BMI The Park Hospital

Quality Report

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

Overall summary

BMI The Park Hospital is operated by BMI Healthcare Limited. The hospital has 66 beds. Facilities include five operating theatres, a five-bed level two care unit, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care and outpatients and diagnostic imaging. We inspected surgery.

We carried out an unannounced focused inspection of BMI The Park Hospital on 30 May 2019, in response to concerning information we had received in relation to the management of the regulated activities at this location.

During this inspection we inspected using our focussed inspection methodology. We inspected the key questions of safe and well-led only. We did not provide an overall or key question rating at this inspection, as we did not carry out a comprehensive inspection.

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

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

Our findings were:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff knew how to access systems to allow them to complete their training
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled most infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Summary of findings

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The hospital had a vision for what it wanted to achieve and a set of values, to turn it into action. The vision and values were patient focused.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.
- Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.

However:

- Having a carpet in the corridor did not conform with Health Building Note 00-09: Infection control in the built environment.
- In two treatment rooms, both for clinical use, taps were aligned to run directly into the drain aperture. This meant contamination from the waste outlet could be mobilised and did not conform with Health Building Note 00-10 Part C.
- We found inconsistences with daily temperature checks and found there was a total of 11 days between 1 March 2019 and 30 May 2019 where there had been no fridge temperature checks.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		During this inspection we inspected using our focussed inspection methodology. We inspected the key questions of safe and well-led only. We did not provide an overall or key question rating at this inspection, as we did not carry out a comprehensive inspection.

Summary of findings

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BMI The Park Hospital

Services we looked at:
Surgery

Summary of this inspection

Background to BMI The Park Hospital

BMI The Park Hospital is operated by BMI Healthcare Limited. It is an independent hospital registered with the Care Quality Commission to provide a range of treatments and procedures to people in an inpatient and outpatient setting. It is an independent healthcare hospital in Arnold, Nottinghamshire. The hospital primarily serves the communities of Nottinghamshire but does however, accept patient referrals from outside this area. The hospital provides inpatient services to adults and children over the age of 12 and outpatient services to the whole population.

The hospital has had a registered manager in post since December 2018.

Our inspection team

The team that inspected the service comprised a CQC inspection Manager, Michelle Dunna, one other CQC inspector, and a specialist advisor with expertise in surgery. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about BMI The Park Hospital

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

The hospital is registered to provide the following regulated activities:

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

Surgical facilities at BMI The Park Hospital includes 66 individual en suite patient rooms divided over two wards. Rufford Ward is predominately for surgical and medical inpatients, whilst Wollaton Ward is mainly for pre-op assessment, day case and ambulatory care patients. There are five operating theatres and an eight-bedded recovery area for patients recovering immediately post-surgery.

During the inspection, we visited Rufford and Wollaton wards and the operating theatres. We spoke with 28 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, doctors and senior managers. We spoke with two patients.

During our inspection, we reviewed:

- Six sets of patient nursing and medical records
- Four NEWS2 charts
- Three medicine administration records
- Observed two surgical procedures.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected five times, and the most recent inspection took place in May 2018, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (May 2018 to April 2019)

- In the reporting period May 2018 to April 2019, there were 2,319 inpatient and 5,337 day case episodes of care recorded at this hospital; of these 34% were NHS-funded and 66% other funded.

Summary of this inspection

- During the same reporting period 2,319 patients stayed overnight at this hospital; of these 29% were NHS-funded and 71% other funded.

One hundred and eighty two surgeons, 75 anaesthetists, two physicians and 15 radiologists worked at the hospital under practising privileges. There was one regular resident medical officer (RMO) who worked on a rotational one week rota. In addition, a further RMO worked in the level 2 unit. The service employed 77 registered nurses (38 contracted / 39 bank), 40 health care assistants (23 contracted / 17 bank) and 47 receptionist (37 contracted / 10 Bank), as well as having its own bank staff.

The accountable officer for controlled drugs (CDs) was the registered manager who was also the executive director.

Track record on safety (May 2018 to April 2019)

- Two never events.
- Clinical incidents 516 no harm, 162 low harm, 19 moderate harm.

Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA).

Eleven incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA).

Zero incidences of hospital acquired Clostridium difficile (c.diff).

Zero incidences of hospital acquired E-Coli.

Eighty seven complaints.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Histology
- RMO provision

Surgery

Safe	
Well-led	

Are surgery services safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Mandatory training was a mix of e-learning and face to face training sessions. All staff were expected to complete annual updates and protected time was provided mostly during working hours and managed by the department managers. Staff told us that if mandatory training was completed in their own time then their managers would add this to their roster to ensure they were paid.
- Mandatory training and non-mandatory training was booked online by the individual staff members. After the training had been requested this was then approved by managers. Staff told us that they were notified on their online learning programme when their training needed to be updated. Managers were able to view all staff training records to monitor the completion rates.
- Examples of training included manual handling, infection prevention and control, fire safety, safeguarding training and recognising a deteriorating patient which included sepsis training. The completion rate of mandatory training between the reporting period from April 2018 to April 2019 ranged from 80.8% to 94.4%. At the time of our inspection the most up to date data provided by the service showed that the completion rate for mandatory training was 90.4%, just above the service's target completion rate of 90%
- Staff had access to additional training necessary for their role. For example, a training package was being developed for registered nurses and assistant practitioners to enable them to care for patients who had undergone cardiac surgery.
- The resident medical officers (RMOs) received mandatory training through their RMO agency.
- Staff told us that there was no specific training around care of patients with learning disabilities and autism. Staff did tell us that there was dementia awareness training and dementia champions. A dementia champion is someone with excellent knowledge and skills in the care of people with dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

- Staff were trained in the safeguarding of children and adults to a level appropriate to their role. Senior staff received training at level three. Staff told us that they had received training on female genital mutilation (FGM).
- All staff we spoke to were aware of their responsibilities within safeguarding. They knew who the safeguarding lead was for children and adults. There was also posters displayed in staff areas with the safeguarding lead details on and how to contact them. Staff told us they would approach these individuals should they need advice or need to refer a safeguarding concern to the local authority.
- Safeguarding policies and procedures were available to all staff through the provider's intranet.

Cleanliness, infection control and hygiene

The service controlled most infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The service ensured systems, process and practice reflected National Institute for Health and Care Excellence (NICE) CG74 regarding surgical site Infection (SSI). As of May 2019, the hospital's SSI rate was at 0.5%. This was better than BMI Healthcare Limited (0.54%) and better than the national average (0.9%).

Surgery

- Between May 2018 and April 2019, the hospital had zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) and zero incidences of hospital acquired Clostridium difficile (c.diff).
- Patients who needed a vascular access device had their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device. Staff had been trained and competency assessed in Aseptic Non Touch Technique (ANTT). ANTT is a tool used to prevent infections in healthcare settings.
- There was infection prevention and control patient risk assessments tools in place. These were completed pre-operatively and risk assessments for Methicillin-resistant Staphylococcus Aureus (MRSA), Creutzfeldt-Jakob Disease (CJD), wound infection risk and any other additional identified patient risks.
- There was a named infection prevention and control (IPC) Nurse, staff were aware of who this was and how to contact them for advice. Raising awareness of IPC practices and developing IPC link practitioners to facilitate continued improvement in patient outcomes had been implemented.
- All staff were seen to be adhering to the bare below the elbow policy. Sanitising gel available to use on entry to the ward within patient rooms and in corridors. Staff were seen to use the sanitising gel and practiced good hand hygiene techniques.
- The wards, theatres and recovery areas were visibly, clean and tidy. This included clinical areas, corridors, bathrooms, offices and storage rooms.
- On the wards there was a system for ensuring equipment was clean. 'I am clean' stickers were clearly visible, dated and signed to indicate cleaning had taken place. We observed patient-care equipment to be visibly clean. Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients.
- 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. In theatres a staff member was seen wearing the appropriate clothing as per guidelines. This included gown, elbow long clothes mask and visor, they were seen to appropriate dispose of infected items of clothing before leaving the processing room.
- Ward staff told us that they followed specified procedures for patients who required a urinary catheter and its removal as soon as it was no longer needed. We saw that this was recorded in the patients' record and completed correctly. This was to minimise risk of infection.
- In the theatre suite, there was a designated area and appropriate equipment available for the cleaning of endoscopic equipment. Other equipment used for surgical procedures was cleaned and sterilised off site by an external provider.
- Patients were treated in individual rooms apart from in the recovery area, intensive care unit and the ambulatory care unit, where disposable curtains were used to provide screening and privacy for patients. Dates were in place on the curtains to identify when they needed changing.
- 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 to reduce risk of cross contamination between patients. Hand hygiene audit data provided by the hospital from April 2018 to April 2019 showed 100% compliance in all areas apart from outpatients which had a compliance rate of 95%.
- An observational was carried out to check that standard precautions were being adhered to, and on the cleanliness of patient equipment (Standard precautions are the infection prevention measures that should always be adopted by all healthcare workers.) Audit data from April 2018 to April 2019 showed 100% compliance.
- Staff working in theatres who were involved in the decontamination of endoscopes were trained by an external company. We saw expiry dates of endoscope sterilisation was clearly documented.
- At the time of our inspection staff told us that the decontamination machines used for endoscopes were not working. To ensure that endoscopes were decontaminated they were being sent to an external provider. All endoscopes were cleaned with the correct disinfectant and placed in a sealed bag within a container ready to be taken for decontamination.
- In two treatment rooms, both for clinical use, taps were aligned to run directly into the drain aperture. This meant contamination from the waste outlet could be mobilised and did not conform with Health Building Note 00-10 Part C.

- A carpet was in place on the corridor in the ward area. Carpets should not be used in clinical areas. This includes all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances. This did not conform with Health Building Note 00-09: Infection control in the built environment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- All inpatients were accommodated in en-suite private rooms, which were located off the main ward corridors, and were equipped with a nurse call bell and emergency buzzers.
- On the wards and in theatres the resuscitation trolley was checked daily. Checklists were available on resuscitation trolleys and these were completed daily.
- Resuscitation equipment was safe and ready for use in an emergency. We checked at random ten single-use items all of which were sealed and in date. There were service stickers on emergency equipment showing it had been serviced and was up date.
- The operating department was modern and purpose built. It included five operating theatres, one theatre was dedicated to endoscopy and minor local anaesthetic procedures.
- Within the theatre we saw staff follow regulations around accountable items. Accountable items are items that are not retained in the patient following a surgical procedure, for example surgical instruments, sponges and sutures. All accountable items were documented on paperwork and checked by two members of staff, one of which was a qualified practitioner.
- We saw a safety tested sticker was attached to electrical items showing when it had been inspected. All items we checked in theatre were in date and were safe to use. Of the ten pieces of electrical items we checked on Wollaton ward, one item did not have a visible safety tested sticker demonstrating when the equipment was next due for service. This was brought to the attention of staff at the time and the piece of equipment was immediately removed from the ward area to ensure it would not be used, the asset number required for servicing was noted so service of the equipment could be arranged.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

- Pre-operative assessments were provided for patients undergoing planned surgery to identify any co-existing medical conditions, identify the level of individual risk, and prepare patients for their procedure**.** Administration staff told us that all patients would receive a minimum of a phone call for a pre- operative assessment. If during the telephone pre-operative assessment there were any uncertainties about the patient being suitable for the procedure they would be invited to a face to face pre-operative assessment where more information could be obtained.
- There was access to an on-site level two and three critical care facility supported by an on-call consultant intensivist from a local NHS trust. A 'Care and Communication of the Deteriorating Patient' (CCDP) course was delivered on a rolling programme to registered nurses. Content included NEWS2, sepsis and acute kidney injury (AKI). Staff could identify and respond appropriately to deteriorating patients.
- Nursing staff used a national early warning scoring system (NEWS2) to record routine physiological observations including blood pressure, temperature, and heart rate. NEWS2 was used to monitor patients and to prompt support from medical staff when required. We reviewed four sets of patient observations and found that these had been completed correctly.
- We did not see evidence of a sepsis tool being used within the records we looked at, as none of the four sets we reviewed indicated that this was required. All staff we spoke with told us that they knew how to use the tools provided to identify potential sepsis.
- The hospital had a service level agreement (SLA) with the local NHS acute trust, ambulance service and the local critical care network. These 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.
- We observed a pre-operative team brief, all theatre staff were present and discussed each patient's requirements, procedures, and equipment and identified any potential issues. During our inspection it

was identified that a patient was listed to have a left side joint replacement but had consented to a right side joint replacement, an electronic incident form was completed and the surgical list order was altered so that the incident could be resolved. Post-operative de-brief was observed, both the pre-operative and post-operative team briefs were documented.
- We observed two surgical procedures, the World Health Organisation (WHO) safety checklist procedure had been followed correctly during a surgical both procedures. We reviewed WHO safety checklists in three sets of patient records and found that they had been correctly completed.

Nursing and support staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Surgical patient admissions were known in advance, staffing was calculated using an electronic staffing tool. This ensured staff numbers were planned according to how many patients there were. The level of staffing could also be adjusted depending on patient need. Additional staff could be allocated if patients with additional needs were identified.
- Staff told us that they usually had enough staff to keep patients safe. All staff we spoke to told us that they were well supported by their managers within the department they worked in.
- There were paediatric trained nurses available who led and coordinated the care of children. Staff told us that when caring for children a member of staff trained in European paediatric advanced life support (EPALS) was available.
- There were registered nurses on the ward and in the chemotherapy day unit that had obtained additional training with Macmillan to support patients admitted for cancer treatment.
- We observed a handover of patients between nursing staff and physiotherapy staff on the ward. This took place in a room behind the nurses station with a closed door to maintain patient confidentiality
- The hospital held a register of bank staff who had worked at the hospital before. Bank staff were employed by the hospital to cover unfilled shifts for example, sickness or annual leave. On occasions the hospital would use agency nurses to cover unfilled shifts. Managers told us that they liked to use agency staff that had worked shifts in the hospital before where possible.
- The average use of bank nurses between April 2018 and April 2019 was 10.3%. For the same reporting period average agency use was 0.25%.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- There were 274 consultants who worked at the hospital under practising privileges. These included surgeons, anaesthetists, physicians and radiologists. Practising privileges refers to medical practitioners being granted the right to practise in a hospital after being approved by the medical advisory committee (MAC)
- As part of their practicing privileges consultants were to visit inpatients each day and were contactable by telephone 24 hours a day, whilst they had patients in the hospital. At the time of our inspection we saw entries in two in patient medical notes advising staff of which consultant was covering and overseeing the care of their patients while they were away.
- Resident medical officers (RMOs) provided medical cover 24 hours a day. RMOs worked a seven-day roster and were on call for emergencies 24 hours a day. The RMOs worked at the hospital regularly and knew the hospital and its routine well.
- RMOs were employed by the hospital through an agency. Mandatory training for the RMOs was the responsibility of the agency which employed the RMOs.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- Patients' individual care records, including clinical data, were written and managed in a way that kept patients safe. Nursing records were kept at the patient's bedside in patient rooms. Medical records were kept in a separate secure room behind the nurses station.
- There was a system in place that allowed staff to visually see if a patients notes had been completed for

admission and if they were ready for theatre. They also used a labelling system that matched the room the patient was in to advice where the notes were for example in theatre.

- We reviewed six sets of inpatient medical and nursing records. Nursing records included prescription charts, observation charts, risk assessments and care plans, all clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.
- We found that medical records were legible, accurately completed and up to date. We saw two consultant entries that advised staff as to who was looking after and overseeing the care of their patient's while they were away.
- Integrated care records/care pathway 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.
- On discharge, discharge summaries were sent to the patient's general practitioner (GP). Summaries included, where appropriate, any medication changes. A copy of the summary was also given to the patient. The GP summaries were sent electronically however, staff we spoke to told us that not all GPs used the same system and some were unable to receive an electronic copy. Staff were alerted by the electronic system when the discharge summary had been sent, if there was no alert then staff told us they printed a paper copy for the patient to give to their GP by hand.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

- Medicines were stored securely in locked cupboards in each department. Stock levels were monitored by ward and pharmacy staff. For inpatient drug rounds nursing staff used drug trolleys, we checked ten randomly selected drugs from two drug trolleys. The medicines were found to be in date and appropriately stored. Staff had used stickers on bottled liquid drugs to alert other staff as to when it had been opened.
- We looked at controlled drugs (CDs) . Controlled drugs are medicines liable to be misused and requiring special management. We checked the CD register and found these to be in order. We saw stock balances of CDs were checked daily by two members of staff. All checks were signed and dated.
- Controlled drugs were double locked (kept in a locked cupboard inside another locked cupboard) and mounted to an internal wall. Staff told us that CDs were always checked and administered by two members of registered staff.
- We observed that medicines requiring cool storage were stored appropriately and fridge temperatures monitored daily. Medicine room temperatures were also checked daily. However, we found inconsistences with daily temperature checks and found there was a total of 11 days between 1 March 2019 and 30 May 2019 where there had been no fridge temperature checks.
- We looked at three prescription and medicine administration records (MARs) on the wards and theatre. We saw administration of medicines was being recorded appropriately. 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.
- All surgical implants used in theatre suite were documented in a register and included relevant patient details as well as product identifying information.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

- Between May 2018 and April 2019 the hospital reported two never events. We were assured by managers and the senior leadership team that these had been reported and investigated appropriately and lesson were learned to prevent similar incidents occurring. 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.
- Including the two never events, between May 2019 and April 2018 the hospital reported 708 clinical incidents. Of the total number of clinical incidents 516 were no harm, 162 were low harm, 19 were moderate harm and nine were serious incidents
- All staff that we spoke to during our inspection told us that they were encouraged by managers to report incidents and near misses. Staff new how to raise an incident or near miss and told us this was done by completing a form on an electronic incident reporting system.
- Staff told us that they received feedback from any incidents that they had reported this was sent to their work email. Staff informed us that they were made aware of learning points and feedback from other incidents through team meetings.
- Incidents and near misses were discussed at monthly clinical meetings which were attended by a manager or senior team member from each department. This was then shared with staff by their managers.
- All staff were aware of their responsibilities around duty of candour and could give examples of when it would need to be applied. Duty of candour is when the organisation is required to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

Are surgery services well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- Executive leadership at this location was provided by an executive director, who was also the registered manager, a director of clinical services and a director of operations.
- The overall lead for the surgery service was provided by a Clinical Service Manager (CSM) and included the ward areas and pre-op assessment. An additional CSM was the lead for theatres.
- Leaders understood the challenges to quality and sustainability and cited their biggest challenge as nurse staffing. Nurse staffing was managed through the use of 'regular' agency and bank staff. Staffing shortages were communicated, on a daily basis, through the 'Comm cell' communications meeting held with the executive leadership team.
- Generally, leaders were described as visible and approachable and staff described strong, visible leadership at executive level. However, some CSMs felt disempowered as a result.
- Clear priorities were in place for ensuring sustainable, compassionate, inclusive and effective leadership. Staff development included access to a 'level three' leadership and management training course (ILM). At the time of our inspection, 13 staff had commenced this course in March 2019. In addition, the director of operations had commenced the CMI level five leadership and management course. This course is part of the Operational leaders Advance apprenticeship course. It is a work based programme of experiential learning and study.
- Healthcare assistants or support workers were encouraged to train as assistant practitioners (AP). APs in nursing, are university trained to competently deliver health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistants or support workers. Three APs were in post in the ward areas and one in the pre-assessment unit.
- There was a lead for mental health within the hospital who had appropriate expertise in this area. An occupational health nurse had attended a Cognitive Behaviour Therapy (CBT) course, had a National Vocational Qualification (NVQ) in mental health awareness and was a qualified adult educator and a qualified Psychologist. The occupational health nurse's working hours had recently been increased to offer mental health related education and awareness to staff.

Vision and strategy

The hospital had a vision for what it wanted to achieve and a set of values, to turn it into action. The vision and values were patient focused.

- The hospital vision was "…to be the hospital of choice for patients, staff and consultants delivering outstanding care you can trust; let's achieve excellence together".
- Underpinning the vision were five values collectively known as "Playing your PART": **P**assionate, **P**atient focussed, **A**ccountable, **R**espect and **T**rust.
- Staff knew and understood what the vision and values were. Without exception, all staff demonstrated the hospital's values during their day to day work.
- Anonymous information received prior to our inspection suggested senior managers {the executive team} at this hospital did not always behave in such a way as to reflect the vision and values of this hospital. We did not observe this during our inspection. The inspection team spoke with seven members of staff, when asked about the behaviours of the senior team all agreed senior managers did demonstrate the vision and values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.

- Anonymous information received prior to our inspection suggested a bullying culture across the hospital. We did not observe this during our inspection. The inspection team spoke with seven members of staff specifically about how well-led the service was. None raised concerns regarding 'bullying'.
- Generally, we saw a culture centred on the needs and experience of people who used the services with staff who felt positive and proud to work in the organisation. However, there were small 'pockets' of staff who described the culture as "improving, but not there yet".
- Employee engagement indicators were included in the 2018 BMiSay staff survey. The employee engagement index (EEI) is derived by applying weighting to the positive responses, corresponding to their degree of positivity (100 for Strongly Agree, 80 for Agree). The overall engagement index for this hospital was 70/100. This was significantly higher than the score of 61/100 achieved in 2017 and was significantly higher than the overall provider score of 63/100.
- Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. A Freedom to Speak Up Guardian (F2SUG) had been in post since December 2018. Since this date there had been one staff contact. Staff we spoke with were aware of the F2SUG.
- Processes and procedures were in place to ensure the service met the duty of candour. For example, duty of candour training was included in the provider's Documentation and Legal Aspects e-learning module. As of May 2019 overall compliance was 95.6%.
- The provider ensured that they complied with the Competitions and Marketing Authority (CMA) Order that came into force in April 2015 by not inducing any of the consultants to bring patients to the hospital. All consultants were treated the same.
- There were mechanisms for providing all staff at every level with the development they needed, including for example appraisals. As of May 2019, the overall appraisal compliance rate for bank staff was 94.6% and substantive staff was 96%. This was better than the hospital target of 90%.
- Arrangements were in place for granting and reviewing practising privileges (PPs). The service currently had 291 consultants working under PPs. PPs were reviewed biannually. As of May 2019 there were 73 (25%) outstanding biennial reviews. Of these, 28 (9.6%) had been booked in for forthcoming appointments, 45 (15%) were to be arranged. Senior leaders told us, due to consultants' schedules the service experienced challenges to book reviews. The data however indicated, that substantial improvement had been made since the new executive director had been in post.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities.

- Hospital clinical governance meetings were held monthly. We reviewed the minutes of six meetings and saw where there had been good attendance which included the executive director and the chair of the medical advisory committee (MAC). Minutes included for example, a review of actions from previous minutes, a review of the clinical governance report, lessons learned from RCA reports (if applicable), a review of clinical performance / regulatory compliance issues, a review of risks and IPC performance.

- All levels of governance and management functioned effectively with information shared at senior management level through to ward/department level. Weekly senior management team meetings were held to discuss operational issues and plan future projects. Heads of departments (HOD) met monthly to update all clinical service managers of current plans and future strategies and ward/department meetings were held monthly with HOD and teams.
- In addition, there was monthly clinical governance, health and safety and facilities meetings.
- There were effective arrangements in place to ensure good channels of communication; for example, comm cell, staff forum and staff engagement forum.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and we saw a good reporting culture. Lessons learned, and themes identified from reported incidents were shared widely. Staff demonstrated a good awareness of recent Never Events and serious incidents that had occurred in other BMI Hospitals.
- The hospital medical advisory committee (MAC) met bi-monthly. We reviewed the minutes of six meetings. Minutes were clear, balanced and demonstrated an appropriate level of challenge. Standard agenda items discussed included for example; the executive director report, the clinical governance report, medical performance report, quality improvements, the risk register and consultant applications for practicing privileges.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- There were arrangements for identifying, recording and managing risks, issues and mitigating actions. Recorded risks aligned to what staff told us was 'on their worry list' and to anonymous information received by us prior to this inspection. Recorded risks included for example, staffing, lack of trained staff in endoscopy to meet Joint Advisory Group (JAG) accreditation and an increased number of staff at retirement age.
- Anonymous information received prior to our inspection suggested staffing levels were low and impacted negatively on staff breaks, the delivery of care and treatment and sickness levels. During this inspection we observed staff to be busy. However, staffing levels met planned levels and patients were observed to be receiving safe care and treatment in a timely way. Whilst most staff, we spoke with, raised staffing as a concern, most staff felt staffing levels had been appropriately addressed over the previous months and felt there was an improving picture.
- Following our inspection we received the staff utilisation data for the reporting period April 2018 to May 2019. Data showed, that over time, the service had become more efficient with utilising their staff.
- The service considered developments to services or efficiency changes and assessed and monitored the impact on quality and sustainability.
- We saw an information board in the hospital meeting room. The board was designed such that any member of staff could easily see how the hospital was performing. It was discussed in heads of departments meeting and the staff forum. Where a segment was not green an action plan was developed to improve performance. The action plan would then be attached to the hospital improvement board.
- In addition, the hospital improvement board was where anyone could suggest an idea for improvement to develop services or improve efficiency. The ideas were then discussed at senior management level where they were ranked depending on payback potential, importance for safety and difficulty of implementation. Safety issues were always rank first and then the rest were picked by ease of implementation and biggest payback.
- A member of the senior management team would be made accountable for the project and would pull together a suitable team to deliver.
- Potential risks were taken into account when planning services. A Business Continuity Plan (BCP) aimed to ensure BMI The Park Hospital core business was maintained during unexpected interruptions, such as an internal major incident (e.g. fire, flood) or a severe or protracted emergency, such as influenza pandemics. This policy applied to all staff.
- There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems were in place to identify where action should be taken. Overseen by the quality and risk manager audits included for example,

infection prevention and control (IPC), WHO surgical safety checklist, medicines management, governance and cash management. In addition, a clinical self-assessment audit was routinely completed by heads of departments and staff.

- An annual executive summary was submitted to the provider by the executive director of the hospital. We reviewed the executive summary (dated December 2018) and saw evidence of processes in place to manage and monitor current and future performance of the hospital. The summary included for example; providing support to a local NHS trust for orthopaedic surgery, length of stay, net revenue for inpatient stays and improvements and developments within the hospital.
- In order to monitor and track progress for individual departments the provider had developed an electronic platform for discussion, data collection, digital storage and action planning all in one place. We reviewed the electronic platform and saw where appropriate actions were in place following a particular audit. For example, an action following an IPC audit had been to discuss consultant IPC practice at the medical advisory committee (MAC). The electronic platform showed the date this had been completed and by whom.
- The service had a strategy for continuous improvement in infection prevention and control, which included the use of the National Nosocomial Infection Surveillance (NNIS) SSI risk score. NNIS SSI risk scores have been shown to be reliable indicators of patients' overall risks for surgical site infection.

Managing information

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

- Policies and guidelines were available to staff through the 'BMI Learn' platform. In addition, policies and guidelines were advertised through the hospital 'weekly news'. Staff had 30 days to read new policies whereupon they were expected to click complete on the platform. Staff compliance was monitored through the hospital clinical governance meetings.
- Staff had sufficient access to information and were given opportunities to challenge if appropriate. A monthly staff forum for all staff was delivered by the executive director and included information such as for example, the vision and values, patient satisfaction, profit, coding, serious incidents and the future.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The views and experiences of staff were gathered and acted on to shape and improve the services and culture through the 'BMiSay' engagement survey. The 2018 BMiSay staff survey was launched on 03 December and closed on 21 December 2018. Results for this hospital showed the hospital had improved on their 2017 scores in all but one question (51/52); I can rely on the other people in my team. The survey also showed, the percentage number of engaged employees had significantly increased from 37% in 2017 to 51% in 2018.
- The provider engaged with the public through a patient satisfaction survey based on the NHS Friends and Family Test (FFT). BMI Healthcare has 58 private hospitals across England, Scotland and Wales. In the North region BMI The Park Hospital was one of 19 hospitals. Results for this hospital showed the hospital to be in the top 10 for overall quality and second for patients extremely likely to recommend the hospital as a place to receive treatment.
- We reviewed the executive director's current executive summary for this hospital and saw evidence of partnership working with a local NHS trust to help improve services for patients. Plans were in place to offer additional surgical capacity to the trust in a bid to relieve winter pressures.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

- Leaders and staff strived for continuous learning, improvement and innovation and we saw considerable improvements had been made in infection prevention and control (IPC) practices. Improvements included for example; raising awareness of IPC practices and developing IPC Link practitioners to facilitate continued improvement in patient outcomes, the development of an IPC induction programme for all new starters,

improved reporting processes for infections to enable the service to capture and treat infections early and prevent outbreaks' revisiting the anti-microbial stewardship policy for testing pre-operative urines to reduce the number of unnecessarily prescribed antibiotics in patients with no signs and symptoms of infection, a new service level agreement with UK Orthopaedic Microbiology Society (UKOMS) to improve outcomes and treatment processes for patients, an enhanced Aseptic Non Touch Technique (ANTT) programme to facilitate clinical performance and keep infection rates continually low and a standard operating procedure (SOP) to ensure adequate advice and cover in the absence of the IPC Lead.

- In addition, further improvements and developments within the service included for example; increased ratings on public websites due to a continued focus on patient satisfaction, improved Mandatory training from 80% in June 2018 to 91.9% in December 2018, completing the first Angioplasty since Feb 2018 and reducing coding errors from 40% to 22% due to increased focus.
- The service had introduced multidisciplinary pharmacy ward rounds focussing on pain, antimicrobials, Deep vein thrombosis (DVT) prophylaxis and medication side effects.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure carpet in the corridor conforms with Health Building Note 00-09: Infection control in the built environment.
- The provider should ensure all clinical use taps conform with Health Building Note 00-10 Part C.
- The provider should ensure there is consistency with daily fridge temperature checks.