oncology patients and 155 in-patients. Oncology patients were cared for within the cancer centre on site, or if an inpatient stay was required, on Rufford ward. The cancer centre was open between 7am and 7pm, Monday to Friday. This consisted of a consulting room, four private treatment rooms and a bay with four patient areas allocated for chemotherapy treatment. There was an adjoining unit managed by a separate provider, providing radiotherapy.

The endoscopy service operated between 7am and 7pm, Monday to Friday. Endoscopy procedures are carried out under local anaesthetic or sedation in theatres. Patients admitted for endoscopy were initially seen in the ambulatory care area then transferred to the theatre for the procedure. The theatre area consisted of a bay with six curtained areas, a toilet and decontamination room for equipment. Between September 2015 and August 2016 there were 945 procedures undertaken in this department with the most common procedure being colonoscopy (476). A colonoscopy is a test to look at the inner lining of the large intestine (rectum and colon).

The cardiac catheterisation laboratory was closed for refurbishment during our inspection. During this work, procedures were undertaken in a mobile laboratory, which was on site on Mondays. Between September 2015 and August 2016 there were 492 procedures undertaken in this department.

During the inspection, we spoke with 12 staff including nurses, medical staff, therapists, supporting staff and senior managers. We also spoke with four patients and one relative. 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 five patient care records and we observed interactions between staff and patients.

Good

Medical care

Summary of findings

We rated this service as good because:

- Staff were encouraged to report incidents. Incidents and lessons learned were discussed at integrated governance meetings and shared with all staff.
- There was good multi-disciplinary working and relationships throughout the department, with the rest of the hospital and local NHS acute trusts.
- Nursing, medical and allied healthcare professionals were caring and patients were positive about their care and experiences. Patients were treated with dignity and respect.
- Care and treatment was provided in line with national guidelines and the service contributed data to relevant national audits.
- Without exception, staff we spoke with were consistently positive about local leadership across all areas in medical care services at this hospital.
- The culture of the ward, endoscopy (theatre team) and oncology team was nurturing and staff were professionally supportive of each other.
- Medical records documentation did not always meet satisfactory standards. The handwriting was not always legible. Daily reviews by consultants for inpatients were not documented within the medical records which meant patients may not receive the planned care.
- Systems were not always reliable to keep people safe. The national early warning scoring system was not always accurately completed.
- Some of the patient rooms and corridors did not comply with the requirements of regulations for infection control as they were carpeted.

Are medical care services safe?

Good

We rated safe as good because:

- Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses.
- All patient areas were visibly clean. Infection prevention and control processes were in place and equipment had been checked in line with the hospital's policy.
- Staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Equipment was readily available, maintained and serviced.
- Staff assessed and responded appropriately to potential risks to patients.

However:

- Systems were not always reliable to keep people safe. The national early warning scoring system was not always accurately completed.
- The environment within one inpatient ward was carpeted and a refurbishment plan was being implemented.
- Medical records documentation did not always meet satisfactory standards. The handwriting was not consistently legible. Daily inpatient reviews by consultants were not consistently documented within the medical records, which meant patients may not receive planned care.

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. We were told incidents were reported on paper records before the end of the shift or within 24 hours. They were then transcribed onto a database within a further 48 hours. On Rufford ward we saw incident reports that had been completed by staff.
- Training had commenced for the roll out of an electronic system from October 2016.
- Without exception, all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the paper reporting system.

Good

Medical care

- There were no never events in this service between April 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between April 2015 and March 2016 there were 635 clinical incidents reported for the hospital as a whole, of which 85 (13%) occurred in medicine and oncology. Of the total number of clinical incidents for the hospital, 490 (77.2%) were no harm, 134 (21.1%) were low harm and 11 (1.7%) were moderate harm.
- The service reported one serious incident between January 2016 and August 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. (NHS England, March 2015).
- The serious incident related to an emergency whilst a patient was undergoing a bronchoscopy procedure. (A bronchoscopy is a procedure in which a hollow, flexible tube called abronchoscopeis inserted into the airways through the nose or mouth to provide a view of the airways). We reviewed the full investigation report for this incident. The investigation report was thorough and showed a robust review had taken place and relevant staff were involved in the review or investigation. The investigation report highlighted the duty of candour requirement. The patient was given a full apology at the time and formally in writing.
- The incident involved communication difficulties outside of the hospital. Therefore, learning was shared within the service and with the local NHS hospitals and ambulance providers, which indicated cross-organisational learning took place.
- The director of clinical services and quality manager reviewed all incidents within one week. Investigations took place if needed to identify underlying causes and learning was shared at monthly integrated governance meetings. We reviewed the integrated governance meetings of January 2016 and March 2016, which included discussion of incidents and actions taken. For example, omission of signatures in medication charts. This was monitored and staff were reminded to sign all medication charts.
- Staff reported getting feedback from incidents through email, staff meetings, board 'huddles', (these are brief and routine meetings for sharing information about potential or existingsafetyproblems facing patients and staff) and during handovers. All staff we spoke with were able to tell us of incidents they had reported and of serious incidents that had occurred on other hospital sites. For example, a patient fall, a drug error and pressure damage.
- There had been nine deaths reported for the hospital between April 2015 and March 2016. Eight of the deaths had been expected and one unexpected. We reviewed the integrated governance meeting of 25 January 2016 and saw that the unexpected death was discussed. The death had occurred more than 28 days post-surgery and the coroner had ruled it was not related to the surgery undertaken at this hospital.
- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- Staff we spoke with had a good understanding about duty of candour. Staff talked of being open and transparent with the public.
- We saw examples where duty of candour had been applied appropriately. An open and honest approach had been recorded when a diabetic patient was delayed in oncology.

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

- The hospital submitted data for National Health Service (NHS) patients to the NHS safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harm, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in the vein.
- Data for Rufford ward from July 2016 to September 2016 showed an average harm free care rate of 100%.
- The safety thermometer data was not displayed in the hospital and ward staff we spoke with were not aware of the scheme.

- There was no single safety-monitoring scheme for other inpatients on Rufford ward. However, monthly audits did take place to monitor performance in some areas, for example VTE and falls.

Cleanliness, infection control and hygiene

- The BMI Park Hospital participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE are a self-assessment of non-clinical services, which contribute to healthcare, delivered in both the NHS and independent or private healthcare sectors in England. The programme encourages the involvement of patients, the public and stakeholders, both nationally and locally, who have an interest in healthcare and assessing providers. The assessment of cleanliness for this hospital from February 2016 to June 2016 demonstrated a compliance level of 95%, which was worse than the England average of 98%. The planned refurbishment of the patient rooms hoped to address this shortfall.
- In this hospital, there were no cases of Clostridium difficile (C. difficile) infections between March 2015 and April 2016 occurring in the division of medicine. C. difficile is an infective bacterium that causes diarrhoea and can make patients very ill.
- Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Hospital wide between March 2015 and April 2016 there were no cases of MRSA reported at this hospital.
- Meticillin-sensitive Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Hospital wide between March 2015 and April 2016 there were no recorded cases of MSSA at this hospital.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene.' These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Hand hygiene audit data provided by the hospital for the period May 2016 to July 2016 showed over 95% for Rufford ward and the chemotherapy unit.
- Throughout the hospital ward, oncology and endoscopy areas we observed all staff to be compliant with best practice regarding infection prevention and control policies. All staff were observed to wash their hands or use hand-sanitising gel between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. There were antimicrobial gel dispensers available on entry to the clinical areas. However, there were no signs indicating where hand gel dispensers were for visitors on entry to wards or departments.
- We saw use of 'I am clean' stickers in the ward areas to indicate where staff had signed to say equipment had been cleaned and was ready for patient use.
- All patient rooms on the ward area were single rooms, this enabled isolation of patients at risk of spreading infection to others. There were no patients requiring isolation during our inspection.
- The corridor outside patient rooms on Wollaton ward was carpeted. Staff told us this area was used by patients, relatives and staff but that no clinical care was delivered in the area. We noted the carpet looked old. HBN 00-09 Infection control in the built environment states in clinical areas where spillages are anticipated (including patient rooms, corridors and entrances) carpets are not recommended.
- The hospital did have a procedure for dealing with spillages in this area. However, we could not be assured it was sufficient. The hospital was in the process of upgrading all flooring to comply with HBN 00-09. The flooring in the ward areas was part of a plan of works which was scheduled to commence in spring 2017.
- Precautions were taken in endoscopy when seeing people with suspected communicable diseases or patients at risk of spreading infection to others. Information received during our inspection stated these patients would receive their procedure at the end of a list.

Environment and equipment

- All patients were accommodated in en-suite private rooms, which were located off the main ward corridors. All rooms were equipped with a nurse call bell and emergency buzzers.
- However, clinical wash hand basins were not available in all patient bedrooms; this is contrary to Health Building Note 00-09: Infection control in the built environment section 3.28 hand hygiene facilities. This was on the risk register and plans to address this problem were included in the ongoing refurbishment work.

- The cancer care centre was in an adjoining building and included three private rooms and a four person bay area with privacy curtains.
- The endoscopy suite was within the theatre suite and comprised of a separate waiting and recovery area for six patients on either trolleys or chairs separated by curtains. There was no male /female separation within this area except the curtains. This meant staff could not see patients at all times and could present a risk to patient safety.
- One toilet for both male and female patients was available outside the waiting area for endoscopy patients.
- We observed a single endoscopy theatre with an attached endoscope cleaning room and two separate clean drying cabinets. However, during our inspection we identified the signage on the doors was incorrect, used endoscopes were in the room marked as clean. We informed the theatre team of this during our inspection.
- During our unannounced inspection, the signage in the endoscopy area had not been addressed. It was bought to the attention of staff again and temporary signage was put in place.
- We checked the resuscitation equipment on Rufford ward, theatres and the cancer centre. The resuscitation equipment on the wards was clean, single-use items were sealed and in date, and emergency equipment had been serviced. We saw equipment had been checked daily by staff and was safe and ready for use in an emergency.
- We observed 14 items of patient-care equipment. All items were observed to be clean and ready for use. Patient equipment had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Control of Substances Hazardous to Health (COSHH) was in line with guidance from the Control of Substances Hazardous to Health Regulations (2002). We found hazardous cleaning fluids and flammable liquids were stored in locked cabinets away from patient areas.
- We saw an identifiable locked cabinet in the clinic room on Rufford ward containing these substances. A list of current COSHH substances was displayed on the outside of the cabinet.

Medicines

- A paper based medicine administration record chart was in use at this hospital. A pharmacist visited all wards each weekday and there were arrangements to contact a pharmacist for advice and to obtain medicines out of hours. We saw pharmacy staff checked the medicines patients were taking when they were admitted were correct and records were up to date. Medicines interventions by a pharmacist were recorded on the medicine administration charts to help guide staff in the safe administration of medicines.
- There were local microbiology protocols for the administration of antibiotics and we saw evidence of these in practice. A microbiologist from a local NHS trust was also available for support and guidance in relation to antibiotic prescribing.
- We saw a medicines management and prescription chart audit for Rufford ward for January 2016. The audit identified areas of poor practice; for example medication fridge temperatures were not recorded on a daily basis and the thermometer had not been calibrated within the past 12 months.
- During our inspection the fridge temperatures were checked daily in line with hospital policy.
- Three prescription charts were checked as part of the audit and were found to be generally compliant against all of the audited measures. We saw an action plan had been formulated to address the issues raised.
- We looked at prescription and medicine administration records for six patients on Rufford ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were complete. However, doctors' signatures on three of the charts were illegible. The hospital does not have a signature legend for each of its practising consultants. A signature legend is a list of signatures and initials with a block capital copy of the name used to ensure names are legible. This meant we could not be assured staff could identify prescribers by their signature.
- Records showed patients were getting their medicines when they needed them. If patients were allergic to any medicines, this was recorded on their chart. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant patients had access to medicines when they needed them.

- Medicines, including intravenous (IV) fluids, were stored securely and we saw controlled drugs were stored and managed appropriately.
- We saw Rufford ward had two medicine trolleys locked and secured to the wall within the clinic room. The nurse in charge of each area held the keys.
- Access to the hospital pharmacy out of hours was available if required. The nurse in charge for the hospital and the resident medical officer (RMO) held individual keys, which had to be used at the same time to enter.
- Patients were asked to complete a pre-admission questionnaire, which included information about the medicines they were currently taking. If necessary, additional information could be obtained from the patient's general practitioner (GP).
- Staff in the hospital completed an annual drugs calculation assessment and had additional training in the administration of intravenous drugs. We asked the hospital to provide data to confirm how many staff had completed this training and assessment but to date it has not been received.

Chemotherapy Suite

- The chemotherapy suite had introduced electronic prescription and medicine administration records specific to the needs of their patients, which facilitated the safe administration of medicines. However, some consultants had not transferred onto this new system and were still using paper based prescription records. This meant pharmacy and nursing staff were using two systems, which could lead to errors due to lack of consistency. Senior managers were aware of this inconsistency and planned to introduce extra training to support the consultants in using the new electronic chemotherapy prescription records.
- We looked at the prescription and medicine administration records for two patients on the unit. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were receiving their medicines when they needed them, as prescribed.
- Medicines, including those requiring cool storage, were stored appropriately. We saw controlled drugs were stored appropriately.
- The pharmacy team visited the unit daily. We saw pharmacy staff checked medicines patients were taking when they were admitted were correct, that records were up to date and the medicines were prescribed safely and effectively.
- There was access to spill kits, skin irritation packs and a drug used when chemotherapy drugs had leaked into surrounding skin tissues. The drug had clear and detailed instructions with it on how to use it. A copy of the policy for the management of cytotoxic chemotherapy extravasation was seen, and a copy was available with the kits on the unit. (Extravasation is the inadvertent leakage of a vesicant solution from its intended vascular pathway (vein) into the surrounding tissue. A vesicant refers to any medicine or fluid with the potential to cause blisters, severe tissue injury (skin/tendons/muscle) or necrosis if it escapes from the intended venous pathway).
- Chemotherapy was prepared on site in a sterile, aseptic room within the pharmacy department. The pharmacy does not hold a manufacturing licence so only produced items in response to a patient prescription. We saw standard operating procedures were in place for all aspects of prescribing and dispensing of cytotoxic preparations. The isolator (sterile units for the safe preparation of medications) were audited by an external pharmacist and action plans produced as a result of their reports.
- During our inspection, the isolator temperature control was not working effectively. The senior pharmacist told us that as the temperature was high, therefore staff were rotating to ensure they were not in the room for extended periods. The temperature and pressures in the isolator suite were monitored on a regular basis. No drugs were stored in the isolator. The medicines were transferred from the temperature controlled environment for the minimum period of time to manipulate for reconstitution. There have been no concerns raised by the aseptic QC inspector.
- The isolator was on the hospital risk register. The issue with the temperature of the unit was due to extreme weather conditions, this was not the usual temperature in the unit. To manage the risks the temperature was monitored closely. The air conditioning system was reported to the maintenance team for investigation and when the weather returned to normal there were no longer any concerns.

- The aseptic suite was serviced and maintained twice a year. There was a service agreement with a local NHS trust for quality assurance of the aseptic suite which involved a range of tests carried out monthly and three monthly.
- The hospital managers and pharmacy were in the process of deciding the best action for the preparation or purchase of chemotherapy medicines in order to address the problems with the isolator.
- An anaphylaxis kit, in tamper evident packaging, in date and fit for use, plus a secondary cardiac treatment box, were also available.

Records

- During our inspection, we reviewed nine medical and nursing care records and 13 patient observation and sepsis screening pathways. Records were paper-based, nursing notes were held at the patient's bedside and medical notes in trolleys on the main ward corridors. We observed notes trolleys were stored securely and were in an area where a member of staff could see at them all times.
- The majority of records were legible, accurately completed and up to date. However, in three of the records, we found the handwriting of medical staff was illegible and there was no consistent documentation of a daily medical review. We escalated this to a member of the senior nursing team on the wards who believed this to be an oversight as patients were reviewed every day by either the consultant or the resident medical officer. Lack of documentation might mean patients may not receive care as planned by the medical team.
- There was a rolling programme of records audits. Action plans and re-audits mostly showed improvements in the services. The documentation audit for November 2015 identified a general adherence to standards of 81% against a target of 90%.The clinical manager audited 10 sets of clinical care notes and identified that consultant daily progress notes were only completed in 33%, a consultant discharge summary was completed in 10% and 0% of consultant entries were dated, timed and signed.
- Actions identified included creating an action plan to address areas identified as achieving less than 100%. The results and all plans were to be discussed at the next integrated governance committee meeting in January 2016. We reviewed minutes from this meeting and the discussion was minuted to take place at the March 2016 meeting. However, we reviewed these minutes and there was no discussion minuted. This meant that we could not be assured that the documentation audit was being used to improve. Re-audit was to take place the following quarter to check if improvements occurred.
- We reviewed overall adherence of documentation standards from January 2016 to August 2016, in three out of eight audits the 90% standard was achieved.
- Nursing care records included care plans for; breathing and circulation, pain, communication, pressure area care, wound care, mobility, elimination and continence, nutrition and fluid balance, personal hygiene, rest and sleep, psychological and emotional well-being, promoting health and safe care and discharge.
- We saw risk assessments were completed as part of the integrated care records. These included pressure ulcers, malnutrition and a moving and handling assessment. All clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.
- Patient records were multidisciplinary and we saw where nurses, doctors and allied health professionals, including physiotherapists, had made entries.
- Integrated care records for endoscopy patients were in use. These covered the entire patient pathway from pre-operative assessment to discharge risk assessments, and included the five steps to safer surgery checklists, operating notes, observations and recovery records.
- We saw care records in the cancer centre included a holistic needs assessment as recommended in the NHS England document commissioning person centred care for people affected by cancer 2016. A holistic needs assessment includes early discussion on a range of subjects, for example physical, practical and emotional concerns.

Safeguarding

- Senior hospital managers were in the process of undertaking adult safeguarding training. This was in response to the recent internal promotion of the director of clinical services (adult safeguarding trained). There was an agreement in place for the director of clinical services to be a safeguarding point of contact whilst training took place.

- Six senior nurses told us they were all undertaking children's safeguarding level three. However, they were unsure of when exactly this training would take place.
- All staff had access to the provider's safeguarding policies and procedures via their intranet and from the safeguarding resource folders.
- Staff undertook an on-line electronic safeguarding adult training module as part of their mandatory training programme. All staff were required to undertake level one and two training for both vulnerable adults and children and young people. Data provided by the hospital showed that more than 95% of staff had completed this training.
- Staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns.

Mandatory training

- Staff and managers at BMI The Park followed the BMI healthcare mandatory training matrix requirements. All staff, dependent on their role, had a role specific mandatory training. For example, information security, fire safety and moving and handling was applicable to all staff whereas blood transfusion and intravenous administration training was only for staff who required the necessary skills in these areas, for example, oncology staff. Most training was done by e- learning, in some cases followed by workshops and assessments. Staff completed their training during their work time and all staff we spoke with said they were up to date with their training requirements.
- All ward staff had competency and mandatory training folders on the ward. We looked at four of those; they were all up to date and provided evidence of completion of mandatory training.
- The e-learning system emailed staff and the ward manager six months prior to the expiry of their training and monthly thereafter prior to training expiring.
- Individual staff and managers could access and monitor progress of mandatory training. Overall hospital achievement was monitored by the director of nursing and reported at the integrated governance meetings. Information provided by the hospital as of May 2016 showed completion of mandatory training was 94%, which was above the target of 90%.
- Dementia awareness training was included as an e-learning module as part of mandatory training for clinical staff. The provider supplied the training records of 229 staff, of which 133 had dementia awareness training included as mandatory. The compliance rate for nursing staff who were required to complete the training was above the hospital's target of 95%.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but the medical advisory committee checked assurance of their mandatory training.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The RMOs received advanced life support (ALS) and paediatric advanced life support training via the RMO agency. The director of clinical services had oversight of this training to ensure competency was achieved.

Assessing and responding to patient risk

- Nursing staff used a national early warning scoring system (NEWS), based on the national early warning score, to record routine physiological observations such as blood pressure, temperature, and heart rate. NEWS was used to monitor patients and to prompt support from medical staff when required.
- During our inspection of this hospital, we reviewed four patient observation charts. We found nursing staff did not always adhere to guidelines for the completion and escalation of NEWS; frequencies of observations were not always appropriately recorded on the observations charts.
- Two out of four observation charts had full physiological observations recorded however all four charts did not have urine output recorded. This meant patients fluid requirements may not have been identified.
- NEWS scores had been completed at each time of recording the patient's observations in all four charts we reviewed. However, scores had been calculated incorrectly in two of the four charts. The incorrect calculation could have led to the patient not receiving timely medical treatment for a low blood pressure.
- However, the patients' treatment records did actually reflect the treatment required to increase the patients' blood pressure. This meant that despite the calculations being wrong care was given to the patient in accordance with their medical condition.
- All of the charts reviewed had different methods for recording blood pressure, pulse or respiration values For example dots, crosses, arrows and numbers. This meant

staff unfamiliar with the charts may interpret them wrongly. We raised these inconsistencies with the director of clinical services during our inspection. We were informed they would be reviewed.

- We reviewed the results of an audit of NEWS records from July 2016. The audit showed that 69% of the sample observations had been scored on the NEWS charts, but that 100% of the scores were correct. Following this audit, the hospital planned to provide further training for staff both on line and face to face.
- Before oncology patients attended the cancer centre for chemotherapy, they attended a pre-assessment appointment where staff assessed risks relating to the treatment. This clinical assessment included baseline physical measurements and blood tests.
- All patients were advised to purchase an electronic thermometer for use whilst undergoing chemotherapy treatment. All patients were aware of the need to contact the hospital should they feel unwell or have a high or low temperature. This was to ensure early detection and treatment of possible infection.
- Nursing staff used a triage log sheet based on the United Kingdom Oncology Nursing Society for all calls. If a patient's condition deteriorated, for example, if they complained of temperature, vomiting or pain, nursing staff asked the patient to return to the hospital for assessment and contacted the patient's consultant for advice.
- The hospital had a service level agreement (SLA) with the local NHS acute trust, ambulance service and the Mid Trent Critical Care Network. This meant patients could be transferred to the nearby NHS acute trust for care and treatment should their condition deteriorate with the emergency ambulance service providing transport.
- A team of staff led by a consultant cared for patients treated in the endoscopy suite. They used a document based on the World Health Organisation (WHO) safety procedures: the WHO surgical safety checklist to ensure each stage of the patient's journey was managed safely. Following the procedure patients were transferred to the recovery area in theatres and cared for by recovery staff until they were safe to be discharged or transferred to the ward if necessary.
- A programme of monthly audits was in place for the five steps to safer surgery checklist. Ten sets of notes were audited per month against 18 standards. We reviewed the audit for January 2016, February 2016 and March 2016 and saw the compliance target of 95% or more had been achieved for each month.

Nursing staffing

- BMI The Park Hospital used a corporate nurse dependency and skill mix planning tool when planning staffing in line with National Institute for Health and Care Excellence (NICE) staffing guidance.
- Patient admissions were known in advance and staffing levels calculated using an electronic labour monitoring tool, this ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs, for example additional health care assistants (HCA) were allocated when patients with dementia were to be admitted. Ward nursing staff we spoke with told us that additional qualified members of staff were allocated from the bank during busy periods to ensure staffing levels were safe and patient needs could be met.
- The labour monitoring tool was completed proactively for each week and then reviewed on a daily basis by the senior nurse and the bank nurse co-ordinator to ensure correct staffing and skill mix.
- Staffing levels were displayed on a patient information board at the entrance to the wards. During our inspection, we observed that actual staffing levels were in line with planned levels.
- Ward sisters told us there were no nurse vacancies at the time of our inspection.
- We observed a handover of the nursing staff on Rufford ward. These took place between shifts in an office on the ward to ensure confidentiality. Nursing staff used printed handover sheets containing all relevant patient information, which ensured staff were well informed about the plan of care for each patient. These sheets were placed into confidential waste at the end of the shift.
- The hospital used bank staff and wherever possible agency staff who had worked there before. Bank staff are those employed by the hospital to cover unfilled shifts due to sickness or annual leave. The average use of bank or agency nurses between April 2015 and March 2016 was 6.8%, which was lower than the average of independent acute hospitals.

Good

Medical care

Medical staffing

- There were 227 consultants who had been granted practising privileges at BMI The Park. Of these, between April 2015 and March 2016, 154 consultants (68%) had carried out episodes of care. Practising privileges refers to medical practitioners being granted the right to practise in a hospital after being approved by the medical advisory committee (MAC). All the consultants worked at local NHS trusts. Eight of these were oncology consultants.
- Nursing staff told us consultants visited in-patients at least once every 24 hours and were available via telephone 24 hours a day, seven days a week whilst they had patients in the hospital. If they planned a period of absence a fellow consultant would be identified to cover and the hospital informed. We saw evidence of this when a covering consultant had been to see a patient for a colleague and arranged admission to a local NHS trust.
- Nursing staff on the ward told us they had no difficulty contacting the medical staff. We saw the mobile phone numbers of the consultants were available to ward staff.
- The endoscopy service was a consultant led service. Nursing staff said consultants were available when needed.
- The medical advisory committee (MAC) monitored outcomes of individual consultants and fed back any concerns.
- Resident medical officers (RMOs) provided 24 hour medical cover to the ward for all specialities, on a rotation system. The RMOs worked at the hospital regularly and knew the hospital and its routine well. RMOs were advised of cover arrangements for any consultant on leave.
- A RMO, trained in advanced life support, provided medical cover 24 hours a day, seven days a week for all patients. The RMO worked a seven-day roster and was on call for emergencies 24 hours a day, seven days a week. To ensure the RMO was not overtired and remained safe to provide care, nursing staff would only wake the RMO overnight in case of an emergency. We saw that staff made a record of these overnight call-outs, which meant service leads had assurance the RMO was safe to practise.
- RMOs were provided by an agency. Mandatory training for the RMOs was the responsibility of the agency. The clinical experience, qualifications and record of mandatory training was checked by the hospital before they commenced working and monitored on a yearly basis.
- There were systems, processes and standard operating procedures to support effective handover between the RMO, consultants and other clinical staff. They were reliable and appropriate to keep patients safe.

Major incident awareness and training

- There was a comprehensive business continuity plan in place. It detailed how staff should respond to, for example, loss of heating, loss of gas, adverse weather conditions and a bomb threat. A folder containing full details of the plan, including useful contacts with telephone numbers was kept at the reception desk. Senior staff told us they were aware of the plan and their responsibilities.
- There was a member of the senior management team on duty each day that was responsible operationally for any major incident affecting the hospital. Out of hours, there was an on call rota and staff were aware of whom to contact in case of a major incident.

Are medical care services effective?

Good

We rated effective as good:

- Care and treatment was planned and delivered to patients in line with current evidence based guidance, standards and legislation.
- There was good multi-disciplinary working and relationships throughout the department, with the rest of the hospital and local NHS acute trusts.
- Patients told us their pain was well managed and staff were quick to respond to requests for pain relief.
- The hospital provided a seven-day service for inpatients with effective on-call arrangements to meet patient needs.

Evidence-based care and treatment

- Staff had access to a range of corporate guidelines via the intranet. We saw these guidelines were up to date and referenced to current best practice from a

combination of national and professional guidance, such as the National Institute of Health and Care Excellence (NICE), Royal Colleges and General Medical Council (GMC).

- We saw staff followed NICE guidelines relating to the assessment and prevention of venous thromboembolisms (VTE). All patients were assessed on admission to identify those who are at increased risk of VTE.For example; patients with active cancer or having cancer treatment, aged over 60years or with a history of deep vein thrombosis (DVT).
- The oncology unit followed best practice guidance in the care of their patients using NICE guidelines and up to date clinical aspects were discussed at local oncology meetings. This was attended by the acting oncology lead nurse and ensured collaborative working within oncology teams in the wider NHS. The information was then disseminated across the oncology team.
- The oncology consultants were on site at the start of a patient's treatment and visited each evening to be available post chemotherapy, should the patients have any questions or concerns.
- Endoscopy staff followed National Institute for Health and Care Excellence (NICE) guidance but did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited. The hospital was in the preliminary data collection stages of working towards JAG accreditation.

Pain relief

- Patient's pain was assessed, scored both in the oncology pre-assessment appointment and on admission. We observed pain scores documented in the care plans and recorded on the NEWS charts.
- We saw staff used an intentional rounding tool, which was completed hourly during the day and two hourly overnight. (Intentional rounding is a structured approach whereby nurses check patients at set times to assess and manage their care needs.) This tool prompted staff to regularly ask patients about their needs, including pain levels.
- There were no medical patients on the ward during our inspection. Patients we spoke with in the cancer centre told us their pain was well managed. They told us nursing staff were quick to respond to requests for pain relief.
- Pain scores assessed the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief. Nursing records we checked demonstrated staff were identifying the patient's level of pain and evaluating the effects of pain relief.
- We saw documentation that showed staff discussed pain relieving medication with patients prior to discharge and advised them to contact the hospital if they had any concerns.

Nutrition and hydration

- Patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to endoscopy procedures. Records showed checks were made to ensure patients had adhered to fasting times before procedures went ahead.
- Staff followed best practice guidance on fasting prior to endoscopy. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- We saw anaesthetic staff prescribing medication to ensure effective management of nausea and vomiting should this occur.
- There were arrangements in place to refer patients to a dietician if required.

Patient outcomes

- BMI The Park participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- Information was displayed on Rufford ward and provided to the inspection team in relation to these audits. For example from January 2016 to September 2016, results identified that BMI The Park had a 94% overall attainment rate for audits in the corporate audit programme.

- Infection prevention and control audit results during this period were 100%, patient falls audit results were 94% and consent audit results were 88%.
- Nursing staff used a national early warning scoring system (NEWS), based on the national early warning score, to record routine physiological observations such as blood pressure, temperature, and heart rate. NEWS was used to monitor patients and to prompt support from medical staff when required.
- We reviewed the results of an audit of NEWS records from July 2016. The audit showed that 69% of the sample observations had been scored on the NEWS charts, but that 100% of the scores were correct. Following this audit, the hospital planned to provide further training for staff both on line and face to face; this was planned to be completed by December 2016.
- BMI The Park contributed to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) national audit data.The most recent request received was for a study on Chronic Neurodisability. However, no data was submitted as no patients matching the criteria were treated at the hospital within the relevant period of time. Data was submitted to The Mental Health in General Hospitals NCEPOD study in April 2016 (to be published winter 2016).
- Results on patient outcomes were compared with other locations within the region and across BMI Healthcare through the corporate clinical dashboard. This used data from the incident and risk reporting data base. This allowed the hospital to review their own data and compare it with hospitals of a similar size within BMI Healthcare to enable them to plan patient care.
- The hospital participated in cancer networks. The consultants discussed the care of their BMI The Park patients along with their NHS patients in the appropriate meetings at the NHS acute trust.
- Within the oncology department incidence of neutropaenic sepsis and chemotherapy extravasation (leakage of infused medication into the tissue) were monitored however, due to low numbers of patient admission in relation to this, audit was not warranted and investigation took place through the incident reporting process. This ensured staff awareness of potential problems.
- From April 2015 to March 2016 there had been 15 unplanned transfers of inpatients to another hospital and 18 unplanned readmissions within 28 days of discharge. This number of unplanned transfers and readmissions was not high when compared to other independent acute hospitals. There were no re-admissions or transfers of paediatric patients.
- The hospital provided a root cause analysis investigation report of an unplanned transfer of a patient to a local NHS trust from July 2016 which we reviewed. The hospital had identified learning points from this investigation, for example, terminology to be used when communicating with ambulance staff.
- Endoscopy staff followed National Institute for Health and Care Excellence (NICE) guidance but did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited. The hospital was in the preliminary data collection stages of working towards JAG accreditation.

Competent staff

- Applications from consultants to obtain practising privileges were considered by the medical advisory committee (MAC). The term “practising privileges” refers to medical practitioners not directly employed by the hospital but who have permission to practise there. For consultants who were granted ‘practising privileges’ to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer’s (RO) name.
- We reviewed the personal files of five consultants working at the hospital under a practising privileges arrangement. All five files demonstrated arrangements for granting and reviewing practising privileges were appropriate and the consultants were skilled to carry out the care and treatment they provided. We saw where staff had undergone a whole practice appraisal in the last year and had a revalidation date set by the General Medical Council (GMC).
- There were 227 consultants who had been granted practising privileges by the medical advisory committee (MAC). Of these, eight held practising privileges for oncology.
- From April 2015 to March 2016, seven of the consultants had relinquished their practising privileges for various reasons. In the same period, 29 consultants had been

suspended for documentation non-compliance; of these 18 had been re-instated and 11 remained on suspension. One consultant had been suspended due to an ongoing investigation at the NHS trust they were also employed at. There were no consultants on supervised practise during this time.

- There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date.
- It was a requirement of BMI Healthcare practising privileges (PP) policy that consultants remain available or arrange appropriate alternative named cover at all times when they had inpatients in the hospital. PP is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital.
- The nurses working in the oncology unit were all appropriately trained and had completed competencies in the administration of intravenous chemotherapy, through a nationally recognised course. Nursing staff attended an annual BMI organisational update. One nurse in the cancer centre is an independent prescriber.
- There were specialist nurses in infection prevention and control, breast care and colorectal care. This meant that patients and staff had access to up to date clinical advice at all times.
- Rufford ward had a practice development nurse to assist with training and developing staff for one day a week.
- Staff had access to training and development opportunities to advance their professional skills, experience and to aid development of their service. The hospital was supporting healthcare assistants to attend an assistant practitioner course. Two staff were on the programme and funding has been secured for four more starting in October 2016.
- New staff completed an induction programme and a performance review meeting at six weeks after commencement in employment. We spoke with two new staff who said their induction process was thorough and they were undergoing on the job competency training. Their mentor and practice development nurse was supporting them. Staff were supernumerary for an agreed period during their induction phase. This could be extended if the member of staff required additional support.
- Data provided by the hospital showed for the reporting period October 2015 to September 2016, more than 90% of registered nurses on the wards and all of the staff within the theatre department (which included endoscopy) had received an appraisal.

Multidisciplinary working

- Ward sisters and the nurses told us there was strong multidisciplinary team (MDT) working with a daily ward round attended by medical, nursing, pharmacist and therapy staff.
- There was a physiotherapy manager, a team of physiotherapists and occupational therapists that worked seven days a week as part of the MDT.
- Patients were discussed and treatment protocols agreed by the cancer MDT as part of BMI healthcare hospitals group cancer standards. This ensured a team approach and national guidance was used in selecting the best treatment for a patient, this met Government standards.
- Oncology, endoscopy and ward nurses had good working relationships with the resident medical officer and colleagues in pharmacy and x-ray. The oncology nursing team told us oncology consultants trusted them and listened to their opinion.
- Staff in the oncology unit had good working relationships with their peers in other local NHS trusts. For example; they attended breast care team meetings at the local NHS trusts and shared information in order to improve the patient experience.
- There were a number of service level agreements in place for services to be supported or provided to the hospital, for example transfer of patients if necessary to a local NHS acute trust.

Seven-day services

- On-call arrangements were in place to ensure patients had rapid access to services if required.
- Operating theatre sessions were available Monday to Friday from 8am to 8pm. Additional sessions were available on Saturdays if required. Two theatres were available at all times for patients requiring an urgent return to theatre. For example, in case of any complications following endoscopy/bronchoscopy procedures.
- There were two resident medical officers (RMOs) available 24 hrs per day seven days per week, one for the wards and one for critical care.

- Imaging and x-ray facilities were available from 8am until 6pm Monday to Friday. On-call radiology staff provided a weekend and out of hours service if required and a consultant radiologist was able to report on any images taken out of hours.
- A pharmacy service was provided six days a week, Monday to Saturday. An on-call pharmacist was available outside of normal pharmacy hours for inpatient requirements.
- Pathology services were available Monday to Friday. In addition, there was an arrangement with a local NHS acute trust for urgent tests and microbiology services out of these hours.
- Diagnostic equipment was available 24 hours a day, seven days a week for the inpatient wards and critical care unit if required. There was a magnetic resonance imager (MRI), a computerised tomography scanner (CT), and a mobile x-ray machine on site and the radiographer was on-call.

(MRIand aCT Scanare two different ways to create pictures of the inside of the body using medicalimagingtechnology).

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included risk assessments, care plans and case notes. Information and guidance regarding specific procedures or conditions was available through the organisation's intranet.
- Staff had access to electronic and paper copies of hospital policies and guidelines on the ward and in the cancer centre.
- Staff had access to paper patient records, including all pre-assessment documentation. We saw results of diagnostics tests were filed within the medical notes. We were told consultants could also access the results of diagnostic tests electronically.
- Oncology patients were given a folder that contained a chemotherapy record booklet at their pre-assessment appointment. This served as a record of their treatment plan, including clinical advice on potential side effects and out of hours contact details. Patients were asked to keep this booklet in a safe place and bring it with them at each chemotherapy appointment. This information was also recorded in patients' medical notes.
- Oncology nurses communicated with other healthcare professionals involved in patients' care. They sent letters to general practitioners (GPs) confirming pre-assessment information for the patients about to start chemotherapy courses. This meant GPs were informed when a patient was about to undergo treatment and might require their support.
- Patients and GPs received same day discharge information, which included medication use, possible side effects and a telephone contact number in case of a problem.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The records we reviewed showed all patients had been consented for their endoscopy procedure. Consent forms fully described the procedure completed as well as associated risks. Full signatures were included from the consenting clinician and patient. Consenting generally took place on the morning of the procedure.
- Completed consent forms were seen in the oncology patient records. These were clear and concise and showed consent had been obtained from the patient for planned treatment. Quarterly consent audits were completed as part of the hospital audit programme.
- We saw a consent audit from June 2016, which compared 10 sets of patient records against 15 standards. Audit results showed 100% compliance in 12 out of the 15 standards measured. Areas for improvement were identified, for example in the recording of information provided to the patient and a further audit was planned for September 2016.
- Mandatory training for clinical staff included consent. Data provided by the hospital showed more than 95% of staff required had completed the training.
- At the time of our inspection, there were no patients with a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. The hospital had an up to date adult resuscitation policy, which clearly identified the process for decisions relating to DNACPR orders. Patients' resuscitation status was documented both before and during their admission within the hospitals admission pathway booklets.
- Staff training for consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards was an e-learning module. Deprivation of liberty safeguards provides for the lawful deprivation of liberty of patients who lack the

capacity to consent to their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their own best interests, to protect them from harm.

- At the time of our inspection, there were no patients who lacked capacity or patients requiring deprivation of liberty safeguards. Service leads confirmed there had been no deprivation of liberty safeguard applications made within the previous 12 months.

Are medical care services caring?

Good

We rated caring as good because:

- Staff responded compassionately when patients needed help and supported patients emotionally. This was reflected in their care and treatment.
- Staff positively interacted with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was mostly positive about the care and treatment they had received.
- Patients were involved and encouraged to be active partners in their care and in making any decisions.
- Staff supported and organised the Team Spirit support group in the cancer centre.

Compassionate care

- The National Health Service (NHS) Friends and Family Test is a satisfaction survey that measures patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family. For the period between October 2015 and March 2016, 100% of NHS patients who completed this survey said they would recommend the hospital. However, response rates to the survey were between 13% and 32%, which was lower than the England average within the independent sector for NHS patients.
- We spoke with four patients and one relative during our inspection and received three completed comment cards from patients. Without exception, patients reported staff were polite, friendly and approachable and were always caring and respectful. One patient told us, "the care on the ward from all members of staff was first class."
- We saw a letter from a patient to the team on Rufford ward that said, "The reason I survived so well was entirely due to the fact the staff at every level went that extra mile to ensure I wanted for nothing."
- Patients were cared for in individual rooms; we saw staff knocking on doors and waiting for a response before entering. Patients we spoke with told us staff were kind and caring and that they had been treated with dignity and respect.
- We saw patient's names were displayed on their individual rooms, but only after written consent had been obtained.
- We observed staff supporting oncology patients in a caring and compassionate manner. There was evidence of a good rapport between patients and their nurses and staff demonstrated professionalism and knowledge that provided reassurance and support to their patients during their treatment.
- One oncology patient told us, "The centre makes you feel more like a person than a patient, the staff are more like my friends," and another patient said, "I felt that once I started treatment at The Park that I became part of a caring family. I always say that it is a great comfort to feel that I have got the best possible people on my side."
- The wards included single gender accommodation, which promoted privacy and dignity. However, as endoscopy lists were mixed there was a potential that in the endoscopy recovery privacy and dignity could be compromised.

Understanding and involvement of patients and those close to them

- Oncology patients told us they felt involved in the planning of their care. They told us they had received full information about their treatment and the care and support that would be offered during their treatment and afterwards.
- Two patients told us they liked the fact that their chemotherapy treatments were arranged on the same days so they met the same group of friends each time. They said this helped them talk about what they were going through.
- Staff gave patients and relatives information about the signs and symptoms to look out for following chemotherapy, and what they could do to relieve them. They also gave them in and out of hours contact details in case of advice or concerns.

Good

Medical care

- Patients we spoke with said they were told about any new medicines prescribed and what they were for in a way that they understood; and they continued to get their medicines at home where appropriate. One patient said, "The staff are very thorough explaining the side effects and how to manage them."
- Nursing staff also signposted patients to information specific to them depending on their condition and personal circumstances, for example, advice on how to talk about cancer to young children.
- A patient we spoke with undergoing an endoscopy procedure had been provided with relevant information, both verbal and written, to make an informed decision about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had and they were very happy with the individual attention received from the consultant.

Emotional support

- Patients commented they had been well supported emotionally by staff. For example, in relation to side effects of chemotherapy.
- All patients at the BMI The Park cancer centre had access to a psychologist specialised in helping people to cope with and adjust to the emotional impact of living with cancer.
- The psychologist developed individual treatment plans for patients and/or relatives. One patient told us the psychologist was. "…invaluable in helping me come to terms with how cancer had affected my relationship."
- All patients and relatives were invited to attend 'Team Spirit' an oncology support group for anyone currently receiving chemotherapy or who had previously undergone treatment at BMI The Park cancer centre. The group provided additional support and encouraged patients and relatives to make contact with other people in a similar situation. The group had recently had a cake sale and arranged a craft day for the children of patients.
- Staff at the cancer centre also ran an interactive cancer survivors course called Hope. The course was provided over six weeks and aimed to help patients develop the skills required for surviving cancer. One patient told us as a result of the Hope course, "I was able to develop coping mechanisms to help me come to terms with the fact I was now a cancer survivor."
- The course had taken place three times during 2015 to 2016 and plans were now in place for it to run every six weeks as extra staff had received training in facilitating the course.
- Ten patients provided feedback about the courses held in October 2015 and March 2016. All ten described the course as excellent. For example, "the course providers were compassionate and kind" and, "the emotional support I have received from this course will help me in my everyday life, it was amazing."
- Patient feedback was collected after a recent art therapy day. Without exception, comments were overwhelmingly positive. For example, "find it very therapeutic, helps release all the negativity of living with cancer" and, "wonderful, thank you would highly recommend to anyone going through the roller coaster of cancer."
- During December 2015, staff at the BMI The Park cancer centre wanted to offer emotional support to the families of patients that had died during the year, in order to do this they invited family and friends to hang a star on the Christmas tree in memory of their loved ones.

Are medical care services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered in a way which met the needs of the local population.
- Patients were admitted on a planned basis for treatments, this included self-funded patients and National Health Service (NHS) patients.
- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- The hospital only cancelled care and treatment when necessary. The reason for the cancellation was fully explained in person. Access to further appointments for care and treatment was promptly arranged.

However:

- There was limited information for non-English speaking patients.
- Some staff were unsure of the complaints procedure or the availability of complaints leaflets.

Good

Medical care

Service planning and delivery to meet the needs of local people

- The majority of patients at BMI The Park were non-NHS (74%). NHS patients used the 'NHS e-referral' system. This means NHS patients had a legal right to choose which hospital or clinic toattend for outpatient appointments, choose which consultant-led team would be in charge of their treatment, as long as that team provides the treatment required.
- The hospital introduced an ambulatory care pathway for surgical and endoscopy patients in May 2016. (Ambulatory care is a service where some procedures may be undertaken without the need for an overnight stay and which may have quicker healing and recovery times than traditional methods.)
- During our inspection, ambulatory care was part of Wollaton ward; work was ongoing to create a dedicated area with its own complement of staff. A team leader was in position and staff from Rufford ward supported the admission process and prepared patients for their procedure. The plan for the future was for staff to be employed as extra to the ward establishment.
- Staff delivered oncology services to meet the needs of patients. One member of staff told us, "We just want to be the best and do everything we can to provide the care our patients deserve."
- The hospital was able to admit patients directly from the cancer centre onto Rufford ward if inpatient palliative care was required.
- Senior nursing staff reported it was relatively easy to plan the workload, as all procedures carried out at the hospital were elective. For example, bank and flexible contract staff could be used during busier times or reduced during periods of consultant leave or at public holidays.

Access and flow

- Admissions to the cancer centre or for endoscopy were planned. This meant the hospital did not have any waiting lists for endoscopy or chemotherapy treatments.
- Patients were offered treatment according to their availability and the clinical need or urgency for the treatment.
- Staff gave chemotherapy patients a choice of appointment times, whilst at the same time patients were scheduled to ensure there was flow through the unit, taking into account patients' varying treatment times.
- Patients suspected of having cancer, could have needle biopsies and mammograms on the same day as their initial consultant appointment, if required. This prevented further appointments and reduced waiting times for results.
- Between March 2015 and April 2016, the hospital met all of the NHS patients waiting times for admitted patients beginning treatment within 18 weeks of referral.
- In the unfortunate event that a patient's procedure was cancelled on the day of surgery for non-clinical reasons, the patient was offered a prompt alternative date within 28 days of the original date convenient to the patient. Between March 2015 and April 2016 the hospital cancelled 33 procedures for a non-clinical reason, in all cases the patient was offered a prompt alternative date within 28 days.
- Discharge planning started during the pre-assessment stage of the pathway. Patients were assessed and any additional equipment or support they may require post admission was identified. An occupational therapist worked within the pre-operative assessment clinic and was involved in safe discharge planning for patients.

Meeting people's individual needs

- Staff treated patients as individuals. Rufford ward staff gave an example of how they made reasonable adjustments for a patient living with dementia, by allowing their relative to stay in order to help ease anxiety for the patient.
- The hospital had a standard operating procedure for chaperoning as part of the 'Privacy and Dignity' policy (2015), outlining arrangements for adults. We saw chaperone notices displayed around the hospital.
- Staff told us that occasionally patients receiving chemotherapy stayed overnight in the hospital if they were frail or nauseous and had no support at home.
- Complimentary therapies were available to all patients and relatives at the BMI The Park cancer centre, including aromatherapy, massage and art therapy.
- Patients on the oncology unit had access to a range of literature such as local breast cancer support groups and information on types of cancer including bowel and bladder.

Good

Medical care

- Staff did not receive any specific training about caring for individuals with learning disabilities, but recalled learning from their safeguarding adults training. Patients with individual specific needs were able to visit the clinical environment prior to any treatment interventions to see the clinical area, meet staff and reduce fears.
- We saw staff following the hospital's 2015 privacy and dignity policy. For example we observed all staff knocked on patient bedroom doors and asked for permission to enter.
- We saw rooms available so bad news could be delivered to patients and families in private.
- Staff we spoke with said they could access translation services for patients whose first language was not English. This meant these patients were able to hold detailed discussions about their care and treatment. However, staff were unsure if leaflets could be provided in different languages. We did not see evidence of these in the ward areas.
- Patients we spoke with told us the food provided was of high quality. However, inpatient-led assessments of the care environment (PLACE) scores for the period February 2016 to June 2016 were 78%, which was lower than the England average of 91%.
- The chefs catered for all diets and prepared any specific foods to meet patients' preferences and needs, such as lactose intolerant and coeliac disease, as well as specialist diets. One patient in endoscopy complained to us that the offer of tea and biscuits post procedure was not sufficient particularly as previously sandwiches had always been provided.

Learning from complaints and concerns

- Patients and relatives had various ways of raising concerns. These included completing a satisfaction survey questionnaire or hospital website enquiry forms, written complaints or verbal complaints.
- The hospital had an up to date complaints policy with a clear process to investigate, report and learn from a complaint.
- Some staff we spoke with were unsure of the complaints procedure and, whilst comment cards were freely available on the wards, were unable to show us where the complaints leaflets were kept.
- From November 2015 to April 2016, the hospital received 63 complaints. The executive director had overall responsibility for all complaints. The Quality and Risk Manager tracked complaints and assigned each complaint to the relevant head of department for investigation.
- We reviewed the process for management of three complaints. All three were reviewed and responded to within the 20 day timeline, patients were responded to sensitively and an apology was given.
- Staff told us they would listen to concerns and act to resolve the problem as soon as it had been identified. There were procedures for sharing and learning from complaints across the hospital.
- Complaints were discussed at senior level in the MAC and integrated governance meeting, monthly at the Heads of Department meeting, weekly at the Executive Team meeting and at the daily communication meetings.
- Learning from complaints included staff in the cancer centre producing a poster to give clear information regarding extra blood test costs for patients and families.
- The hospital demonstrated a commitment to improve its handling of complaints and to ensure lessons were learnt across the organisation in response to patient feedback and through active participation in peer review using the Patients Association Good Practice Standards on complaints handling. The BMI The Park hospital was a member of the Nottingham and Nottinghamshire Health and Social Care Complaints Network.

Are medical care services well-led?

Good

We rated well-led as good because:

- There was a clear governance structure in place, which oversaw quality, audit and risk.
- Staff were aware of the values of the organisation and were passionate about good patient care.
- Without exception, staff we spoke with were consistently positive about local leadership across all areas in medical care services at this hospital.
- The culture of the ward, endoscopy (theatre team) and oncology team was nurturing and staff were professionally supportive of each other.

- Staff spoke positively about the 'no blame' culture of the team.

Vision and strategy for this this core service

- The service had a clear corporate vision in place to be achieved by 2020. There were eight strategic priorities focused on patient experience and outcomes whilst maintaining financial viability. The strategy for BMI The Park reflected the corporate vision; investment in facilities and equipment, introducing models of care that improved capacity, such as ambulatory care and engaging with consultants to provide the best and most up to date care.
- Managers told us the vision was to expand service provision. There was an ongoing programme of refurbishment to help the service achieve the strategy. The hospital was refurbishing Wollaton ward and the cardiac catheter laboratory during our inspection.
- Hospital staff told us they were excited about the refurbishment plans and developments for the hospital.
- The oncology service had achieved its vision and continued to develop its strategy to meet the needs of its patients with The Macmillan Quality Environment Mark(MQEM), a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.
- Endoscopy staff were aware of the corporate strategy for the department to improve facilities for patients and achieve JAG accreditation.
- The BMI strategic plans were shared with staff through heads of department and senior nurse meetings
- Both clinical and non-clinical staff used the National 6Cs which are a set of values that underpin compassion in practice, a vision and strategy for all health and care staff on a daily basis. The '6Cs' help staff to focus on six key areas; care, compassion, competence, communication, courage and commitment. These values were displayed in all areas and staff we spoke with told us they followed them.

Governance, risk management and quality measurement for this core service

- A risk register was held at this hospital with the top ten risks identified including the cardiac catheter laboratory and the aseptic suite. Risks included a description, controls in place to mitigate the risk and a summary of actions taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register.
- The risk register highlighted key risks to the service. Risks were discussed at monthly senior management team meetings and we saw risks were weighted depending on severity and actions were taken to mitigate them. The risk register was monitored through the integrated governance committee.
- There was a clear governance and risk management structure with well-defined accountabilities. The executive team used various methods to gain assurances from the ward to the board. There were committees in place, which fed into the integrated governance committee and the Medical Advisory Committee (MAC). Committees included health and safety, heads of department and infection prevention and control.
- The MAC met quarterly and the minutes for the last three MAC meetings demonstrated key governance areas were discussed including incidents, complaints and practising privileges.
- The integrated governance committee was chaired by the executive director and met every two months. We reviewed four sets of minutes of these meetings and saw incidents, complaints, patient outcomes and audit were amongst the agenda items discussed. The meetings were well attended by managers. However, junior staff were not included in the meetings. Feedback and meeting minutes were available to all staff.
- The hospital worked within the BMI hospital committee terms of reference. This structure allows for an appropriate cascade of information from the hospital management team meetings via the management team meeting (Heads of Department) and subsequently to individual departments.
- Monthly team meetings were held within the wards, the operating theatre and the cancer centre. We reviewed minutes, which showed information was cascaded to staff.
- Staff told us they found the daily 15-20 minute 'huddle' a useful way of communicating information quickly across the hospital. Senior staff and heads of department discussed daily activity, incidents and complaints at these meetings.
- The BMI The Park Hospital policy was not to admit medical patients with primary respiratory or cardiac complaints. The ward occasionally admitted medical patients, always under the care of the consultant, for example multiple blood transfusions or oncology patients requiring symptom control or end of life care.

- Senior clinical staff maintained quality measurement and performance dashboards for each service. They discussed outcomes at the integrated governance meetings and made comparisons with other BMI healthcare hospitals. Clinical staff had access to these performance dashboards.
- The medical advisory committee (MAC) had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant was required to complete biennial reviews with the MAC chair, where data on their clinical performance was discussed. The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals.

Leadership and culture of service

- The executive team at BMI The Park included an executive director (ED), supported by a director of clinical services and a director of operations. The director of operations was responsible for administration such as medical records and secretaries and the support services for example catering, reception, housekeeping and porters. The director of clinical services oversaw theatres, the wards, physiotherapy, pharmacy and the diagnostic services. The executive team reported to the regional management team of the BMI organisation.
- The operating department was overseen by the theatre manager, who was also responsible for pre-operative assessment and ambulatory care. The deputy theatre manager was the lead for endoscopy services. The clinical services manager was in charge of the wards, the critical care unit, outpatients department and the cancer service.
- The executive and senior management team were well known and well regarded by staff we spoke with, although there were mixed views about the visibility of the ED amongst more junior staff. At the time of our inspection, the director of clinical services had only been in post a few weeks, but had been an internal appointment and was therefore well known to all staff at the hospital. Staff told us senior managers were supportive and approachable.
- Nursing staff told us they would be comfortable raising concerns either directly with the consultants and anaesthetists or with the senior management team.
- All staff we spoke with were clearly passionate about patient care. Staff we met were all welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service.
- Without exception, staff we spoke with were consistently positive about local leadership across all areas in medical care services at this hospital.
- The clinical staff said they, “really loved working at the hospital, it’s like one big family, everyone knows each other” and that they felt valued, respected and listened to.
- The culture of the ward, endoscopy (theatre team) and oncology team was nurturing and professionally supportive of each other.
- Rufford ward held monthly meetings with a standard agenda, which covered business and staff issues such as complaints, incidents, new policies and staff training.

Public and staff engagement

- Service leads monitored patient feedback posted on the internet in order to monitor quality, for example NHS Choices. Feedback was also received from insurance companies funding some of the procedures.
- A ‘you said, we did’ feature had been introduced. This had resulted in the design of a poster illustrating to patients and visitors the different uniforms and roles of staff within the hospital.
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. Patient feedback cards were available in the bedrooms and a notice board displayed the recent survey results for patients. The clinical manager sent copies of any patient satisfaction surveys to staff specifically mentioned by patients or families.
- BMI carried out a biennial staff survey (every two years). At the time of the inspection, the 2016 staff survey had been completed and results had been published in May. The response rate for BMI The Park hospital was 50% (114 completed surveys).
- The 2016 staff survey results showed 86% staff were committed to doing ‘Their best for BMI Healthcare’ and 86% of staff said ‘I am clear about my objectives and what is expected of me.’ Least positive results included ‘BMI introduces changes effectively’ (25%) and ‘Communication is good between different part of hospital and corporate site’ (65%). Actions following the

staff survey included improving communication at team meetings and weekly heads of departments meetings and an open door policy with the hospital executive director.

- The survey identified motivating factors for continuing to work at BMI included 69% 'my job', 71% 'the people' and 45% 'the working hours.'
- BMI previously rewarded staff in their corporate 'Above and Beyond' nominations. This had just been updated to celebrate staff that had gone the 'extra mile.' The BMI hospital employee recognition scheme was introduced in August 2016 rewarding staff with shopping vouchers or an additional day off working.

Innovation, improvement and sustainability

- Management had discussed plans to invest in the endoscopy service as they recognised they were not compliant to enable the service to become Joint Advisory Group (JAG) accredited. Plans are now in place and the hospital is in the data collection phase of the JAG accreditation process.
- The service had recently introduced an ambulatory care service and were refurbishing the hospital so the service would have a separate, purpose built reception and recovery area for ambulatory care patients.
- The BMI Park hospital oncology service had been awarded the Macmillan Quality Environment Mark (MQEM), a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. The oncology staff were extremely proud of achieving this award and recognised this award demonstrated that the unit was a place respectful of peoples' privacy and dignity, supportive to users' comfort and well-being, giving choice and control to people using the service.

Good

Surgery

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

Information about the service

Surgical facilities at BMI The Park Hospital include 68 individual en-suite patient rooms divided over two wards. Rufford Ward has 35 rooms, predominately for surgical and medical inpatients, whilst Wollaton Ward was mainly for day case and ambulatory care patients and had 33 rooms. However, the hospital is undergoing a refurbishment programme which means the number of rooms is currently reduced. There are five operating theatres and an eight bedded recovery area for patients recovering immediately post-surgery. The senior team told us that the intensive care unit is available to stabilise inpatients whilst awaiting emergency service to transfer the patient to a local NHS trust and post-surgical patients, requiring level two critical care facilities. The hospital was in the process of developing the service to offer level three care in the forthcoming months.

In the reporting period April 2015 to March 2016 there were 7,839 inpatient and day case patients and the majority of these were non-NHS funded (74%). The majority of NHS funded patients are seen through the NHS e-referral service system. Previously known as 'Choose and Book' the NHS e-referral service is a national electronic referral service which gives low risk patients a choice of place, date and time for their first out-patient appointment in a hospital or clinic and subsequent surgical procedure. Services offered to NHS patients include ophthalmology (cataract), orthopaedics (hip, knee, shoulder, elbow, spine, foot and ankle, hand and wrist), gynaecology, hernia repair, urology, colorectal, gastrointestinal/liver, oral surgery, and podiatric surgery. The hospital does not perform surgical procedures for NHS patients under the age of 18, but does undertake a small number of procedures for children aged 12 and upwards, including minor foot and knee surgery, tonsillectomies, circumcisions and cruciate ligament reconstructions. Between April 2015 and March 2016, the hospital performed 16 day case or inpatient procedures for children aged 12 to 15, and 26 day case or inpatient procedures for young people aged 16 and 17 years.

The five most common procedures performed were eye surgery (474), vasectomy reversal (450), diagnostic bowel surgery (340), primary total hip replacement (258) and replacement of knee joint (247).

The hospital did not have a sterile supplies department, but has a service level agreement with a private provider to ensure reusable equipment is cleaned, sterilised and packed for further use.

Before our inspection we reviewed performance information from and about BMI The Park Hospital. During our inspection we visited the ward areas, operating theatres, recovery area and critical care. We observed the care of patients on the ward, during operative procedures in theatre and in the recovery area. We spoke with five patients and two accompanying relatives. We also spoke with 16 members of staff including nurses, medical staff, therapists, supporting staff and senior managers.

Good

Surgery

Summary of findings

We rated this service as good because:

- Staff were encouraged to report incidents. Incidents and lessons learned were discussed at integrated governance meetings and shared with all staff.
- Nursing, medical and allied healthcare professionals were caring and patients were positive about their care and experiences. Patients were treated with dignity and respect.
- There were effective systems in place to ensure patients received adequate pain relief following their operation. Patients also received a follow-up phone call within 48 hours of discharge to ensure they were coping at home.
- Care and treatment was provided in line with national guidelines and the service contributed data to relevant national audits. Patient outcomes were generally in line with national data.
- Safeguarding training was not given enough priority. There was no evidence that the majority of consultants had received safeguarding training and staff were unclear about their responsibilities relating to female genital mutilation (FGM). Planned level three children's safeguarding was e-learning which is not in line with intercollegiate guidance.
- The critical care unit did not meet the requirements of the Core Standard for Intensive Care Units (2013) which state care must be led by a consultant in intensive care medicine. There was no resident anaesthetist overnight for critical care patients.
- Some of the patient rooms and corridors did not comply with the requirements of regulations for infection control as they were carpeted.
- Staff did not always observe theatre protocols by changing into appropriate clothing within the theatre environment.
- Medical record documentation did not always meet satisfactory standards. The handwriting was not always legible. Daily reviews by consultants for surgical inpatients were not documented within the medical records which meant patients may not receive the care planned by the surgeons. There was no separate systematic daily review sheet for patients within critical care.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- There was no evidence that the majority of consultants had received safeguarding training and staff were unclear about their responsibilities relating to female genital mutilation (FGM). Planned level three children's safeguarding was e-learning which is not in line with intercollegiate guidance
- Medical records documentation did not always meet satisfactory standards. The handwriting was not always legible. Daily reviews by consultants for surgical inpatients were not always documented within the medical records which meant patients may not receive the care planned by the surgeons. There was no separate systematic daily review sheet for patients within critical care.
- The critical care unit did not meet the requirements of the Core Standard for Intensive Care Units (2013) which state care must be led by a consultant in intensive care medicine. There was no resident anaesthetist overnight for critical care patients.
- At the time of our inspection clinical areas were carpeted and a refurbishment plan was being implemented.
- Staff did not always adhere to theatre protocols as we observed staff did not always change into appropriate clothing within the theatre environment.

However:

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.
- All patient areas and theatres were visibly clean. Infection prevention and control processes were in place and equipment had been checked in line with the hospital's policy.
- Staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Equipment was readily available, maintained and serviced.
- Staff assessed and responded appropriately to potential risks to patients.

- Staff used an efficient electronic system to prepare equipment in advance of theatre lists. This ensured equipment was available and reduced potential for delays and errors.

Incidents

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There were no never events reported for BMI The Park between April 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event. We reviewed minutes from the integrated governance committee and theatre team meetings and saw learning from never events occurring at other locations within the company were discussed.
- Between April 2015 and March 2016 there were 635 clinical incidents reported for the hospital as a whole, of which 360 (57%) occurred in surgery. Of the total number of clinical incidents for surgery, 258 (72%) were no harm, 92 (25%) were low harm and 10 (3%) were moderate harm.
- There had been nine deaths reported for the hospital between April 2015 and March 2016. Eight of the deaths had been expected and one was unexpected. We reviewed the integrated governance meeting of January 2016 and saw the unexpected death was discussed. The death had occurred more than 28 days post-surgery and the coroner had ruled it was not related to the surgery undertaken at this hospital.
- Staff told us learning from incidents was shared at monthly team meetings. We reviewed minutes of four team meetings and saw incidents were discussed.
- BMI Healthcare has been part of NHS England's 'sign up to safety' campaign since March 2016. 'Sign up to safety' is a campaign to make UK healthcare services the safest in the world. BMI Healthcare have pledged to put safety first, continually learn from incidents and investigations, be honest when things go wrong, collaborate with other organisations and teams and be supportive to their staff and encourage a positive culture.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most staff we spoke with were familiar with the term 'duty of candour'. We reviewed three reports which had followed the duty of candour process according to policy.

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

- The hospital submitted data for NHS patients to the NHS safety thermometer scheme. This is a system of reporting on harm free care. Data was collected on a single day each month to provide a snapshot of performance in key safety areas. These included; falls, pressure ulcers (damage to the skin caused by a patient being in the same position for too long), catheter associated urine infections (CAUTI) and venous thromboembolism (VTE). VTEs, also known as blood clots, can form in a vein of a patient and have the potential to cause severe harm. Safety thermometer data from September 2016 demonstrated 100% harm free care.
- The safety thermometer data was not displayed in the hospital and staff we spoke with were not aware of the scheme.

Cleanliness, infection control and hygiene

- From February 2016 to June 2016, the hospital scored 95% for cleanliness in patient-led assessments of the care environment (PLACE). This was below the national average of 98%.
- The wards, theatres and recovery areas were visibly clean and tidy. This included not just the clinical areas but also the corridor, bathrooms, offices and storage rooms.
- There was a system for ensuring equipment was clean, for example 'I am clean' stickers. These were clearly visible, dated and signed to indicate cleaning had taken place. We observed patient-care equipment to be clean and ready for use.
- Sanitising gel was available in each room, in corridors and at the entrances to wards; however there were no

obvious signs encouraging patients and visitors to use it. There was access to hand washing facilities and supplies of personal protective equipment (PPE), for example gloves and aprons. We observed staff using PPE appropriately.

- All staff were observed to be compliant with the bare below the elbows policy which enabled effective hand washing and reduced the risk of infection.
- The World Health Organisation (WHO) five moments for hand hygiene focuses on five moments when hand hygiene should take place; these are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings. Hand hygiene audit data provided by the hospital for the period May 2016 to July 2016 showed 100% compliance for theatres and over 95% for Rufford Ward.
- Patient's bedrooms and corridors on Wollaton Ward had short pile carpet which was visibly clean and free from stains. There was a plan in place to replace the carpets in the clinical areas with vinyl flooring, however service leads told us it would not be included in the refurbishment programme in the current financial year. This had been added to the risk register under the heading 'poor patient bedroom and bathroom facilities.'
- Changing into surgical scrubs and theatre caps was a requirement of all staff and visitors to theatres and the surrounding areas and corridors. However, from our observations during inspection this was not always adhered to as we saw five people in non-theatre clothing during the course of our inspection.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. This minimised the infection risk.
- We saw staff adhering to procedures in line with national guidance to minimise the risk of infection to patients undergoing surgical procedures, for example, skin preparation and the use of sterile drapes.
- A designated area was available for the cleaning of endoscopic equipment. Other equipment used for surgical procedures was cleaned and sterilised off site by a private provider.
- The critical care unit had a two-bedded area with a separate gowning lobby for the care of patients with a known or suspected infection. This meant high dependency patients were not put at risk of infection.
- With the exception of the recovery area and the critical care unit, all patients were treated in individual rooms. This reduced the risk of the spread of infection.
- The provider reported no cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia or Clostridium difficile (C. Difficile) within the hospital for the reporting period April 2015 to March 2016. MRSA is a bacterium responsible for several difficult-to-treat infections. C. difficile is an infective bacteria that causes diarrhoea, and can make patients very ill.
- All NHS patients were screened prior to their procedure for MRSA as part of their pre-operative assessment. Non NHS patients were screened if they met certain criteria in line with BMI policy. These included all critical care patients, international patients, those patients scheduled for certain surgical procedures, those who had been admitted from a nursing home and those who had been in hospital within the previous three months.
- Patients who had been an inpatient in a hospital abroad, an inpatient in a hospital in the UK with problems with carbapenemase-producing enterobacteriaceae (CPE) or had been previously positive were screened for CPE. Carbapenems are one of the most powerful types of antibiotics. Carbapenemases are enzymes (chemicals), made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and so the bacteria are said to be resistant to the antibiotics.
- Hospital staff completed an infection risk assessment tool for each patient which, in addition to MRSA and CPE included infection risks for respiratory tract, skin, gastrointestinal, urinary tract, blood born virus and variant Creutzfeldt Jakob disease (vCJD). This assessment allowed staff to put additional precautions in place if additional risks were identified. VCJD is a rare but always fatal neurodegenerative disease which was associated with the consumptions of infected bovine products, but can also be passed on through undetected infected blood products and surgical equipment used on a patient who later developed the disease.
- The hospital reported one case of Escherichia coli (E.coli) within the hospital for the reporting period April 2015 to March 2016. E.coli are a large and diverse group of bacteria usually found in the gut, which can make patients unwell if they are transferred to other body parts.

- Data provided by the hospital showed there were 18 surgical site infections (SSI) reported between April 2015 and March 2016. There were six SSIs for primary hip procedures, which was 2.2% of the total number of procedures, and three SSIs for primary knee procedures, 1.1% of the total procedures. This was above the average of NHS hospitals from April 2010 to March 2015. The SSIs for hip and knee procedures had mainly occurred from April 2015 to December 2015. The remaining SSIs were two in orthopaedic and trauma procedures (0.7%), two in breast procedures (0.8%), three in gynaecology (0.4%), one in upper gastrointestinal tract and colorectal (0.1%) and one in urology (0.1%).
- Service leads told us they were aware of the relatively high rate of SSIs for hip and knee procedures and had undertaken a full review at the end of 2015. Whilst no specific cause had been identified, an action plan had been made with some changes to practice and further audits planned including hand hygiene. We reviewed minutes from the infection prevention and control committee of December 2015. We saw that SSIs and the action plan had been discussed. Theatre staff we spoke with during our inspection were aware of the changes. There had been no recorded SSIs for hip or knee procedures from January 2016 to March 2016.

Environment and equipment

- All patients were accommodated in en-suite private rooms, which were located off the main ward corridors. All rooms were equipped with a nurse call bell and emergency buzzers.
- The ground floor operating department at BMI The Park was modern and purpose built. It included five operating theatres, three of which had laminar flow (a ventilation system which reduces the number of airborne bacteria). One theatre was equipped with digital cameras and displays. One theatre was dedicated to endoscopy and minor local anaesthetic procedures. The recovery area had capacity for eight patients recovering immediately post-surgery, however during our inspection, two of the bays were curtained off as they were being used for equipment storage.
- The hospital performed a small amount of surgical procedures on children between the age of 12 and 18 years. On the day of our inspection there were no paediatric cases. Staff told us there was no dedicated paediatric recovery area. One of the recovery bays was more secluded and had been designated for use as the paediatric bay as and when required. Staff told us children would be moved from recovery into one of the individual rooms on the wards, which had en-suite facilities.
- The critical care unit (CCU) was located next to the operating theatres on the ground floor and accommodated up to five level two or level three patients. The CCU comprised of three beds in the main part of the unit, and two beds in an area with a separate gowning lobby. This meant infected patients could be cared for in the CCU without posing a risk to other patients.
- Access to theatres and the CCU was through a key code entry system. This meant the area was secure and minimised the risk of unauthorised access.
- There was an emergency alarm within the operating theatre. The alarm was tested during our inspection; it was in good working order and covered all areas within the department.
- An operating department practitioner (ODP) and anaesthetist checked the anaesthetic machines and equipment daily in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. This meant anaesthetic machines and equipment were in working order and safe to use.
- Adult resuscitation equipment was available in the ward and theatre areas. There was a paediatric trolley and 'grab and go' bag within the operating department. However whilst there was a paediatric resuscitation trolley on the floor below within outpatients, there was no paediatric trolley on the wards. Staff told us the adult trolley and masks would be used for children who were all over 12 years which was in line with BMI corporate policy, and the Resuscitation Council guidelines.
- Daily checks were undertaken to ensure emergency equipment was present and in working order and consumables were in date. This meant the equipment was ready to be used in an emergency.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory Agency (MHRA) requirements. An external company provided sterile services and supplies. Surgical instruments were readily available for use and staff reported there were no issues with supply.
- Within the operating theatre environment there was a difficult airway trolley, which was suitably equipped and checked on a daily basis.

- The theatre equipment and sterile supplies store was well organised. We saw staff used an electronic system to prepare equipment for operating lists scheduled for the next working day, checking that nothing was missing. This efficient system ensured any equipment issues were reported in advance and rectified so procedures were not delayed.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and environmental cleanliness. A new system for the disposal of offensive waste had recently been introduced and we observed a training schedule to ensure staff were aware of the system.
- Random checks of 23 pieces of equipment across theatres and the wards showed equipment had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for routine servicing. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Physiotherapy and occupational therapy staff undertook patient assessments for equipment to assist with mobility post-operatively. Patients were identified at the pre-operative assessment stage, or whilst on the wards following their procedure. Staff ordered the equipment from an external provider which was delivered to patient's homes.
- Equipment was available for patients with a raised body mass index (BMI) which included hoists, walking frames and some reinforced toilet frames.

Medicines

- Medicines were stored securely including controlled drugs. Controlled drugs are medicines, which are stored in a designated cupboard and their use recorded in a special register. Medicines requiring cool storage were stored appropriately and temperatures monitored daily. Medication room temperatures were also checked daily. All temperatures were within acceptable ranges; this helped to ensure medication did not deteriorate or become less effective.
- Intravenous fluids (fluids that are given directly into a vein) were available and stored appropriately. Intravenous drugs were stored in the same cupboard as local anaesthetic drugs within the operating theatres, which does not follow the guidance of the Royal College of Anaesthetists. We escalated this to the operating theatre managers. On our unannounced inspection we saw these drugs had been moved and were stored separately.
- All medication we looked at was within its expiry date. However, staff did not always date and time liquid medicines that were opened. This had been highlighted as a risk and we saw staff were now using stickers to highlight the date and time the medication was opened.
- We saw a medicines management and prescription charts audit for Rufford Ward from January 2016. The audit identified some areas of poor practice, for example medication fridge and room temperatures were not recorded on a daily basis and the thermometer had not been calibrated within the past 12 months. Three prescription charts were checked as part of the audit and were found to be generally compliant against all of the audited measures. We saw an action plan had been formulated to address the issues raised.
- The hospital issued outpatient prescriptions. Some prescription pads were stored on Rufford Ward however there was no clear log of prescriptions pads or prescriptions issued by the medical staff. This could mean staff or patients having unauthorised access to prescription only medicines. We highlighted this to service leads. On our unannounced inspection we saw the prescription pads were locked in the controlled drug cupboard and a log had been created to ensure all pads and sheets were accounted for.
- We reviewed the hospital controlled drug audit from March 2016, which covered wards, operating theatre and critical care unit. The audit measured performance against 17 standards. The audit identified there had not been a three monthly stock check of the controlled drug cupboards in critical care and the wards by pharmacy staff. We saw an action plan to address this. We asked the hospital to confirm the frequency of this audit but did not receive this data.
- Patients were asked to complete a pre-admission questionnaire, which included information about the medicines they were currently taking. If necessary, additional information could be obtained from the patient's GP.
- We looked at the prescription and medicine administration records for five patients on the wards and theatre. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The

records showed patients were receiving medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.
- Staff told us pharmacy staff attended the ward daily and reviewed prescription charts to ensure medications were correctly prescribed.
- Staff in the hospital completed an annual drugs calculation assessment and had additional training in the administration of intravenous drugs. We asked the hospital to provide data to confirm how many staff had completed this training and assessment but to date it has not been received.

Records

- We reviewed ten sets of nursing and medical records for both day case and long stay surgery. Records were paper-based. Nursing records such as prescription charts and observation charts were stored in the patient's room. Medical notes were stored securely in locked trolleys at the nurses' station.
- Patient care plans were multidisciplinary and we saw where nurses, doctors and allied health professionals, for example physiotherapists, had made entries.
- Integrated care records for day case surgery and long stay surgery were in use. These covered the entire patient pathway from pre-operative assessment to discharge risk assessments, and included the five steps to safer surgery check lists, operating notes, observations and recovery records.
- We saw risk assessments were completed as part of the integrated care records. These included pressure ulcers, malnutrition and a moving and handling assessment. All clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.
- Staff on the critical care unit completed a summary of care for inclusion in the medical records for patients being transferred to the ward, in line with the Core Standards for Intensive Care Units 2013. This meant all nursing and medical staff had access to the details of the care and treatment provided in the critical care unit.
- The majority of records were legible, accurately completed and up to date. However, in three of the ten records, we found the handwriting of medical staff was illegible and there was no documentation of daily medical review. We escalated this to a member of the senior nursing team on the wards who believed this to be an oversight as patients were reviewed every day by either the consultant or the resident medical officer. Lack of documentation may mean patients do not receive care as planned by the medical team.
- Within the critical care unit, there was no separate systematic daily review sheet for medical staff which is considered good practice. As there were no patients in critical care during our inspection, we reviewed three sets of notes for patients who had recently been cared for. Clinical decisions had been recorded on a history sheet by the resident medical officer, but there was no documented evidence of a daily medical ward round review.
- The hospital provided the results of a surgical documentation audit of ten sets of records from August 2016. The audit showed general compliance of 86% against the documented standards. However, 60% of the record did not have a completed anaesthetic assessment, 20% had a consultant daily progress note and 10% had a consultant discharge summary. The audit recommended feedback to the clinical lead meetings, departmental meeting and the medical advisory committee (MAC).

Safeguarding

- There were named leads for both adult and children safeguarding, who would support staff if they raised any safeguarding concerns.
- All staff had access to the provider's safeguarding policies and procedures via their intranet and from the safeguarding resource folders.
- Staff we spoke with had a good understanding of how to protect patients from harm and abuse. They understood the process and we were assured referrals were made and escalated if appropriate.
- Staff undertook an on-line electronic safeguarding adult training module as part of their mandatory training programme. All staff were required to undertake level one training for both vulnerable adults and children and young people. Data provided by the hospital showed more than 95% of staff had completed this training. All staff we spoke with told us further training to level three was to be provided, but it was unclear how soon and for whom this training would be provided.
- The hospital performed only surgical procedures on children over 12 years. Paediatric nurses were booked to provide one to one care for these patients on the wards

and the surgery would only proceed if these specialist nurses were available. Staff told us parents and carers were encouraged to stay with an anaesthetised child and the paediatric nurse would also be in attendance.

- There were no paediatric patients or nurses present during our inspection however we were told the paediatric nurses had received level three children's safeguarding training. None of the other clinical staff had received level three safeguarding training. Service leads told us three members of management had received level three children's safeguarding training. It was planned that nursing staff would complete additional safeguarding level three e-learning by the end of 2016 however this is not in line with the intercollegiate guidance which states that level three training should be face-to-face.
- Some of the staff we spoke with both on the wards and in the operating theatre who supported patients through gynaecology procedures had not received specific training on female genital mutilation (FGM) and were unclear about their responsibilities. Service leads told us there had been no cases FGM reported from this hospital.
- The hospital provided data from October 2016 showing the safeguarding training that had been recorded for the consultants who had been granted practising privileges. This data showed that 78 (29%) consultants had completed adult safeguarding. The data showed that this training was not always recent, for example one consultant's training was completed in November 2011. Of the 13 consultants who specialised in gynaecology there was evidence that one had completed adult safeguarding in December 2012.

Mandatory training

- The majority of mandatory training was provided as e-learning. All staff groups were expected to complete mandatory subjects including infection prevention and control, equality and diversity, moving and handling, fire safety, safeguarding adults and children, information governance (IG) and health and safety training. Data supplied by the provider showed 94% of staff had completed their mandatory training, which exceeded the target of 90%.
- Additional training was scheduled for staff depending on their staff group and role, for example, clinical staff were also required to complete living with dementia training.
- Basic life support for adults was part of mandatory training. Clinical staff had additional training in either basic or intermediate paediatric life support. Within the operating theatre, 14 staff had completed the paediatric basic life support and 16 had completed the paediatric intermediate life support. The resident medical officer (RMO) had completed advanced paediatric life support (APLS) and was on site 24 hours a day, seven days a week.
- RMOs were provided by an agency. Mandatory training for the RMOs was the responsibility of the agency. The clinical experience, qualifications and record of mandatory training was checked by the hospital before they commenced working.
- The organisation had a sepsis policy. Nursing and theatre staff we spoke with knew who the lead for sepsis was, and had received e-learning training.

Assessing and responding to patient risk

- All patients, including NHS patients, saw their named consultant at each stage of their surgical pathway.
- We reviewed the hospital's exclusion guidelines for surgery for NHS patients. These included grossly obese patients with a body mass index (BMI) of over 40, patients with an incapacitating disease which was a constant threat to life, patients with an unstable mental condition receiving psychiatric treatment and those with a history of serious adverse events from previous anaesthetics.
- Whilst the hospital did carry out a limited amount of surgical procedures on children over 12 years of age, no NHS patients under 18 years were accepted. The hospital did not have access to a named consultant paediatrician; however consultants admitting children were responsible for their care until they were discharged.
- All patients being referred for surgical treatments would either have a pre-operative telephone assessment or be seen in the pre-operative assessment clinic approximately two weeks prior to the procedure, dependant on whether investigations were required prior to the procedure. In the clinic, baseline observations would be recorded and pre-operative investigations would be arranged, for example a blood test, MRSA screening or X-rays.
- The pre-operative assessment clinic was nurse-led however staff told us they would involve the medical

team and anaesthetists for additional review if required. During our inspection we saw evidence of staff within pre-operative assessment appropriately escalating concerns relating to pre-operative patients.

- Surgical procedures were only performed on patients who had been assessed as low risk. Anaesthetists calculated the patient's American Society of Anaesthesiologists (ASA) grade as part of their assessment of patients about to undergo a general anaesthetic. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels with level one being the lowest risk. The hospital only undertook procedures for patients graded as levels one to three although we were told a patient who was borderline level four may be accepted but would be assessed on an individual basis.
- The hospital used surgical day case or inpatient booklets for each patient. These booklets included the pre-operative assessment checks and risk assessments, admissions and pre-operative checks, anaesthetic and operating records, including a record of swab and needle counts. Details of care given in recovery and post operatively on the ward were also included, together with a discharge checklist. This booklet ensured all important and relevant information was kept in one document, and could be accessed by the multi-disciplinary team.
- Risk assessments were completed as part of the integrated care records. These included pressure ulcers, malnutrition, falls risk, moving and handling and an assessment of intravenous fluid cannula sites. We reviewed ten patient records and found all patients had risk assessments completed. In two of the records we saw patients had been assessed as high risk for pressure ulcers with preventative care specified, however there was no evidence in the notes this care plan had been followed. We highlighted this omission to the ward nursing staff.
- Staff told us VTE screening was completed for all patients on admission and again within 24 hours of the procedure if still an inpatient in line with National Institute for Health and Care Excellence (NICE) recommendations. Audit data from a sample of 20 patients provided by the provider for March 2016 and April 2016 showed 100% of patients had a documented VTE assessment on admission and 81% of applicable patients had a 24 hour assessment documented. We reviewed ten patient records and saw VTE assessments had been completed.
- Two patients had developed a hospital acquired VTE or pulmonary embolus (PE) in the reporting period between April 2015 and March 2016. A PE is a blockage of an artery in the lungs. The most common cause of the blockage is a blood clot.
- A resident medical officer (RMO) was available 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient's clinical condition.
- The hospital used a system to record routine physiological observations such as respiratory (breathing) rate, blood pressure and pulse in order to monitor patient's physical condition. This was used as part of an adult national early warning score (NEWS) or paediatric early warning score (PEWS). Observations were taken and recorded from the pre-operative assessment checks and formed a baseline for subsequent recordings. If the score increased nursing staff were alerted to it and a response was instigated. This ranged from increasing the frequency of observations to an urgent review by the patient's consultant or their anaesthetist. The critical care outreach team were also on-call for deteriorating patients. Patient records we reviewed showed the NEWS and PEWS charts had been completed and calculated accurately. No escalation was required for any of the patient NEWS or PEWS charts we reviewed.
- We reviewed the results of an audit of NEWS records from July 2016. The audit showed that 69% of the sample observations had been scored on the NEWS charts, but that 100% of the scores were correct. Following this audit, the hospital planned to provide further training for staff both on line and face to face.
- Staff used an intentional rounding tool which was completed hourly during the day and two hourly overnight. (Intentional rounding is a structured approach whereby nurses check patients at set times to assess and manage their care needs.) Patients were asked 'How are you?' and checks included a general assessment of pain and comfort, toileting requirements and access to drinks and the call-bell.
- There were arrangements to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion in theatres of the Patient Safety First's Five

Steps to Safer Surgery – an adaptation of the World Health Organization (WHO) surgical safety checklist. We observed the theatre team completing the five steps to safer surgery throughout the 'sign-in' before induction of anaesthesia, to the 'sign-out' as the patient left theatre. All stages were completed correctly.

- A programme of monthly audits was in place for the five steps to safer surgery checklist. Ten sets of notes were audited per month against 18 standards. We reviewed the audit for January 2016, February 2016 and March 2016 and saw the compliance target of 95% or more had been achieved for each month.
- BMI The Park Hospital was part of the Mid Trent Critical Care Network. Level two and three patients could be cared for on site, but if a patient required transfer to another facility for critical care this would be undertaken using the Mid Trent Critical Care Network transfer protocol.
- Theatre staff participated in a team briefing, called a 'huddle', before the start of each day's theatre list. This briefing was attended by the theatre manager and staff from each of the five theatres. Discussions included details of the planned procedures, staffing and equipment and ensured patient risk was highlighted and minimised.
- A supply of blood was available in the hospital for use in an emergency and was located in close proximity to the operating theatres. There was an agreement in place with a neighbouring NHS trust for additional blood should this be required. Patients at risk of bleeding during surgery were identified and additional units of blood would be made available for surgery. Patients undergoing specific surgery, for example hip and knee replacements, had blood samples saved so that blood could be matched and accessed for them in a timely way.
- There was a massive haemorrhage procedure (MOP) in place should a patient experience an excessive blood loss, which can be life threatening. Staff we spoke with were aware of the MOP and understood their responsibilities. The MOP included obtaining additional blood products from a local NHS trust. Regular drills were carried out which included the participation of the NHS trust to ensure the MOP was robust. Following a recent drill in January 2016 potential delays due to local traffic were highlighted. This led to the amount of emergency blood products routinely held at BMI The Park Hospital being increased from four to six units. The hospital was equipped with blood warming equipment in the event of a patient requiring a transfusion, but did not have access to a rapid blood infuser, which is a recommendation of the Royal College of Anaesthetists.
- The hospital had a service level agreement (SLA) with the local NHS acute trust, ambulance service and the Mid Trent Critical Care Network. This meant patients could be transferred to the nearby acute trust for care and treatment should their condition deteriorate with the emergency ambulance service providing transport.

Nursing staffing

- BMI The Park Hospital used a corporate nurse dependency and skill mix planning tool when planning staffing in line with National Institute for Health and Care Excellence (NICE) staffing guidance.
- There were two wards at this location. Rufford Ward was the mixed surgical and medical inpatient ward whilst Wollaton Ward was mostly for day case and ambulatory care patients. Surgical patient admissions were known in advance and staffing calculated using an electronic staffing tool which ensured staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs, for example additional health care assistants (HCA) were allocated when patients with dementia were to be admitted. Ward nursing staff we spoke with told us additional qualified members of staff were allocated during busy periods to ensure staffing levels were safe and patient needs could be met. Senior nursing staff we spoke with told us of recent changes to the parameters of the nursing tool which meant staff were allocated less time for discharging patients.
- Elective surgery lists for children over the age of 12 years were co-ordinated by the inpatient ward staff to ensure suitably qualified paediatric nurses were available to provide one to one care for children for the whole of their stay. However, service leads told us paediatric nurses may not be available in the event of a child's unplanned overnight stay, since they were booked for a specific list.
- Staffing levels were displayed on a patient information board at the entrance to the wards. During our inspection we observed actual staffing levels were in line with planned levels.
- The critical care unit employed a small team of six permanent staff (five whole time equivalent staff). The

staff worked a flexible rota to suit the needs of the service. Critical care staff provided the outreach service for wards. Additional staffing requirements would be met by bank staff.

- The nurse to patient ratio on the critical care unit between January 2016 and March 2016 had been 1:1.
- We observed a handover of the nursing staff on Rufford Ward. These took place between shifts in an office on the ward to ensure confidentiality. Nursing staff used printed handover sheets containing all relevant patient information which ensured staff were well informed about the plan of care for each patient. These sheets were placed into confidential waste at the end of the shift.
- The hospital did use bank and agency staff and wherever possible used staff who had worked there before. Bank staff are those employed by the hospital to cover unfilled shifts due to sickness or annual leave. The average use of bank or agency nurses between April 2015 and March 2016 was 6.8%, which was lower than the average of independent acute hospitals. There had been no use of agency nursing staff in theatre between January 2016 and March 2016. The average use of bank and agency health care assistants and operating department practitioners (ODP) between April 2015 and March 2016 was 20.9%, which was higher than the average of independent acute hospitals.
- We saw a comprehensive agency staff induction checklist in use within the operating theatres to ensure agency staff were familiar with the environment, equipment and procedures.

Surgical staffing

- 'Practising privilege' refers to medical practitioners being granted the right to practice in a hospital after being approved by the medical advisory committee (MAC). All the consultants worked at local NHS trusts. They included those with specialties such as orthopaedics and ophthalmology.
- There were 227 consultants who had been granted practising privileges at BMI The Park. Of these, between April 2015 and March 2016, 154 consultants (68%) had carried out episodes of care.
- From April 2015 to March 2016, seven of the consultants had relinquished their practising privileges for various reasons. In the same period 29 consultants had been suspended for documentation non-compliance; of these 18 had been re-instated and 11 remained on suspension. One consultant had been suspended due to an ongoing investigation at the NHS trust they were also employed at. There were no consultants on supervised practise during this time period.
- Consultants and anaesthetists could be contacted 24 hours a day and could return to the hospital within 30 minutes. Nursing staff on the ward told us they had no difficulty contacting the medical staff. We saw the mobile phone numbers of the consultants and anaesthetists were available to ward staff.
- Consultants visited in-patients at least once every 24 hours and were available via telephone 24 hours a day, seven days a week whilst they had patients in the hospital. If they planned a period of absence a fellow consultant would be identified to cover and the hospital informed.
- A resident medical officer (RMO), trained in both adult and paediatric advanced life support, provided medical cover 24 hours a day, seven days a week for all patients. The RMO worked a seven day roster and was on call for emergencies 24 hours a day, seven days a week. To ensure the RMO was not overtired and remained safe to provide care, nursing staff would only wake the RMO overnight in case of an emergency. We saw staff made a record of these overnight call-outs which meant service leads had assurance the RMO was safe to practice.
- The hospital worked within the recommendations of the Association for Perioperative Practice with regard to numbers of staff on duty during a standard operating list. This comprised two nurses, an operating department practitioner (ODP), a health care assistant (HCA), a consultant surgeon and an anaesthetist.
- There was an on call rota for theatre staff in the event of a patient needing to return to theatre, with most staff living within 30 minutes of the site. The rota included an ODP, scrub nurse, recovery nurse and an HCA as well as the consultant and anaesthetist.
- The critical care unit did not meet the requirements of the Core Standard for Intensive Care Units (2013) which state care must be led by a consultant in intensive care medicine. In addition the consultant must be immediately available 24/7, be able to attend within 30 minutes and undertake twice daily ward rounds. At BMI The Park, patients in critical care were managed by the consultant surgeon and anaesthetist. There was no anaesthetist resident overnight to cover patients in the critical care unit however we were told the anaesthetists responsible for cardiac patients were resident for 24

hours post-surgery in case of complications. Service leads told us they were in the process of implementing a rota so a consultant intensivist would be available for critical care would be available for the critical care unit 24 hours a day, seven days a week. It was also planned for the on-call consultant to undertake twice daily ward rounds. This rota was planned to be in place by the end of 2016. In addition to a Resident Medical Officer (RMO) working hospital wide, two critical care RMOs had recently been appointed by the hospital in order to provide 24 hour a day, seven days a week cover for patients in the critical care unit. However, these RMOs were not consultants.

Major incident awareness and training

- BMI The Park Hospital did not have a designated role or responsibility in the nearby NHS acute trust's major incident policy.
- There was a comprehensive business continuity plan in place. It detailed how staff should respond to, for example loss of heating, loss of gas, adverse weather conditions and a bomb threat. A folder containing full details of the plan, including useful contacts with telephone numbers, was kept at the reception desk of each area. Senior staff told us they were aware of the plan and their responsibilities, for example the policy had been used following a concern about the on-site boiler.

Are surgery services effective?

Good

We rated effective as good because:

- Care and treatment was planned and delivered to patients in line with current evidence based guidance, standards and legislation.
- There was good multi-disciplinary working and relationships throughout the department and with the rest of the hospital.
- Patients told us their pain was well managed and staff were quick to respond to requests for pain relief.
- The hospital proved a seven day service for inpatients with effective on-call arrangements to meet patient needs.

However:

- Whilst patients we spoke with were happy with the food provided, patient-led assessments of the care environment (PLACE) scores for the period February 2016 to June 2016 were 78%, which was lower than the England average of 91%.

Evidence-based care and treatment

- Staff had access to a range of corporate guidelines via the intranet. We saw these guidelines were up to date and referenced to current best practice from a combination of national and professional guidance such as the National Institute of Health and Care Excellence (NICE), Royal Colleges and General Medical Council (GMC).
- Staff followed NICE guidelines relating to the assessment and prevention of venous thromboembolisms (VTE) and preoperative tests and assessments.
- We saw the hospital participated in a number of national audits, for example Patient Recorded Outcome Measures (PROMS), the National Joint Registry (NJR) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For patients this means better experience, involvement and outcomes. During 2015-2016, four commissioning for quality and innovation (CQUIN) requirements had been identified by the Clinical Commissioning Group (CCG) for NHS patients treated at the hospital.
- We reviewed an audit of the physiotherapy services provided to inpatients from November 2015. Areas for improvement included the documentation of treatment plans in patients' notes. The action plan showed that this had been fed back to staff and further quarterly audits were planned to monitor the quality of records.

Pain relief

- Patients we spoke with on the wards following their surgery told us their pain was well-managed. They told us nursing staff were quick to respond to requests for pain relief.

- Patient's pain was assessed and given a score both in the pre-operative assessment clinic and again on admission. We observed pain scores documented in the care plans and recorded on the NEWS charts.
- Staff used an intentional rounding tool which was completed hourly during the day and two hourly overnight. (Intentional rounding is a structured approach whereby nurses check patients at set times to assess and manage their care needs.) This tool prompted staff to regularly ask patients about their needs including pain levels.
- Pain assessment scores used on the ward assessed the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief. Nursing records we checked demonstrated staff were identifying the patient's level of pain and evaluating the effects of pain relief on a consistent basis.
- Staff discussed pain relieving medication with patients and leaflets prior to discharge.
- Nursing staff telephoned patients 48hrs following discharge and enquiries were made regarding their pain management. Plans to control pain were made if a patient was in any discomfort.

Nutrition and hydration

- Patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Records showed checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- Staff followed best practice guidance on fasting prior to surgery. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- We reviewed ten sets of records and saw there were accurate and complete records to show fluid intake and output was monitored after surgery.
- We saw anaesthetic staff prescribing medication to ensure effective management of nausea and vomiting should this occur.
- There were arrangements in place to refer patients to a dietician if required.

Patient outcomes

- BMI The Park Hospital had not been identified as an outlier for surgery by the Care Quality Commission. (Outliers are where the hospital has performed worse than the national average).
- BMI The Park Hospital took part in national audits focusing on patient outcomes; such as the National Joint Register (NJR), the Patient Recorded Outcome Measures (PROMS and where appropriate the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- The hospital submitted data to the Private Healthcare Information Network (PHIN). PHIN is an independent, not-for-profit organisation that publishes data to help patients make informed decisions regarding their treatment options and to help providers improve standards.
- Data was submitted to the Intensive Care National Audit and Research Centre (ICNARC). We reviewed the ICNARC report for April 2015 to March 2016 which showed that the hospital was performing in line with other comparable providers.
- The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. Outcome measures data from 614 completed operations had been submitted to the NJR for 2015. The hospital's average consent rate was 73%, which did not meet the NJR requirements for 2015. The consent rate for 2016 to date was 84% (January to May 2016).
- Service leads told us the hospital had recently registered with the Breast and Cosmetic Implant Registry (BCIR). The BCIR is currently being developed and will provided details of all breast implant procedures completed in England by both NHS and private providers. We saw the hospital was maintaining a paper based record of procedures and implants until the electronic register was active.
- Patient reported outcome measures (PROMS) for hip replacements (NHS patients only) for the period April 2014 to March 2015 were within the expected range and the England average. PROMS for knee replacements for the same period were higher than the England average.

- EQ-VAS or EQ-5D indexes, both of which are additional measures of patient health outcomes, showed health gains were higher when compared to the England average for total knee replacements and were about the same as the England average for total knee replacements.
- Physiotherapy staff told us they were trialling the submission of data to JointPRO. JointPRO is a remote, internet based tool that captures joint-specific patient reported outcomes, which gives feedback to patients and real time information to the provider.
- From April 2015 to March 2016 there had been 15 unplanned transfers of inpatients to another hospital and 18 unplanned readmissions within 28 days of discharge. This number of unplanned transfers and readmissions was not high when compared to other independent acute hospitals. There was no re-admissions or transfers of paediatric patients.
- The hospital provided a root cause analysis investigation report of an unplanned transfer of a patient to a local NHS trust from July 2016 which we reviewed. The hospital had identified learning points from this investigation for example terminology to be used when communicating with ambulance staff.
- There were 12 cases of unplanned return to the operating theatre in the reporting period April 2015 to March 2016.

Competent staff

- Applications from consultants to obtain practising privileges were considered by the Medical Advisory Committee (MAC). For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's (RO) name.
- We reviewed the personal files of five consultants working at the hospital under a practising privileges arrangement. All five files demonstrated arrangements for granting and reviewing practising privileges were appropriate and staff were competent and skilled to carry out the care and treatment they provided. We saw where staff had undergone a whole practice appraisal in the last year and had a revalidation date set by the General Medical Council (GMC).
- There were 227 consultants who had been granted practising privileges by the medical advisory committee (MAC). Of these, nine held practising privileges for cosmetic surgery and data provided by the hospital showed all were on the General Medical Council (GMC) specialist register for cosmetic surgery.
- Surgeons only performed operations they were used to performing at the acute trusts where they were employed. This ensured they were competent and confident in undertaking the procedures.
- Staff were encouraged to share concerns about poor performance. Service leads took appropriate action when practice concerns were highlighted and gave an example of learning from this process, for example changes to the probation documentation for newly appointed nursing staff.
- Data provided by the hospital showed, for the reporting period October 2015 to September 2016, more than 90% of registered nurses on the wards and all of the staff within the theatre department had received an appraisal. Appraisal rates for other non-registered staff on the wards was 80% and over.
- All nursing staff working within the critical care unit, including bank staff, had undertaken post registration training in critical care nursing.
- Service leads told us health care assistants (HCA) were being supported to undertake further education courses to develop their skills and competencies. Two HCAs had already started and a further four planned to start later in the year.

Multidisciplinary working

- Staff told us there was good multi-disciplinary team working. Staff communicated well and treated each other with respect.
- Team briefings were held each morning for theatre staff to review the operating lists with the surgeons and anaesthetists, which were documented and signed. We saw this documentation was audited every three months to ensure appropriate staff attended and significant information shared.
- There was a multidisciplinary team approach to pre-operative assessment; this involved nurses, medical staff physiotherapy and occupational therapy staff.
- Discharge planning was commenced in the pre-operative assessment clinic and involved consultants, physiotherapists and occupational therapists. Equipment identified to be essential to safe discharge was identified and ordered from an external agency.

- There were a number of service level agreements in place for services to be supported or provided to the hospital for example transfer of patients if necessary to a local NHS acute trust.
- The critical care outreach team were available on-call to support ward staff for deteriorating patients. Physiotherapy staff were also on-call for patients with respiratory emergencies.

Seven-day services

- Operating theatre sessions were available Monday to Friday from 8am to 8pm. Additional sessions were available on Saturdays if required. Two theatres were available at all times for patients requiring an urgent return to theatre.

There were resident medical officers (RMO) available 24 hours per day seven days per week, one for the wards and one for critical care.

- Physiotherapy services were provided seven days a week. Core service hours were Monday to Friday from 8.30am to 4.30pm and staff worked an on-call service out of hours and at weekends. Imaging and x-ray facilities were available from 8am until 6pm Monday to Friday.
- On-call radiology staff provided a weekend and out of hours service if required and a consultant radiologist was able to report on any images taken out of hours.
- A pharmacy service was provided six days a week, Monday to Saturday. An on-call pharmacist was available outside of normal pharmacy hours for inpatient requirements.

Pathology services were available Monday to Friday. In addition there was an arrangement with a local NHS acute trust for urgent tests and microbiology services out of these hours.

- Diagnostic equipment was available 24 hours a day, seven days a week for the inpatient wards and critical care unit if required. There were MRI and CT scanners and a mobile x-ray machine on site and the radiographer was on-call.

Access to information

- Staff had access to electronic and paper copies of hospital policies and guidelines on the ward and in theatres.
- There were systems, processes and standard operating procedures to support effective handover between the RMO, consultants and other clinical staff. They were reliable and appropriate to keep patients safe.
- Prior to surgery, patients were required to attend an assessment clinic run by a qualified nurse. The booking form and NHS letter were available at the clinic for NHS patients. Patients were asked to complete a comprehensive pre-admission questionnaire prior to their surgery. This included their past medical history and their current medication. Further information was gathered during the assessment to assess whether a patient was suitable for surgery, for example height, weight and blood pressure. Appropriate blood tests were also undertaken if necessary and we saw the results were filed within patient's medical records.
- Staff had access to patient records, including all pre-operative assessment documentation. We saw results of diagnostics tests were filed within the medical notes. We were told consultants could access the results of diagnostic testing electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The records we reviewed showed all patients had been consented for their surgical procedure. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient. Consenting generally took place on the morning of the surgery.
- Staff told us there was a two week period between a consultant appointment and surgery for patients requesting cosmetic surgery in order to comply with guidance on the two-week 'cooling off' period. This meant patients had time to change their minds before proceeding with surgery.
- Where an interpreter had been used to gain consent from the patient there was a place on the consent form for their signature to state they had relayed the information to the patient correctly.
- We saw a consent audit from June 2016 which compared 10 sets of patient records against 15 standards. Audit results showed 100% compliance in 12 out of the 15 standards measured. Areas for improvement were identified for example in the recording of information provided to the patient and a further audit was planned.

Good

Surgery

- Mandatory training for clinical staff included consent, Mental Capacity Act (MCA) and Deprivation of liberty safeguards. Data provided by the hospital showed more than 95% of staff required to complete the training were compliant. At the time of our inspection there were no incapacitated patients or patients with Deprivation of Liberty Safeguards. Service leads confirmed there had been no Deprivation of Liberty Safeguards applications made within the previous 12 months.
- At the time of our inspection there were no patients with a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. The hospital had an up-to-date adult resuscitation policy which clearly identified the process for decisions relating to DNACPR orders. The patients' resuscitation status was documented both pre and during their admission within the provider's admission pathway booklets.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback from patients and those important to them about the care they had received and the way staff treated them was positive.
- Patients told us staff were kind and caring and treated them with dignity and respect.
- Patients felt involved in the planning of their care.
- Staff followed a structured approach to ensure patients were comfortable and their needs were met.

Compassionate care

- The NHS Friends and Family Test is a satisfaction survey that measures patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family. For the period between October 2015 and March 2016, 100% of NHS patients who completed this survey said they would recommend the hospital. However, response rates to the survey were between 13% and 32%, which was lower than the England average of independent sector NHS patients.
- We spoke with five patients and two relatives during our inspection and received three completed comment cards from patients. Without exception, patients reported staff were polite, friendly and approachable, always caring and respectful. One patient told us, 'the care on the ward from all members of staff was first class.'
- Patients were cared for in individual rooms; we saw staff knocking on doors and waiting for a response before entering. Patients we spoke with told us staff were kind and caring and they had been treated with dignity and respect.
- From February 2016 to June 2016, the hospital scored 78% for privacy, dignity and wellbeing in patient-led assessments of the care environment (PLACE). This was below the national average of 83%.
- We saw patient's names were displayed on their individual rooms, but only after written consent had been obtained.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in the planning of their care. They told us they had received full information about their treatment and the care and support would be offered following the procedure.
- Patients and relatives told us they had felt completely involved with their care and had received explanations of the procedures they would have, with the care and support they would need following their operation.
- One patient we spoke with described how, on the day of his surgical procedure, staff made a phone call from the recovery area to relatives to offer reassurance and support.
- The hospital included information about costs of treatments within the consent form to ensure staff could sensitively discuss this with them.

Emotional support

- Patients told us staff provided emotional support. One patient told us the staff looking after him had always answered the call bell very promptly which was reassuring.
- Patients told us staff regularly checked on their wellbeing and to ensure their comfort.
- Staff told us they had time to sit with patients and discuss the patient's fears and reassure them.

Are surgery services responsive?

Good

Surgery

Good

We rated responsive as good because:

- Access to surgical services was planned to meet the need of local patients and there was easy access to the services for both NHS and self-funded patients.
- Patients were admitted on a planned basis for elective surgery, this included self-funded patients and NHS patients.
- Cancellations were minimal and managed appropriately.

However:

- There was no dedicated area for children within surgery.
- There was limited information for non-English speaking patients.
- Whilst we saw complaints were investigated within appropriate timescales, some staff were unsure of the complaints procedure or the availability of complaints leaflets.

Service planning and delivery to meet the needs of local people

- Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff could plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- The hospital introduced an ambulatory care pathway for surgical patients in May 2016. Ambulatory care is a service where some surgical procedures may be undertaken without the need for an overnight stay and which may have quicker healing and recovery times than traditional methods. During our inspection, ambulatory care was based as part of Wollaton Ward, however we saw work was underway within the hospital to create a dedicated area.
- At the time of our inspection there were no patients living with dementia on the wards. Staff told us patients' needs would be identified at the pre-operative assessment clinic, and additional staffing would be provided to support these patients.
- Between April 2015 and March 2016, the hospital performed 16 day case or inpatient procedures for children aged 12 to 15, and 26 day case or inpatient procedures for young people aged 16 and 17 years. However there was no dedicated paediatric ward or recovery area and children were being cared for in an adult area. Service leads were aware and told us the majority of paediatric patients were older teenagers requiring treatment for sports injuries.
- The physiotherapy department comprised four treatment rooms and a gymnasium. Physiotherapy was included for those admitted to surgery as inpatients. Services included ward visits and outpatient appointments including group classes and one-to-one sessions.

Access and flow

- The majority of patients at BMI The Park were non NHS (74%). Those patients who were funded by the NHS used the 'NHS e-referral' system to make appointments were convenient to them.
- Staff working within theatre told us of patient delays from the ward to the operating theatres, especially at the start of the day. Service leads acknowledged better co-ordination between ward and theatre was required and were considering different options to improve the flow for example staggered admissions times for patients. An ambulatory care unit was being constructed which it was hoped would also improve patient flow.
- All surgical patients discharged from the hospital, including those who had day case procedures, received a follow-up telephone call 48 hours later to ensure they were managing at home. Any issues would be addressed during the phone call, if possible, or patients would be booked in for an outpatient review with the consultant or nurse. Surgical patients could contact the physiotherapy team on discharge for advice or if they had concerns about their recovery.
- Consultants booked critical care beds for their elective surgery patients. Surgery dates would be planned to ensure availability of beds. Non-elective admissions to critical care were made by the multi-disciplinary team including the consultant and anaesthetist responsible for the patient.
- Data provided by the hospital showed the hospital cancelled 33 procedures for a non-clinical reason between April 2015 and March 2016. All of these patients were offered another appointment within 28 days of the cancelled appointment.

- The referral to treatment pathway is the key access target for NHS-funded patients, stipulating that no patient should wait longer than 18 weeks from referral to the start of their treatment. Targets for admitted patients beginning treatment within 18 weeks of referral were abolished in June 2015. The hospital met the target of 90% of admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period before the targets were abolished (April 2015 and May 2015). Above 90% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 2015 to March 2016) except for August2015 and September 2015.
- Discharge planning was started during the pre-operative assessment stage of the pathway and patients' needs post discharge were identified. An occupational therapist worked within the pre-operative assessment clinic and was involved in safe discharge planning for patients, for example whether the patient would require any equipment to help keep them safe.
- Between April 2015 and March 2016, there were 732 level two critical care bed days available within the hospital. The occupancy rate for the same reporting period was 238 level two bed days used (33%).
- Between April 2015 and March 2016, there were 1098 level three critical care bed days available within the hospital. The occupancy rate for the same reporting period was 21 level three bed days used (2%).

Meeting people's individual needs

- The admission process and care provided was the same for self-funded patients and NHS patients.
- Patients with a learning disability or those living with dementia were identified at the earliest stage of the referral process and plans made to ensure they were appropriately cared for by providing additional staff to support them.
- Dementia awareness training was included as an e-learning module as part of mandatory training for clinical staff. The provider supplied the training records of 229 staff, of which 133 had dementia awareness training included as mandatory. The compliance rate for staff who were required to complete the training was above the hospital's target of 95%.
- Staff demonstrated an awareness of the religious needs of patients. We were told a prayer room would be created for patient's and relative's use if required. Additional facilities had been provided for a student who was on a placement at the hospital during a religious festival, and adjustments made to the timetable accordingly.
- Information leaflets given to patients were written in English only. Service leads told us leaflets could be obtained in other languages if required, however some staff we spoke with were unclear as to how these would be sourced
- Staff told us they used both telephone and face to face interpreting services for patients whose first language was not English.
- The hospital provided three meals a day for all in-patients and choices were varied. Menus were offered depending upon patients' personal, medical or religious needs, for example gluten-free, vegan, vegetarian and Halal foods and would be identified at the pre-operative assessment clinic. However, there was no dedicated menu for children and young people although staff told us that they tried to cater for special requests within reason.
- Patients we spoke with told us the food provided was of high quality. However in patient-led assessments of the care environment (PLACE) scores for the period February 2016 to June 2016 were 78%, which was lower than the England average of 91%.
- There were no patients in the critical care unit at the time of our inspection. Staff told us relatives had open visiting for patients within critical care and could also offer overnight stays for relatives in order to reassure relatives and comfort patients.
- Staff told us the psychological needs of patients considering cosmetic surgery was considered by surgeons. Patients were given at least two weeks between the consultation and procedure in case they wished to change their mind, and referral to other health professionals would be made if mental health issues were identified.

Learning from complaints and concerns

- A comprehensive complaints policy was in place which gave clear guidance to all staff about their role, responsibilities and timescales for responding to complaints and concerns. The policy was based on recommendations made within national reports and

inquiries, in particular the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report) (2013), and the Berwick Review (2013), both of which focused on patient safety.

- The hospital's executive director was ultimately responsible for the complaints process. We reviewed meeting minutes from team meetings and the Integrated Governance Committee meetings and saw details of complaints were shared and discussed.
- Details of all complaints were entered onto an electronic system. We reviewed a complaint made about the ward environment and saw that a reply had been sent within the timescales outlined in the BMI complaints policy.
- Some staff we spoke with were unsure of the complaints procedure and, whilst comment cards were freely available on the wards, were unable to show us where the complaints leaflets were kept.
- Data provided by the hospital showed between April 2015 and March 2016, there were 115 complaints made about the service, none of which were referred to the ombudsman or the independent healthcare sector complaints adjudication service (ISCAS).

Are surgery services well-led?

Good

We rated well-led as good because:

- The clinical governance structure was robust and the senior management team met regularly to review quality and safety of the surgical services, however there was poor oversight of some key safety measures.
- The risk register was regularly updated and we saw the senior management team were aware of the main risks to the service and mitigating plans were in place.
- Staff we met were welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service.

However:

- Whilst there was a clear corporate vision and strategic priorities, the strategy for services for children was still being formulated and not all of the service leads were clear about the vision and strategy for the service.

Vision and strategy for this this core service

- The service had a clear corporate vision in place to be achieved by 2020. There were eight strategic priorities focused on patient experience and outcomes whilst maintaining financial viability. The strategy for BMI The Park reflected the corporate vision; investment in facilities and equipment, introducing models of care than maximised capacity, such as ambulatory care and engaging with consultants to provide the best and most up to date care. There was an ongoing programme of refurbishment to help the service achieve the strategy. However, the strategy for services for children was still being formulated and not all of service leads we spoke with were clear about the vision and strategy of surgery at BMI The Park.
- The service improvement action plan for 2016 demonstrated the hospital's focus on quality, safety and efficiency.
- Staff values were based on the 'six Cs'; care, compassion, competence, communication, courage and commitment. These values were displayed in all areas and staff we spoke with told us they followed them.

Governance, risk management and quality measurement for this core service

- There was a clear governance and risk management structure with well-defined accountabilities. The executive team used various methods to gain assurances from the ward to the board. There were committees in place which fed into the integrated governance committee and the Medical Advisory Committee (MAC). Committees included health and safety, heads of department and infection prevention and control.
- The MAC met quarterly and the minutes for the last three MAC meetings demonstrated key governance areas were discussed including incidents, complaints and practising privileges.
- The integrated governance committee was chaired by the executive director and met every two months. We reviewed four sets of minutes of these meetings and saw incidents, complaints, patient outcomes and audit were amongst the agenda items discussed. The meetings were well attended by managers however more junior staff were not included in the meetings.
- Monthly team meetings were held within the wards, critical care and the operating theatre. We reviewed minutes which showed information was cascaded to staff.

Good

Surgery

- There was a hospital wide risk register which highlighted key risks to the service. Risks were discussed at monthly senior management team meetings and we saw risks were weighted depending on severity and actions were taken to mitigate them. The risk register was monitored through the integrated governance committee.
- Performance activity and quality measurement was recorded and reported centrally to allow comparison with other BMI hospitals.
- However service leads were unable to demonstrate that there was robust oversight of all safety and quality measures, for example in relation to appropriate safeguarding training for consultants in line with intercollegiate guidance.

Leadership / culture of service related to this core service

- The executive team at BMI The Park included an executive director (ED), supported by a director of clinical services and a director of operations. The director of operations was responsible for administration such as medical records and secretaries and the support services for example catering, reception, housekeeping and porters. The director of clinical services oversaw theatres, the wards, physiotherapy, pharmacy and the diagnostic services. The executive team reported to the regional management team of the BMI organisation.
- The operating department was overseen by the theatre manager, who was also responsible for pre-operative assessment and ambulatory care. The clinical services manager was in charge of the wards, the critical care unit, outpatients department and the cancer service.
- The executive and senior management team were well know and well regarded by staff we spoke with, although there were mixed views about the visibility of the ED amongst more junior staff. At the time of our inspection, the director of clinical services had only been in post a few weeks, but had been an internal appointment and was therefore well known to all staff at the hospital. Staff told us senior managers were supportive and approachable.
- Staff within the operating theatres and on the wards reported good working relationships between the multi-disciplinary team. Nursing staff told us they would be comfortable raising concerns either directly with the consultants and anaesthetists or with the senior management team.
- All staff we spoke with were clearly passionate about patient care. Staff we met were all welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service.

Public and staff engagement

- Service leads monitored patient feedback posted on the internet in order to monitor quality, for example NHS Choices. Feedback was also received from insurance companies funding some of the procedures.
- A 'you said, we did' feature had been introduced. This had resulted in the design of a poster illustrating to patients and visitors the different uniforms and roles of staff within the hospital.
- The hospital participated in the BMI Healthcare staff survey. We saw the results of an undated survey showing the ten most and least positive responses to 45 questions asked. The top three most positive responses were 'I am committed to doing my very best for BMI healthcare', 'I am fully trusted to do my job' and, 'I find my job interesting and fulfilling.' The three least positive results were, 'I am paid fairly for the job I do', 'BMI Healthcare introduces changes effectively' and, 'BMI Healthcare recognises achievement.'
- The hospital had forged links with the local university and had facilitated student nurse placements at the hospital.
- Service leads told us staff loyalty was rewarded through long service awards.

Innovation, improvement and sustainability

- The service had recently introduced an ambulatory care service and were refurbishing the hospital so the service would have a separate, purpose built reception and recovery area for ambulatory care patients.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

There were 43,278 outpatient attendances at BMI The Park between April 2015 and March 2016. Most were adults and 1380 (3.1%) were children and young people under 18 years. During this period, 122 children and babies up to the age of two, 877 children aged from three to 15 years and 381 young people between 16 and 17 years attended the outpatient clinics.

The BMI The Park hospital has practising privilege arrangements for over 227 doctors and dentists. The hospital offers treatment under a range of 28 specialties. These specialties include ophthalmology (cataract), orthopaedics (hip, knee, shoulder, elbow, spine, foot and ankle, hand and wrist), gynaecology, hernia repair, urology (male and female urology, including prostate surgery), colorectal, oral surgery, podiatric surgery, and gastrointestinal/liver outpatient consultations. NHS patients account for approximately 26% of the activity undertaken at BMI The Park Hospital, the majority under the choose and book NHS contract. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

The outpatient service also carried out some minor procedures such as steroid injections and removal of sutures.

The diagnostic imaging service had 21 radiologists who worked under practising privileges. The hospital had a cardiac catheter laboratory, fluoroscopy, full field digital mammography (FFDM), plain film, static computerised tomography (CT) and static magnetic resonance (MR) imaging, and ultrasound scanning. Pathology services were outsourced.

The outpatient consulting rooms were being refurbished when we inspected, the outpatients consultations were held along one of the outpatient corridors and in rooms along the Wollaton Ward corridor whilst waiting for completion of the refurbishment.

We spoke with seven outpatients, two imaging patients, four managers, two nurses, one sister, one paediatric/ safeguarding lead nurse, two healthcare assistants, three reception and administrative staff and one consultant.

We observed care, spoke with staff and looked at ten sets of patient medical records.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

We rated this service as requires improvement because:

- Staffing arrangements did not protect patient safety. The hospital depended on bank staff who did not all receive mandatory training, and who were not always available if a child had an appointment at short notice. The hospital did not have a clear system for allocating sufficient nursing staff to support clinics or for booking clinic rooms.
- Equipment checks were not robust to keep people safe. Checks for cardiac monitoring equipment were overdue in diagnostic imaging.
- The hospital had not defined its vision for outpatients or for children's services. Its risk register and risk assessment approach did not include the risks to children, and there were no dedicated areas for children in outpatients.
- The services did not use data and performance monitoring to improve quality. Participation in national and clinical audits and benchmarking was poor. There was a lack of formal monitoring of how responsive the service was for outpatients and no quality and performance dashboard reported publicly.
- Outpatient appointments did not always run on time, and we heard from patients that appointments could be up to 30 minutes later than scheduled.
- Public engagement and learning from patient comments in outpatients was limited. Although there was a corporate range of informative leaflets, there were no specific leaflets for outpatients who were children, or leaflets in alternative formats.

However:

- Staff learnt from safety and quality incidents and shared learning across the hospital, and governance arrangements supported this well. There was an effective process for investigating serious incidents. Staff had a good understanding of safeguarding and how to react to concerns.
- The patients we spoke with told us staff were kind, caring and they were likely or extremely likely to recommend the service. Patients received clear information prior to their appointment and were able to ask questions and get clear responses during their appointment. Nurses, doctors and imaging staff obtained consent to care and treatment in line with legislation and guidance.
- Staff considered the individualised needs of patients when planning care. Services coordinated appointments to enable patients to see a number of services in one day. Nurses, doctors and imaging staff combined their skills well in a good multidisciplinary team approach to meeting the needs of patients using the service.
- The hospital had a clear vision for its imaging services and imaging staff contributed to strategic decisions. Outpatient staff had strong leadership at service level with the ability to problem solve.
- Waiting times for outpatient appointments were within the national guidelines. Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Staffing in outpatients was dependent on bank staff. The hospital did not require bank staff to complete mandatory training if they worked less than 80 hours per month in line with BMI policy, which was a risk to the quality and safety of patient care.
- There were no dedicated areas in outpatients for children and their safety was not fully risk assessed. Because the service depended on bank nurses, a children's nurse could not always be there if a child came in at short notice for an appointment.
- The hospital did not have a clear system for allocating rooms or ensuring that sufficient nursing staff were there to support clinics
- Equipment was not tested systematically in diagnostic imaging, which meant that checks for cardiac monitoring equipment were overdue.

However:

- Staff learnt from safety and quality incidents and this was shared across the hospital.
- Staff at all levels were aware of safeguarding and how to react to concerns.
- There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour (meaning staff should act in an open and transparent way in relation to care and treatment provided). Staff told us they would apologise and inform the patients or their carers if incidents occurred.

Incidents

- There were no never events in outpatient and diagnostic imaging services from April 2015 to March 2016.
- Over the same period, 130 clinical incidents occurred in outpatient and diagnostic imaging services (21% of the hospital total) which was similar to other independent hospital outpatient departments. BMI The Park incidents across the hospital were below the average for BMI hospitals. One serious incident occurred in diagnostic imaging services in June 2016. No serious incidents occurred in outpatients services between April 2015 and March 2016.
- The diagnostic imaging service had a clear process for reporting and learning from incidents. From July 2015 to June 2016, one serious incident occurred, in June 2016. This involved post operatively x-raying a patient twice by mistake. The service reported an Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) incident to the Care Quality Commission in June 2016. Staff contacted the radiation protection supervisors and reported the incident on an incident form, recording the dose, and the radiation protection advisor commented and notified IR(ME)R. Staff explained the double exposure to the patient and apologised. Managers investigated the incident and re-wrote the procedure outlining who could request x-rays so Resident Medical Officers (RMOs) did not duplicate post-operative requests. The imaging service shared this learning at the clinical leads group and integrated clinical governance group meetings.
- BMI Healthcare applied successfully for 'Sign up for Safety' in March 2016. Sign up for safety is a campaign to make all UK healthcare services the safest in the world. As well as putting safety first, this campaign encouraged staff to be open and honest. Staff we spoke with understood the duty of candour. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Staff we spoke with understood their responsibility to raise concerns, and gave examples of issues in outpatients they had raised, for example around consent for an outpatient minor surgery procedure.
- Morbidity and mortality cases were discussed at the integrated governance meeting. There had been no recent outpatients incidents to review when we inspected.

Cleanliness, infection control and hygiene

- Outpatient and imaging areas we visited were visibly clean. Outpatient waiting area carpet appeared worn. Staff told us it was due to be replaced under the refurbishment scheme.

Outpatients and diagnostic imaging

- We saw an infection prevention and control audit feedback form for imaging completed in July 2016 which showed scores of 92% to 100% for the general environment and 100% for patient equipment.
- The services took action following infection control and prevention audits. For example, we saw an action plan for the January 2016 infection control and prevention audit. This identified flaky paint and floor damage in a consulting room, which was an infection control risk. Staff requested repairs and the damage was repaired. The hospital planned to replace other items such as cloth chairs and carpets, which were difficult to keep clean, as part of the outpatients' refurbishment.
- The outpatient service identified the risk from infectious diseases and implemented standard precautions. The hospital did not accept patients with drug resistant tuberculosis (TB) and risk assessed other patients for infections at pre-operative assessment.
- The hand hygiene audit of diagnostic imaging scored 100% in May 2016.

Environment and equipment

- The outpatient environment was not tailored to the needs of children. In outpatients, children and young people sat waiting for their appointments in the same area as adults. Their appointments were not always prioritised. The paediatric and allergy consultants saw children first, which ensured the children did not mix with adults, however other specialities did not. The outpatient area was not monitored and when we visited, the doors were wide open to the car park because it was a hot day. The hospital told parents to watch their children carefully. However, the situation was a risk to child patients and to children who were with adult patients.
- Facilities for children were not located sensitively. There was a children's play area in the corner of the outpatient's waiting room. This had child friendly activities and coloured pens and paper. However, it was next to a television set tuned to a 24 hour news channel which may be unsuitable for children to view.
- Equipment testing was not systematic in diagnostic imaging. We observed cardiology equipment, which was overdue for testing. A scanner in cardiology was due to be tested on 9 September 2015; a treadmill used to monitor the patient's heartrate was due to be tested on 23 June 2014. A portable ultrasound unit and portable x-ray unit had no appliance testing stickers on them, so it was unclear when they had last been checked. Managers monitored equipment maintenance but did not have a failsafe system to ensure all equipment was checked. We told the patient safety director about the out of date items of equipment and they arranged for them to be serviced immediately.
- Managers told us diagnostic equipment maintenance was through an annual contract with the equipment manufacturer. The manufacturers provided a same day response if there was any unexpected breakdown. A neighbouring hospital could provide some MRI scans but only on one day a week. The hospital had an arrangement with the local NHS trust to take their patients if the CT scanner broke down. Most patients had their appointments rescheduled at BMI The Park for later in the day or another day. Staff told us that breakdowns were infrequent, twice in the last year. Pressure and helium levels were checked in MRI scanners once a week, and there were maintenance checks every three months. Scanners were checked daily for faults. If there was a problem staff completed an incident form so trends could be monitored.
- The imaging service kept staff safe by issuing badges (dosimeters) which recorded their level of exposure of radiation. Once the dose had reached a certain level, staff could no longer risk exposure. The service carried spare badges for visiting doctors and new staff. All badges were monitored by a local NHS trust as part of the contract with BMI The Park, ensuring an independent overview.
- We observed staff using personal protective equipment including lead aprons. The lead aprons were scanned annually to check for any areas of weakness so they kept staff safe.
- Scanner suites had warning lights to show when imaging involving radiation was taking place. Staff locked the doors when a procedure was under way. Other diagnostic imaging rooms such as the MRI and mammography rooms were locked with key coded pads. There were private changing cubicles and lockers for patients.
- The hospital invested in diagnostic imaging equipment. It had a digital scanner for mammography which an increased level of detail in scanning since January 2016. Staff told us that they were involved in the process of choosing the equipment for the service.
- Adult resuscitation equipment was checked regularly in the diagnostic imaging suite. Staff told us that children

over 12 years were resuscitated as adults if need be. This is not appropriate as children over 12 years old can vary in size and would need children's resuscitation equipment. We escalated this to senior staff who rectified this by the time we visited on the unannounced visit.

- There was one paediatric resuscitation trolley in the hospital which was located in the outpatient corridor. This was convenient for outpatients but not for diagnostic imaging.
- The paediatric emergency trolley had not always been appropriately checked. We found gaps in the checking of the trolley in August 2016 where the trolley had not been checked on five occasions. In addition, checks were being missed on Saturdays. This meant staff could not be assured the paediatric emergency trolley was ready to be used in an emergency.

Medicines

- Medicines were kept securely in locked cupboards in outpatient consulting rooms. Staff checked the temperatures of the lockable medicine fridge temperatures daily. The medicine keys were kept in a key pad locked cupboards.
- In diagnostic imaging, ultrasound guided injections, oral contrast solutions for computerised tomography (CT) and catheter laboratory service medicines were locked appropriately in cupboards. This minimised the risk of harm from medicines being obtained by the public.
- There were no controlled medicines used or kept in diagnostic imaging services.
- The pharmacy department offered support and advice to staff if it was needed.
- Nursing staff told us that prescription pads were issued to consultants but they did not always remember to return them, so nurses had to ensure that the doctors gave them back before they left site. This meant that the service did not have an audit trail of prescription pads used. We escalated this to the senior team who put a system in place to ensure an audit trail was documented whilst we were on inspection.

Records

- Staff kept patient's medical records safe. Staff sorted them into consultation rooms before clinics and then locked the rooms. The medical records were not left unattended or accessible to the public.
- The hospital ensured that medical records were available at consultations for most patients. From January 2016 to March 2016, the hospital recorded that only two patients out of 10,000 were seen without medical records. This meant that the right information was in place for the consultation.
- The medical records team prepared records for clinics at least three days in advance and kept medical records in a secure area. The team had a medical records tracking system so they could see where medical records were if they were not in the medical records office.
- We saw an audit of record locations carried out in June 2016, which checked the location of ten patient's records selected at random. All ten records were in the tracked location, showing the system was reliable. The service also ensured that imaging and most recent clinic letters were included with the records.
- The hospital had a policy of retaining medical records on site. Consultants understood this as part of their practising privileges arrangements. If they removed medical records by mistake, medical records staff contacted them to ask them to return them immediately.
- We randomly checked seven medical records of outpatients, four of which were for child patients. We found all records to be complete, signed, dated, with risk assessments completed, and clear letters to inform GPs.
- The imaging service was implementing the World Health Organisation (WHO) surgical safety checklist. It used a core set of checks and a new standard operating procedure had been agreed. We reviewed 30 completed checklists from 19 August 2016 to 5 September 2016. We found that 12 had the sign out section of the checklist completed but 18 did not. All sample checklists we saw included a completed sign-in section. The service manager had a standard audit form and planned to carry out a monthly audit of ten random sets of notes, but had not yet audited them.

Safeguarding

- Staff in diagnostic imaging were not trained in level three safeguarding. All staff in outpatients and diagnostic imaging were trained to level two. The children's safeguarding lead, who was trained to level three, chaperoned children in imaging if they needed a scan.

Requires improvement

Outpatients and diagnostic imaging

- Five nurses in the hospital had received level three safeguarding training and the hospital planned to extend this to all staff. One of these staff members worked mainly in outpatients. When we inspected it was not clear about timescales and people to be trained.
- The hospital provided information which showed from April 2015 to March 2016, 27% of medical staff had documented safeguarding training. It did not state the level of training completed.
- The children's safeguarding lead and the director of clinical services attended local safeguarding board training and joint Nottinghamshire multiagency meetings to share information and report back any new information with all the staff at BMI The Park.
- The hospital had a corporate Safeguarding of Children policy and a BMI The Park local safeguarding of children policy, both were reviewed the week before our inspection.
- Staff were vigilant about safeguarding and described a concern they had about some children in outpatients. They had assessed the situation and made a referral correctly.
- The hospital made arrangements for a paediatric bank nurse to attend if there were children planned to come in. Their role was to chaperone children for the consultations. If there was no children's nurse available, there were no children's appointments made. However, staff told us consultants added children to their adult clinic list at the last moment, and it was difficult to ensure that a paediatric nurse with the correct skills attended therefore the children did not have a paediatric nurse present at those times.
- The hospital made parents aware of their responsibilities for their children. In appointments letter they asked parents to bring another adult to supervise the children. They also enlisted the help of parents in managing any challenging behaviour.
- There were corporate policies for action to take if staff suspected child abduction, and the treatment of local authority Looked After Children. Staff were aware of female genital mutilation (FGM) but had not had to use this knowledge so far.

Mandatory training

- Mandatory training was completed using an on-line electronic learning package. The training included basic life support, infection prevention and control, manual handling, fire safety and information governance.
- In outpatient clinics, 96.1% of staff completed mandatory training. This was just lower than their 100% target.
- A process was in place to ensure staff not employed directly by BMI had received the appropriate mandatory training. For clinicians who had practising privileges mandatory training was undertaken through their primary employer. BMI The Park Hospital monitored this at the clinician's bi-annual review. The term 'practising privileges' refers to medical practitioners being granted the right to practice in an independent hospital after being approved by the medical advisory committee (MAC)
- Bank nurses who worked less than 80 hours a month were not required to do mandatory training. We looked at the rota for September 2016 and found that six out of ten bank staff worked less than 80 hours a month. This was a risk to the quality and safety of patients accessing the outpatient service, which relied heavily on bank staff.
- Staff were not put on the rota during their induction period and completed BMI learning, chaperone and consent training.
- All Resident Medical Officers had advanced paediatric life support training. They were on site 24 hours a day, seven days a week.
- Diagnostic imaging staff (all nine out of nine) had basic paediatric life support training and the cardiac catheterisation nurse had intermediate paediatric life support training. Of the seven nurses in outpatients, five had basic paediatric life support training and two had intermediate paediatric life support training.

Assessing and responding to patient risk

- The outpatient service had a range of recently agreed risk assessments. These included lists of environmental hazards such as separation and disposal of waste, prevention of needle stick injury and contaminated equipment. The assessments listed current controls, further actions needed and the person responsible.
- The hospital minimised the risk from refractive eye surgery such as laser treatment and cataract operations. There were local rules and procedures agreed in December 2015, in the outpatients department after a visit from the Laser Protection Advisor. The service also had a named laser protection supervisor.
- The hospital had policies to limit risks to children. It had a children's resuscitation policy which included the use

of paediatric early warning system measures (PEWS), this is a set of observations to identify and alert staff to a deterioration in a child's health, and a care of children policy. Both policies were within date.

- If a patient's health deteriorated suddenly, imaging managers told us they would press the emergency button to alert the resuscitation team. This team included the registered medical officer, nurses, intensive therapy unit staff, a theatre practitioner and a porter. The team were trained in Advanced Life Support. Adult patients were then transferred to critical care. Staff called 999 for children to be transferred to the local NHS hospital trust.
- The radiation protection advisors for the hospital were located at a local NHS trust. The hospital had a contract with the NHS trust for this advice and for patients requiring medical physics treatments. The advisors carried out an annual radiation protection audit. The imaging service had radiation protection supervisors for the cardiac catheter laboratory, computerised tomography (CT) mammography, plain film and theatre imaging.
- The imaging service had a procedure to minimise the risk of radiation to females of childbearing age. It defined women of child bearing age as being between 12 and 55 years and recorded the last menstrual period data on the imaging computer system. If there was an uncertainty that the patient was pregnant, they would not carry out the scan. However, if the patient was unconscious and the procedure was urgent, they would scan the patient.
- Nurses told us that sometimes clinics overran and there were no risk assessments to mitigate this. Nurses told us that finishing late, especially in the winter, was stressful for old and frail people who were worried about their transport.

Nursing staffing

- As of April 2016, outpatient services had 2.2 full time equivalent nurses and a nursing sister. The use of bank staff for outpatients was higher than the average of other independent acute hospitals. The hospital used agency staff as a last resort and when we inspected no agency nurses were working in the outpatient service. For the months of January 2016, February 2016 and March 2016, the service used 30%, 39% and 53% bank nurses respectively and 50% of health care assistants in February 2016 and March 2016 were bank staff. The hospital had recruited an additional staff nurse to work 20 hours a week. The hospital did not have a method of assessing safe nurse staffing in outpatients, and there was no national standard.
- Nurses told us that when a number of clinics happened at the same time, it was difficult for them to staff or to act as a chaperone.
- The hospital could not ensure that the nursing skills mix for clinics was appropriate at any given time because the service depended on bank staff.
- Lack of trained staff sometimes meant that children's appointments had to be cancelled. Staff showed us a clinic list which included a child cancelled because the lead paediatric nurse could not attend.
- There were three full time healthcare assistants in outpatient services.
- When we inspected, there were two agency staff working in diagnostic imaging to cover staff who were off sick.
- Although vacancy rates were higher than average for other independent hospitals, sickness and turnover rates were lower than average. There were 0.6% full time equivalent posts vacant for outpatient nurses in April 2016. This was equivalent to a vacancy rate of 21% which is higher than the average of other independent hospitals. Sickness rates (0%) for outpatient nurses and healthcare assistants were lower than the average of other independent acute hospitals for April 2015 to March 2016. Staff turnover was 7.1% for outpatient nurses and 1% for outpatient health care assistants during the reporting period (April 2015 to March 2016). This was lower than the average for independent hospitals.

Medical staffing

- There were 227 consultants who had been granted practising privileges at BMI the Park (practising privileges is a term used when doctors have been granted the right to practise in an independent hospital). From April 2015 to March 2016, the hospital removed practising privileges for seven consultants for various reasons including retirement and other work commitments. The hospital withdrew practising privileges for a consultant who was rude to staff but later reinstated the consultant, because consultants could re-apply for practising privileges after a year. None of the consultants were under supervised practise.

Requires improvement

Outpatients and diagnostic imaging

- If a consultant was unable to attend the hospital, it was their responsibility to make suitable cover arrangements with another practitioner in the same speciality with practising privileges at the hospital. They also had a responsibility to document the arrangement in the patient's hospital record.
- The outpatient service had a folder which contained the details of all consultants and their specialty, contact number, clinic requests and medications they required for their clinics to run effectively. This meant staff were able to contact them easily.
- There was an up to date electronic list of doctors approved to request x-rays. There was guidance on appropriate requesting of radiation diagnostic tests and staff were confident to challenge inappropriate requests. Radiologists and other professional staff in the imaging service worked under practising privileges with around 20 types of radiological specialism.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant if required. Under the conditions of their practising privileges, consultants working at the hospital had to be accessible 24 hours a day, seven days a week. Staff confirmed they were able to contact consultants when required and had not experienced any problems.

Major incident awareness and training

- BMI The Park Hospital was part of a large group of independently owned hospitals. A business continuity plan identified actions to manage any risks in the event of a disaster or a major event where the hospital's ability to provide essential services was severely compromised.
- The hospital had a business continuity plan was issued in February 2016. This was a corporate rather than local policy, which listed overall responsibilities
- Managers we spoke with were aware of the business continuity plan.
- Outpatient and diagnostic imaging services had a backup generator in place in case of a power cut. The generator was tested monthly.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Inspected but not rated.

We found:

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- There was a good multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of patients using the service.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- Consent to care and treatment was obtained in line with legislation and guidance.
- There were audits completed in accordance with the corporate audit programme.

However:

- Participation in national audits and clinical audits was minimal.

Evidence-based care and treatment

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- BMI The Park participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent. However, there were no specific audits concerning how outpatients or imaging services met NICE or Royal College guidelines, for example on diabetes in adults or diagnosis of chronic obstructive pulmonary disease (COPD).
- The imaging service used diagnostic reference levels (the dose set at the average of a group of patient doses)

to ensure exposures were safe. This included gathering the data and establishing the level for patients within a weight tolerance. Diagnostic reference levels were displayed on the office wall.

- The imaging service did not perform scans for individual health assessment involving computerised tomography (CT) or baby souvenir ultrasound scanning.
- The imaging service had a range of local policies and procedures to ensure that it met the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R. It had an Ionising Radiation Safety Policy which outlined governance arrangements, roles and responsibilities, training arrangements and the terms of reference of the radiation protection committee. They had a procedure to correctly identify the individual to be exposed to ionising radiation,
- Nurses were updating and adding to a set of 'how to' guides for local procedures in outpatients, for example 'flexi cystoscopy.' These guidelines were for nurses and support workers to know what equipment was needed, action and reason for it.
- The Medical Advisory Committee approved new techniques, for example a new approach for hip replacement.
- The hospital did not provide any evidence of clinical audits in outpatient services.

Pain relief

- We asked seven patients in the outpatients department if they were asked if they had any pain when they arrived at their clinics. They were not asked about pain on arrival, but were asked if relevant when they saw a consultant.
- The physiotherapists were qualified to administer complimentary pain relief therapies such as acupuncture and reflexology.

Patient outcomes

- There was no evidence of outpatients and diagnostic imaging taking part in national audits.
- The provider did not participate in the Imaging Services Accreditation Scheme. BMI planned to make BMI The Park a pilot site for the Imaging Services Accreditation Scheme in 2017.
- There was no specific quality or safety dashboard for outpatients or diagnostic imaging. Most of the indicators in the hospital's quality accounts applied to inpatient activity. There was a lack of indicators concerning outpatients or imaging. The hospital monitored quality indicators such as C.difficile infection rates, and responsiveness to the personal needs of patients and number of patient safety incidents reported.
- Commissioners visited services, and monitored the quality dashboard and quality schedule monthly to identify any quality issues. Commissioners from both the contract management and quality teams held monthly meetings with the hospital. The hospital achieved all of the Commissioning for Quality and Innovation Schemes (CQUINS) set during 2015/16 and worked with commissioners to develop stretching schemes for 2016/17. None of these schemes applied to diagnostic imaging or outpatient services.

Competent staff

- Numbers of children using the outpatients and imaging services were low, and there was a risk that staff would not be able to revalidate their children's qualification with their professional nursing body.
- The hospital had expertise in prostate scanning as they had two urologists who were prostate specialists. The service had external accreditation for their prostate and cardiac magnetic resonance imaging. They shared information with other BMI hospitals and advised them on prostate scanning.
- Only competent staff could carry out imaging. There were clear records to show who was entitled to administer radiation. A procedure to identify individuals entitled to act as 'operator,' with named individuals in the practitioner statement specifying which individuals should undertake procedures. Staff signed to show they had read the procedure and understood it.
- All radiographers working in diagnostic imaging at the hospital were trained to their professional body Health and Care Professions Council (HCPC) standard. The imaging service had specialist radiographers for mammography and cardiology scanning.
- The hospital carried out appraisals and supervision for medical staff who were employed directly by BMI The Park.
- Medical staff with practising privileges shared details of their NHS annual appraisal which was a requirement to continue working at BMI The Park.
- Nursing staff had appraisals and the hospital showed us that these were 75% complete halfway through the appraisal year.

Requires improvement

Outpatients and diagnostic imaging

Nutrition and hydration

- There was a drinks machine available in the department for patients to access, and food could be acquired from the hospital canteen.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all members of the MDT. Staff reported they worked well as a team.
- Diagnostic imaging held a one-stop breast care clinic every Wednesday, which included a mammography, a consultation, and any other diagnostic imaging and biopsy if needed. Two breast care specialist nurses linked to the end of life care and oncology service to provide a seamless pathway for patients diagnosed with breast cancer.
- Staff we spoke with all said they had good access to medical staff and could discuss patient related concerns with them.
- The imaging service had a contract with the local NHS trust for medical physics and radiation protection advice. This provided BMI The Park with timely access to advice.
- The consultant completed the child health red book following a child's consultation so there was a comprehensive picture of the child's care for all providers and clinicians to read.

Seven-day services

- Diagnostic imaging services were available from 8am to 8pm from Monday to Friday and from 8am to 2pm on Saturdays. There were out of hours on-call arrangements for weekday nights, Saturday afternoons and nights and Sundays.
- Pharmacy opened from 9am to 5pm Monday to Friday and from 9am to 1pm on Saturdays.
- The hospital held outpatient clinics from 7:30am to 8:30pm on Monday to Friday and from 8am to 2pm on Saturday. However, these clinic times could become extended if they were running late or dependent on consultant availability.
- The hospital offered a general practitioner (GP) service for patients who had difficulty seeing their own GP. This was available Monday, Wednesday and Friday afternoons and patients were given an appointment time of 20 minutes, which was longer than the usual GP appointment.
- The physiotherapy department provided services five days a week, with times to suit patients.

Access to information

- Staff told us scan results were not always included in patient notes. However, consultants were able to view them electronically.
- Diagnostic images were displayed on the electronic patient system so referring consultants could see them straight away before they were formally reported. The hospital had IT support from 9am to 7pm.
- Medical records were requested before patient appointments. Appointment lists were printed off daily, which enabled staff to know which patients were attending.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the need to fully inform patients so they could consent to a procedure. Staff at all levels had a high level of awareness of ethical issues around consent, because of an issue which arose with a patient who needed more than one procedure.
- Hospital staff were aware of the BMI group's policy concerning consent. There were a range of different consent forms; for example adults and children requiring general or regional sedation, a consent form for a parent/guardian to sign for their child for procedures not involving general/regional anaesthesia or sedation, and a form for a patient who is unable to give their consent.
- Staff were aware of the Gillick competencies and Fraser guidelines which enable children deemed by staff as competent to make their own decisions regarding treatment and consent.
- We observed a paediatric consultation where the consultant gave parents and child a full explanation of what the procedure would entail, stopping at key points for the parents and child to ask questions. The consultant was informative, clear, unhurried and reassuring to the family.
- Staff told us they understood the principle of assessing capacity and best interests decisions but that they had not had to apply this knowledge.

Requires improvement

Outpatients and diagnostic imaging

- The hospital's consent audit was part of the corporate audit programme, and focused on surgical procedures rather than outpatients or imaging.
- All staff we spoke to could describe the Mental Capacity Act (MCA) 2005, which was important for outpatients or imaging patients living with dementia or suffering a temporary loss of capacity. Staff were familiar with Deprivation of Liberty Safeguards (DoLS). These safeguards aim to ensure that those who lack capacity and are in hospital are not subjected to excessive restrictions.

Are outpatients and diagnostic imaging services caring?

Good

We have rated caring as good because:

- The patients we spoke with told us staff were kind, caring and they were likely or extremely likely to recommend the service.
- Emotional support was offered to patients when they were discharged home.
- Patients received clear information prior to their appointment and were able to ask questions and get clear responses during their appointment.

However

- Staff did not systematically offer chaperones. We asked six patients if they were asked if they wanted a chaperone. Two told us they were not offered a chaperone.

Compassionate care

- The hospital asked patients to complete a Friends and Family Test postcard (a survey which asked how likely a patient was to recommend the service to their friends and family). In June 2016, 98.2% respondents said they were likely or extremely likely to recommend. However, this figure did not include NHS patients. There were 26 patients who completed the survey after receiving diagnostic imaging or x-ray treatment, and 100% of them said they were likely or extremely likely to recommend the service. They praised the quick appointments and friendly staff.
- Most patients told us staff were kind and that the consultants were 'brilliant' and 'fantastic.' Patients told us that receptionists did not always tell them whether clinics were running on time or not. We spoke with seven patients. One patient complained to us that they were not offered a choice of appointment time and had to see the consultant again before re-scheduling the operation. They felt the hospital did not fully explain why they had to do this.
- Patients told us they had a confidential conversation with the receptionist on arrival and did not feel that their conversation could be overheard.
- The service offered chaperones and advertised this through posters in consulting rooms, but not in waiting areas. Staff were trained in chaperoning and they were provided routinely for intimate examinations. However, same sex chaperoning could not necessarily be assured for men wanting male chaperones. We asked six patients if they were asked if they wanted a chaperone. Two told us they were not offered a chaperone.

Understanding and involvement of patients and those close to them

- Patients told us they received clear information before the appointment, by phone and by text. They also received clear information about when they would receive test results or their next appointment date. Patients also received copies of letters sent between the hospital and their GP.
- Patients told us they had their consultant's contact details and were invited to ring the consultant if they were worried about their condition or treatment after leaving hospital. Self-funding patients told us there were sensitive but transparent conversations about treatment cost.
- We observed clinicians introducing themselves and giving patients reassurance. They explained operational procedure clearly and gave patients or their parent's sufficient time to ask questions at key points of the consultation. We asked a parent how they felt about their child's care and they felt it was excellent and the hospital was very supportive.
- Staff informed patients if there was a planned change of consultant, but told us this was rare. Staff also tried to contact patient if a consultant was due to be unavoidably late for clinic.

Requires improvement

Outpatients and diagnostic imaging

- The hospital did not always communicate costs clearly to patients who paid for themselves. They learnt from a complaint about an extra diagnostic cost, however. To ensure patients received the cost information, they added a line to the patient consent form.

Emotional support

- Patients told us that treatment options were discussed with them and that they were encouraged to make their own decision about treatment.
- Consultations rooms were private and could be used to deliver any bad news.
- Two orthopaedic patients told us the hospital rang them after their procedure to check they were recovering well. They felt this was very caring.

Are outpatients and diagnostic imaging services responsive?

Good

We have rated responsive as good because:

- Services were planned and delivered to meet the needs of the local population. Patients could be referred in a number of ways.
- Services coordinated appointments to enable patients to see a number of services in one day.
- Individualised needs of patients were taken into consideration when planning care.
- Waiting times for outpatient appointments were within the national guidelines.
- The hospital demonstrated a commitment to improve its handling of complaints and to ensure that lessons are learned across the organisation.

However we also saw that:

- There were no specific leaflets for outpatients who were children, or leaflets in alternative formats.
- Outpatient appointments did not always run on time, and could be up to 30 minutes late.

Service planning and delivery to meet the needs of local people

- Medicines were stored in a clinical room, which also doubled as a consulting room in the consulting suite. Nursing staff told us they could not enter the room to access medications as this would compromise patients' privacy and dignity when a consultation was taking place. This meant that it delayed other patient's appointments who needed the medication. A member of staff was in the process of conducting a risk assessment around this issue.
- Consulting rooms were clinically appropriate to treat adults. However, they were not adapted to the needs of children. There were no colourful walls or designs to put children at their ease. Some consultants treating children brought child friendly materials to the clinic, such as colouring books or toys.
- There was sufficient comfortable seating in the outpatient waiting area, and a drinks and snacks machine. The imaging waiting area was newly refurbished and pleasant.
- Patients appreciated the free car parking although it could be difficult to find a space during a busy afternoon.
- Signage throughout the hospital was clear and easy to follow.
- Charging was sometimes confusing for patients. Patients received a bill from consultants, and an additional bill from the hospital. Staff thought that these could be combined into one bill, which covered all charges.

Access and flow

- The hospital worked closely with commissioners on planning and delivering local services, and achieved referral to treatment waiting list targets.
- Patients told us they could get an appointment quickly if they needed one. The hospital monitored its performance on the 18 week referral to treatment target (non-admitted). From April 2015 to March 2016 it consistently met the target of 95% of patients to receive definitive treatment within 18 weeks. A patient who originally booked their appointment for three weeks ahead told us that they wanted to be seen quickly and were able to bring their appointment forward to the same week.
- BMI The Park did not record referral to treatment time for oncology patients, 95% of the oncology patients were referred by consultants on site. When a patient was diagnosed with cancer that required onward referral to an oncologist, the patient will be given options of oncologists and appointments to suit them. There were

seven oncology clinics each week with additional options where required. The senior team we spoke with told us these appointments were available in a matter of days and any patient waiting more than two days did so at their own choice.

- The remaining 5% of referrals came from patients switching from the NHS to BMI The Park for prompt consultations or drugs that may not be available to them within the NHS.
- When the oncologist and patient agreed on a course of chemotherapy or radiotherapy the treatment regime commenced within 24 to 48 hours.
- BMI The Park provided a one stop breast clinic where patients accessed a consultant breast surgeon, a consultant radiologist, a breast care nurse specialist and a consultant oncologist.
- Patients were not always offered a choice of appointment times. We spoke to six patients and the partner of a patient. Two of the patients said that they had not been offered a choice.
- A specialist paediatric bank radiographer carried out children's x-rays. Appointments were planned according to the radiographer's availability.
- The diagnostic imaging service could offer same day or next day appointments. There was a direct NHS magnetic resonance imaging pathway for plain head scans, which benefitted patients with a serious neurological issue. Breast scans (mammography) could be reported quickly, within the same day. Screening mammograms took longer as they had to be reported twice
- The imaging service received very positive feedback from a tournament doctor who needed to organise a CT and MRI scan and report the findings quickly for an athlete. The tournament doctor received reported scans within 24 hours and was impressed with the coordination and responsiveness of the service.
- However, staff and patients told us that some outpatient consultants did not keep to appointment times. Staff estimated the average delay to be about 30 minutes, but did not formally record this. Receptionists told us they informed patients about any delay and offered a rescheduled appointment or a phone call if the appointment concerned test results. While we were at reception a patient complained that their appointment was 30 minutes overdue.
- We spoke to seven patients in the outpatient waiting area. Three patients told us that the reception staff did not tell them whether the clinics were running on time or not.
- Rooms were not always available for consultants who needed them. When we inspected, there were two consultants without rooms in the consulting suite. The hospital found them rooms in physiotherapy area or x-ray. Staff told us there was a room planning document, however, it could be edited by anyone. The hospital did not have a clear system for allocating rooms or ensuring that sufficient nursing staff were there to support consultants or to chaperone.
- If a consultant exceeded their appointment times regularly, managers reviewed the clinic template (schedule). However, they told us the last schedule was revised a year ago and there was a consultant who still overran. Staff told us that the occasional consultant did not turn up and this resulted in the clinic being rescheduled and all the patients re-contacted.

Meeting people's individual needs

- BMI The Park's contractual agreement with commissioners excluded some NHS patients. These were NHS patients: under the age of 18 years; grossly obese with a body mass index (BMI) greater than 40; with incapacitating disease which is a constant threat to life; with an unstable mental condition and receiving psychiatric treatment or if there was evidence that previous anaesthetics led to serious adverse events.
- One NHS patient told us they were unhappy with the lack of choice over appointment time. The hospital suggested an appointment time which was inconvenient for them. Staff told them they would have to meet the consultant again to arrange another time. The patient did not receive an explanation for the reason to see the consultant again. They told us the hospital could offer more information about why they needed to do this.
- The outpatient service held paediatric clinics weekly, up to eight per week. The age range was birth to 21 years and could include children with learning disabilities. There were two or three allergy and dermatology clinics a week, and ENT, plastics and orthopaedics as required.
- The imaging service had no equipment specifically for very obese people but scanners could take a patient of up to 32 stone.

Requires improvement

Outpatients and diagnostic imaging

- Staff provided patients with information leaflets and written information to explain their condition. The hospital also displayed corporate informative leaflets on a variety of conditions in the outpatient waiting area. There were no specific leaflets for outpatients who were children. There were no leaflets in large print or alternative formats on display.
- The imaging service used an interpreting service which was bookable in advance and the most common language they used this for was Arabic. They could also obtain leaflets in other languages. They had no arrangements such as hearing loops for patients who had hearing difficulties, but could book a sign language interpreter to attend the appointment if needed.
- The hospital's website was suitable for visually impaired users. Treatment rooms and toilets were wheelchair accessible.
- The outpatient service did not see many vulnerable adults. All clinical staff had level two safeguarding and annual Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training. Staff told us they had not had to use the MCA two stage assessment.

Learning from complaints and concerns

- Between April 2015 and March 2016. BMI The Park reported one formal complaint which was about the treatment by the consultant. The patient had a meeting with the consultant and was offered a second opinion with another consultant.
- Staff explained the complaint process and gave us an example of how they learned from it. An outpatient complained about paying more than expected for their procedure. Staff logged the complaint and wrote an apology letter to the patient, enclosing a complaints leaflet. The hospital investigated the complaint and refunded the money to the patient because they had not explained the costs properly. They planned to amend their consent form to clarify what costs patients could expect.
- The hospital demonstrated a commitment to improve its handling of complaints and to ensure that lessons are learned across the organisation in response to patient feedback through active participation in peer review using the Patients Association Good Practice Standards on complaints handling. The Park was a member of the Nottingham and Nottinghamshire Health and Social Care Complaints Network.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Public engagement and learning from patient comments in outpatients was limited.
- The risk register had not identified risks to children in outpatients or developed actions to mitigate them.
- There was a lack of formal monitoring of how responsive the service was for outpatients and no quality and performance dashboard reported publicly.
- The hospital had not defined its vision for outpatients or for children's services

However:

- The hospital had a clear vision for its imaging services. Staff felt involved in determining the way forward and in important capital investment decisions.
- Governance arrangements ensured that learning from incidents and quality issues was communicated.
- Outpatient staff had strong leadership at service level with the ability to problem solve.

Vision and strategy for this this core service

- The service had clear corporate and local organisational values but the vision for the future for outpatient services was less specific.
- The BMI group's brand promise was to be "serious about health, passionate about care." Its four core themes were safety, clinical effectiveness, patient experience and quality assurance, showing that safety and quality were high priorities. Staff we spoke to demonstrated these values. Managers told us the vision was to expand outpatient service provision.
- The hospital was refurbishing the outpatient consulting suite and cardiac catheter laboratory when we inspected. However, the hospital was still discussing action plans and strategies for children's and outpatient's services, so the vision for these services was unclear.
- The strategy for diagnostics was to invest in new equipment and the best technology. Radiographers were involved in these decisions. The hospital bought

new MRI equipment in January 2016, showing an investment in their future. It also had a new digital mammography machine. The refurbished cardiac catheter laboratory (cathlab) was also part of the vision for growth.

Governance, risk management and quality measurement for this core service

- The hospital held effective monthly meetings with the executive director to address governance issues. The meetings included the Medical Advisory Committee (MAC) meeting, and bimonthly integrated governance meeting and a monthly clinical lead group which focused on problem solving. We looked at a number of clinical governance and MAC meeting minutes and saw that incidents and learning from incidents near misses were discussed. The clinical lead group monitored audits, quality, incidents and risk.
- Staff in outpatients had a daily 'catch up' (handover) meeting to discuss any incidents or new guidance and plan the work for the day.
- Other specialty service meetings took place in their areas and the team leads were responsible to feed back to staff and escalate concerns to the senior management team. As a result, there was a two-way flow of information about quality and safety.
- Imaging services staff attended quality related meetings. The lead radiologist attended the MAC and integrated clinical steering group. This aimed to standard practice and review quality measures.
- Meetings were effective at operational level. There was a daily outpatients handover meeting which enabled nursing staff and care assistants to share information. The sister gave staff feedback, for example about refurbishment and ENT equipment movement and adaptation and discussed the fire safety standard operating procedure. There was time for staff to ask questions, ensuring that it was inclusive.
- The hospital had a monthly outpatients meeting with the chief executive where they discussed staffing, any operational problems, procedures and refurbishments, and any other problems or issues.
- The risk register did not recognise all of the risks to patients. There were no dedicated outpatient's children's facilities and they were not kept separate from adults. When we inspected, children were waiting in an area where the external doors to the car park were wide open. The hospital reminded parents of their responsibilities. The environment, however, was not child friendly.
- There was a backlog of patient letters of about a week due to medical secretaries staffing issues. Medical secretaries told us there was no transparent structure, scale or grading system for pay or advancement in the organisation. They felt they were paid at differing levels and that this could be divisive. It was a recognised problem but management had not taken action.
- The hospital met with commissioners regularly to discuss performance. However, we saw no publicly reported quality or performance dashboards which monitored outpatient responsiveness, for example, in clinic wait times, or monitoring of patients with longer referral to treatment times.

Leadership / culture of service

- The hospital strengthened the leadership of outpatients in March 2016 when it recruited an experienced outpatient sister to manage the service, and a registered nurse with a keen interest in outpatient services. Staff told us the sister was approachable and it was easy to talk to her about any concerns they might have. The hospital recognised the need to further strengthen leadership and was recruiting a Director of Clinical Services when we inspected.
- The sister and her deputy recognised many risks and areas for improvement and set up a work plan to address these. For example, they drafted a number of risk assessments for outpatient clinics and identified that there was no equipment training, the service lacked procedures and that late running clinics were a risk to patients.
- Radiologists told us they felt supported by the director of imaging and the imaging steering group.
- Staff described the hospital as a supportive place to work and 'like a family.' Many staff were long serving.
- However, administrative, unqualified and some qualified nursing staff told us that morale was variable because of staffing and salary levels. They thought the hospital was dependent on the goodwill and dedication of its employees. For example, the medical secretaries were working in excess of their hours to try to catch up with a backlog of consultant's letters.

Requires improvement

Outpatients and diagnostic imaging

- Consultants did not always set a behavioural example. Staff told us a small minority of consultants were rude when they were frustrated about insufficient medication being prepared, or lack of consulting rooms or chaperones being available. Staff had started to record incidents of rudeness, but we did not see how this information was being used.

Public and staff engagement

- Evidence of patients influencing the quality of outpatient services was limited. The hospital had a Patient Satisfaction Group, which was attended by heads of department. This focused on the ward however, and a 'you said, we did' poster was on the ward notice board. Apart from a staff uniform chart posted on the wall, there had been no specific improvements for outpatients resulting from patient feedback.
- The hospital carried out a patient satisfaction survey; patients were encouraged to complete them to improve services.
- The hospital staff were invited to participate in the corporate BMI Healthcare staff survey.
- The executive director had engaged with staff through monthly catch up meetings, where information was shared and staff were able to raise concerns.
- Imaging staff told us they were involved in the hospital's decision making processes, for example, they were on the working group which procured the new mammography scanner. They had also been consulted about the new magnetic resonance imaging (MRI) scanner bought in January 2016.

Innovation, improvement and sustainability

- All staff were focused on continually improving the quality of care for patients. Staff felt that the refurbishment would enhance patient experience and care.
- Award from the Macmillan Quality Environment Mark (MQEM); a quality framework for assessing whether cancer care environments meet the standards required by people living with cancer.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that all staff have an appropriate level of adult safeguarding training.

Action the provider SHOULD take to improve

- The hospital should consider displaying NHS safety thermometer data so that it can be seen by patients and staff.
- The hospital should ensure that daily consultant reviews are documented in the patient medical records.
- The hospital should consider providing a child friendly environment.
- The hospital should ensure that daily consultant reviews are documented in the patient medical records.
- The hospital should ensure national early warning score documentation is consistently completed.
- The integrated governance committee should include staff from all levels within the hospital.
- The hospital should display leaflets and information for patients on how to complain.
- The hospital should provide information for patients in different languages.
- The hospital should ensure seating is washable in patient areas.
- The hospital should audit the imaging reporting turnaround times.
- The hospital should review the risk register regarding the risks posed to children in the outpatients waiting area.
- The hospital should define their vision for the provision of children's services.
- The hospital should formally monitor how responsive the service was for outpatients.
- The hospital should produce specific leaflets for children.
- The hospital should have a clear system for allocating rooms to ensure that sufficient nursing staff are able support booked clinics.
- The hospital should have an induction pack and mandatory training for bank staff to complete.
- The hospital should test equipment systematically in diagnostic imaging.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **13(2) Systems and processes must be established and operated effectively to prevent abuse of service users.** **How the regulation was not being met:** The registered provider must ensure all clinical staff have an appropriate level of adult safeguarding training.