Clifton Park Hospital Limited

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Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated it as good because:

- The patient's environments were safe, clean and well maintained.
- The service implemented robust process with respect to safeguarding.
- The service always had enough staff. Managers ensured that these staff received training, and appraisal. The staff worked well together as a multidisciplinary team.
- Care plans were individualised and included discharge plans.
- Staff planned patient discharge well and liaised with services that would provide aftercare. Patients lengths of stay were short.
- Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They involved patients and families and carers in care decisions.
- The service was well led, and the governance processes ensured that procedures ran smoothly.

However:

- Gaps were noted in the radiology risk assessments. We saw that the action by whom, action by what date, sign when complete fields were not always completed.
- Monitoring of spill kits checks was not documented in the outpatient's area.
- It was not clearly identified that anaphylaxis audits had taken place as they were not identified on the resuscitation trolley audit documentation. The February 2022 resuscitation trolley checklist initially provided as evidence did not specify the areas or locations in which the resuscitation trolleys were located and / or checked. We noted on the resuscitation checklist provided post inspection that anaphylaxis kit checks were documented and had taken place. However, the checklist did not specify the actual location of which resuscitation trolley was checked.
- Signage and directions to the outpatient department location were not always clear.

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving

Summary of findings

services continually.

We rated this service as good because it was safe, effective, caring, responsive and well led.

Outpatients

Good

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- The service managed safety incidents well, learned lessons from them and demonstrated changes to practice as a result.
- Staff provided good care and treatment.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. The service engaged well with patients and the community to plan and manage services.

Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, effective, caring, responsive and well led.

Diagnostic and screening services

Good

We rated it as good because:

Summary of findings

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients and monitored their pain. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Gaps were noted in the radiology risk assessments reviewed as the action by whom, action by what date, sign when complete fields were empty.

Summary of findings

- Monitoring of spill kits checks was not documented in the outpatient's area.
- It was not clearly identified within the radiology department that anaphylaxis audits had taken place as they were not identified on the resuscitation trolley audit documentation.

Diagnostic and screening services are a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

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Summary of this inspection

Background to Clifton Park Hospital Limited

Clifton Park hospital is an independent hospital owned by Ramsay Health Care that is registered to provide the following regulated activities:

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

The hospital has a manager registered with CQC.

The hospital provided a range of elective surgery treatments for NHS and other funded (insured and self-pay) adults in orthopaedics and cosmetic surgery specialties.

In October 2018 Clifton Park Hospital engaged in a partnership with North Yorkshire Orthopaedic Surgeons to form a new registered company – Clifton Park Hospital Ltd. As part of this, outpatient clinics are run from a separate dedicated outpatients building which is in close proximity to Clifton Park Hospital which contained 11 consulting rooms, two treatment rooms and x-ray facilities.

The surgery service had an in-patient ward with 24 inpatient beds, across both single and double rooms. There was also a dedicated pre-assessment clinic. There was an ambulatory day care unit, and two operating theatres and a dedicated recovery area. The hospital also has access to on-site physiotherapy a mobile MRI scanner and a mobile CT scanner.

Our inspection was unannounced (staff did not know we were coming). This was the first time we had inspected this service.

How we carried out this inspection

During the inspection visit, the inspection team:

- Inspected and rated all five key questions.
- Visited the ward, operating theatres, post anaesthetic care unit (recovery area), pre-assessment clinic, ambulatory day care unit, sterile services department, outpatient and diagnostic imaging departments.
- Looked at the quality of the environment and observed how staff were caring for patients.
- Spoke with the registered manager and senior management team for the service.
- Spoke with 40 other members of staff including all grades of medical, allied health professionals, nursing and administrative personnel.
- Spoke with 17 patients who were using the service.
- Reviewed 34 patient records.
- Observed surgical pre-assessment clinics.
- Attended two diagnostic patient consultations.
- Attended two multidisciplinary safety meeting and one physiotherapy meeting.
- Observed one theatre procedure.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

After our inspection, we reviewed performance information about the service and information provided to us by the hospital.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Diagnostics

- The service should ensure that anaphylaxis kits audits are identified clearly on the audit documentation.
- The provider should ensure that radiology risk assessments sign when complete fields are completed and updated as necessary.

Outpatients

- The service should ensure that signage and directions to the service location are reviewed and clarified.
- The provider should ensure that the monitoring of spill kits is documented.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Diagnostic and screening services	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are Surgery safe?

Good

Mandatory training

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

Staff received and kept up to date with their mandatory training. We reviewed training compliance records for all departments within the service. Records showed compliance 91.56% against a corporate annual target of 85% across the hospital. In surgery, (wards and theatre) compliance was 92%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff accessed training through both online e-learning modules and face to face practical skills sessions.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Resident medical officers (RMOs) were employed through a national agency and completed mandatory training with their agency. The hospital received confirmation of the training and kept a record of attendance.

Managers received regular reports that outlined any mandatory training modules that would need to be completed by staff. Managers made staff aware of this and displayed this information within communal staff areas. Managers we spoke with explained consultant staff attended mandatory training at their employing NHS trust, and this was monitored through the appraisal process and as part of a regular credentialing meeting.

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.

The hospital had safeguarding and chaperone policies in place, which contained references to appropriate legislation and best practice guidance. Whilst the service did not see patients under the age of 18, staff received training in safeguarding children.

Staff received training specific for their role on how to recognise and report abuse. Compliance for children and adult safeguarding level one training across the hospital, was 90% and 95% respectively. Where applicable to their role, staff had undertaken additional safeguarding training levels. The RMO received safeguarding training via their agency. Consultants completed safeguarding training at their employing NHS trust and a record of this was kept on their practising privileges file.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the named safeguarding lead for the service and felt able to seek support. We saw contact details for local authority teams displayed throughout the service.

Cleanliness, infection control and hygiene

The service controlled infection risk 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.

Staff accessed hospital infection prevention and control policies on the intranet. The service had also implemented a board assurance framework (BAF) in relation to infection, prevention and control that outlined additional measures to be taken to prevent the spread of COVID-19.

Initial key COVID questions were asked for all patients attending the site as part of the patient's telephone booking and again on arrival to the hospital. Patients could also access the COVID-19 frequently asked questions page on the hospital website.

Patients were risk assessed 14 days prior to surgery and advised to follow either the green or green plus pathway. The length of isolation was dependent on their individual risk factors and required individualised care and shared decision making.

All patients who underwent surgery at Clifton Park Hospital were screened for MRSA prior to their procedure. There were no incidences of a healthcare associated infection in the last 12 months.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Patient seating was impermeable and could be wiped clean. We saw disposable curtains labelled with the date they were last changed. We observed that cleaning records had been completed and were up to date for toilets located on the ward.

The service generally performed well for cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were compliant with arms 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance. We observed staff washed their hands, use hand sanitising gel between patient interactions and changed their personal protective equipment (PPE) where required. This was also confirmed by patients we spoke with.

Good

Surgery

We observed public areas had posters and were clearly marked to promote Covid-19 awareness, hand hygiene and social distancing.

All operating theatres had laminar airflow. Laminar airflow is used to separate volumes of air or prevent airborne contaminants from entering an area. Sterile services equipment, such as surgical instruments, was decontaminated onsite within the sterile services department.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff worked effectively to prevent, identify and treat surgical site infections. Surgical patients were screened for healthcare acquired infections and risk assessments were incorporated into the patient's health record.

The hospital had a designated infection prevention and control (IPC) lead. The hospital had a very low rate of hospital acquired infections and participated in mandatory surveillance of surgical site infections for elective joint surgery. Surgical site infections were monitored by the service and were low.

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.

The design of the environment followed national guidance. We saw documented environmental and Covid-19 risk assessments. All fire extinguisher appliances inspected had been serviced within an appropriate timescale. Exits and corridors were clear of obstructions.

The pre-assessment clinic was located on the ground floor. Lay out of the rooms and equipment was consistent with good access principles. Theatres and ward areas were located on the upper floor. Access to theatre areas was controlled by a fob key.

Patients could reach call bells and patients we spoke with told us staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment. We reviewed the emergency resuscitation equipment trolleys located within theatres and on the surgical ward. These were sealed with numbered with tamperproof tags in place. We reviewed checklists that demonstrated the trolleys had been checked daily and the contents checked weekly in accordance with local policy. The service undertook regular audits of resuscitation equipment. The service maintained regular checks on all decontamination equipment, which were clean, serviced and maintained appropriately.

The service had suitable facilities to meet the needs of patients' families. The service had an ongoing service support contract in place to ensure that planned preventative maintenance of equipment was scheduled.

The service had enough suitable equipment to help them to safely care for patients. There were systems for recording the servicing and maintenance of equipment identified through a central log and equipment compliance stickers, which indicated the dates tests were due.

Staff disposed of clinical waste safely.

Good

Surgery

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

The service implemented an admission criteria, against which patients were assessed for suitability to be treated within the service.

Staff used a nationally recognised tool called the national early warning score (NEWS2) to identify deteriorating patients and escalated them appropriately. The service had a service level agreement with the local NHS trust for emergency transfer of patients. The hospital had a resuscitation policy in place. The RMO was advanced life support (ALS) and European paediatric life support (EPLS) trained. Senior leaders and all staff we spoke with told us they participated in periodic emergency resuscitation scenarios, including major haemorrhage, to test skills.

Pre-assessment was by telephone, face to face and/or a pre-admission medical questionnaire. Discharge planning was considered at this stage; especially requirements for home care packages or involvement of other agencies.

Staff completed risk assessments for each patient in consideration of the hospital's admissions policy, using a recognised tool. They reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. There was a recognition and management of the deteriorating patient policy, which included sepsis. Staff we spoke with were clear about signs and symptoms of deteriorating patients and gave examples of when and how they would escalate a concern. We saw displayed throughout theatres and wards posters prompting staff to remain vigilant for the signs of a deteriorating patient. The service had a clear process in place to manage any incidents of significant blood loss.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Shift changes and handovers included all necessary key information to keep patients safe. We observed a daily, 9:30am multidisciplinary safety huddle, with representation from all departments. Themes discussed included clinical workload, staffing and operational risks. Staff within theatres and ward areas had access to handover documentation that outlines key areas such as incidents, patient feedback and safety alerts.

The hospital conducted observational and documentation audits of compliance with world health organisation (WHO) safer surgery checks. We reviewed the 6 monthly Intra-Operative Journey observational audit which showed 100% compliance with completion of documentation and observed practice. This concurred with WHO safer surgery checks we observed during our inspection.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Patients we spoke with told us staff were always available to assist them.

Good

Surgery

The ward manager could adjust staffing levels daily according to the needs of patients. We reviewed staffing rosta's for the November 2021 – January 2022. The hospital offered pre-booked elective services to patients which allowed for effective planning of staffing, to meet clinical needs. Theatre managers ensured staffing levels were in accordance with the Association for Perioperative Practice (AFPP) minimum staffing guidelines. The surgical ward manager used a safer staffing tool when calculating required staffing levels.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low and reducing vacancy rates; the hospital had 12 vacancies across the service at the time of the inspection, four of which were newly created positions.

The service had a higher than expected sickness rates. As of January 2022, the service had a sickness rate of 8.66% against a target of 3.5%. However, the rate included all Covid-19 related absence, which was the main cause of elevated sickness rate in this reporting year.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank, agency and new staff had a full induction and understood the service.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. There were two locum RMOs who worked alternate weeks, with handover on Thursdays. The RMO was on site 24 hours a day. The RMO we spoke with confirmed they had adequate rest and sleep and felt supported by the consultants and nursing staff.

Managers could access locums when they needed additional medical staff. For example, if the RMO was sick.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

The surgery service was consultant-led. All patients were admitted under a named, validated consultant with practising privileges. The term 'practising privileges' means medical practitioners not employed directly by the hospital but approved to practise there.

Consultants conducted daily ward rounds. This was confirmed by patients we spoke with. Consultants were always contactable by telephone for advice.

There was always appropriate anaesthesiologist cover. Yorkshire Anaesthetic Group provided the service with required anaesthetic cover and a corresponding rota that was provided to the service on a recurring basis one week in advance.

Good

Surgery

Surgical and anaesthetic consultants remained responsible for their patients throughout their stay in hospital and were required to be available within 30-45 minutes or to arrange cross cover with another consultant if they were unable to provide the required level of availability. For example, during annual leave. If a radiologist was required, this was initiated by a consultant surgeon or on-call radiographer.

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.

The hospital had a patient records policy, referenced to general data protection regulations (GDPR) and data protection act 2018.

Patient notes were comprehensive, and all staff could access them easily. Records were predominantly electronic. The exception was medicine prescription charts and a few historic paper records of current patients. The electronic system was introduced November 2021 and staff we spoke with told us they received training.

We reviewed eight sets of electronic patient records. They were detailed, with appropriate nursing risk assessments and individualised care plans. For example, in relation to falls risk and pressure area care. Records contained a nationally approved sepsis-6 screening pathway, completed where applicable. The service undertook regular audits of medical records to ensure compliance. We reviewed audit data that showed the service had an average total score of 93%.

Records were stored securely with individual staff password access. Screens were closed and locked when unattended.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines management audits were completed for all departments and we noted high compliance scores.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed patient's medicines prescription records accurately and kept them up to date. We looked at eight prescription records and all were completed legibly and correctly.

Staff stored and managed all medicines and prescribing documents safely. We saw diligent recording of medicine fridge temperatures and ambient room temperatures where medicines were stored. We reviewed anaesthetic equipment logs that demonstrated daily checks were undertaken of anaesthetic machines and accompanying trolleys.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

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.

Good

Surgery

Staff we spoke with knew what incidents to report and how to report them on the electronic incident reporting system. Staff were aware of the services incident reporting policy and a serious incident investigation policy. They gave specific examples of learning from incidents and changes in practice, which improved patient safety.

Staff raised concerns and reported incidents and near misses in line with provider incident reporting policy.

The service had one never event in theatres in the past 12 months which had been reported and investigated fully prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The service completed regular audits of their compliance in relation to duty of candour and kept a contemporaneous log of incidents where this applied. The service ensured all correspondence relating to duty of candour was documented within the log.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received copies of 'close the loop' reports relating to internal investigations. Close the loop reports were also displayed in staff communal areas for review. Managers signposted staff to these when available. Staff also received a corporate email bulletin containing information relating to incidents where learning may apply to other organisations.

Staff met at handovers and departmental team meetings to discuss the feedback and look at improvements to patient care. The meeting minutes were shared afterwards with all appropriate staff. Patient feedback relevant to the surgical department was displayed within communal staff areas for staff to review.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Are Surgery effective?

Good

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service monitored compliance against the hospitals policies throughout the year by following a corporate audit schedule. We reviewed the results of audits that had been completed prior to January 2022, which showed high rates of compliance across all audits undertaken. These had been completed using an electronic platform, which enabled the provider to easily identify areas for improvement. Action plans were able to be generated from audits completed.

Good

Surgery

Staff we spoke with explained that best practice guidance was regularly reviewed by the head of clinical services. Any changes to guidance were then cascaded down to staff through regular team meetings, staff emails and through their intranet. Heads of Department and the Head of Clinical Services met regularly to discuss and changes in guidance and undertake GAP analysis (a process used to compare current performance with desired and/or expected performance) where required.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Hostesses provided patients with menus and were able to discuss directly with patients any modifications that they may require. All patients we spoke with told us that there was a variety of choices and that the quality of food was good. Mealtimes were specified but flexible according to patient needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients were informed of fasting requirements verbally and in writing at pre-assessment. The service had implemented processes to ensure that there was communication between theatre staff and ward staff regarding food and fluid intake. Staff we spoke with confirmed they followed national guidance which stated patients should receive clear fluids up to two hours and food up to six hours prior to surgery. Post-operative patients and those experiencing nausea and vomiting were routinely prescribed antiemetic (anti-sickness) medicine.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. For example, on the ward, and in theatre recovery, we saw pain scores were monitored as part of the NEWS2 records.

Patients we spoke with told us their pain was managed well and they received pain relief soon after requesting it. The service completed patient experience survey in which pain and nausea management were covered. The service had an average score of 9.6/10 against a corporate average of 9.3/10.

Staff prescribed, administered and recorded pain relief accurately. Staff we spoke with confirmed that if there were concerns regarding the management of pain, these could be escalated to an anaesthetist for review.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were positive,

consistent and met expectations, such as national standards. We reviewed the most recent published Electronic Patient Outcome Measures (ePROMS) data we for the period January 2021 to December 2021, showed patients had a slightly lower than average health gain score and post-operative scores for private hip replacements. However, the service had not been identified an outlier.

In relation to NHS procedures, for the period Apr 20 – Mar 21 ePROMS data reviewed highlighted full pre-op participation rates combined for hip and knee arthroplasty and 70.9% post-op participation rates. The hip health gain score for the service was 23.976, which is above the national average. The knee health gain for the service was 16.571, which is below the national average but had not been identified as an lower outlier.

Managers we spoke with explained they have focused on increasing patient participation and trialling electronic submissions to increase the data and enable an improvement score which they could work to improve against.

The provider had continued throughout the COVID-19 pandemic to submit data to the National Joint Registry (NJR).

The service also submitted information to the private healthcare information network (PHIN). This included information on unplanned transfers, unplanned returns to theatre, unplanned readmissions within 31 days, infections rates, mortalities, patient satisfaction and the number of patients seen. PHIN ensures robust information is received about private healthcare to improve quality data and transparency. The hospital was not identified as an outlier for any of the above listed areas.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. Audit results were regularly discussed at clinical governance meetings as well as ward meetings. Information was made available to staff and displayed in staff areas – but had not been displayed in any public areas.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service ensured that where applicable, consultants were listed on the relevant speciality register.

Managers gave all new staff a full induction tailored to their role before they started work. All staff (including bank and agency) are provided with a role specific induction pack, which includes details of all required mandatory training, competencies and policies to be reviewed and completed. In addition, new starters are provided with a named 'buddy' for additional support.

Managers supported staff to develop through yearly, constructive appraisals of their work. Overall compliance for the service regarding appraisals was 95% as of February 2022. All staff we spoke with commented that they had continued to receive regular appraisals.

Good

Surgery

All consultants had an annual whole practice appraisal and were required to provide evidence of medical indemnity insurance, a nominated covering consultant, a disclosure and barring service (DBS) check, occupational health status and relevant specialist training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, theatre managers outlined that where cancellations had occurred last minute – staff were able to use this time to complete additional learning and training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The service implemented a continuous professional development policy. Staff we spoke with told us that they had been supported by the service to access additional courses to develop their leadership and management skills.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The multi-disciplinary team consisted of nursing staff, consultant surgeon, anaesthetist, pharmacy, physiotherapy and RMO. Consultants were available to attend the service for emergency needs.

Staff worked across health care disciplines and with other agencies when required to care for patients. Doctors, nurses and allied healthcare professionals supported each other to provide good care. Staff held regular and effective multidisciplinary meetings.
The hospital employed a team of physiotherapists who supported patients pre and post-surgery to improve their surgical outcomes

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Consultants were available 7 days a week to provide support to patients under their care. Consultants undertook daily patient reviews and ensure patients remained informed regarding their care and treatment.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Ward staff can access diagnostic services such as x-ray, microbiology and pathology seven days a week. The service had access to anaesthetists, pharmacists and physiotherapists 7 days a week and there is a dedicated on-call rota.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Good

Surgery

Staff assessed each patient's health as part of their pre-operative assessment and provided support for any individual needs to live a healthier lifestyle. Staff provided procedure-specific information leaflets. This facilitated informed consent and enhanced patient recovery by providing better understanding of what to expect and their role in their own recovery. Patients we spoke with confirmed they received useful verbal and written information prior to admission.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The hospital consent policy described consent as a two-stage process. The service undertook regular audits of the completion of consent documentation within patient records, with the results demonstrating high compliance with the providers policy.

Staff clearly recorded consent in the patients' records. Patients we spoke with told us they were provided with enough verbal and written information, to enable them to give informed consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with described the training they received. Training on capacity had been incorporated into the adult safeguarding modules and additional lunch and learn sessions delivered by the head of clinical services. Staff knew how to access policy and get accurate advice on mental capacity act and deprivation of liberty safeguards (DoLS). Staff we spoke with explained patients were individually risk assessed against specified admission criteria and the hospital rarely had patients subject to DoLs orders.

Are Surgery caring?

Good

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. For example, we observed staff preserved patient privacy and dignity by ensuring curtains were closed around them and bedroom doors were closed in accordance with their wishes. All patients we spoke with stated that they felt staff took as much time as required when interacting with them, and that they did not feel rushed during interactions.

Patients said staff treated them well and with kindness. All patients we spoke with praised staff for their caring approach. Patients felt comfortable asking staff for assistance when required. Patients told us that staff treated them with compassion and care. We observed that within staff areas, letters and cards that had been written to staff thanking them for their kindness had been displayed.

Good

Surgery

Staff followed policy to keep patient care and treatment confidential. During our inspection, we observed prompt responses to call bells and patient requests for hot drinks.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Visiting restrictions were in place due to Covid-19, and visitors were subject to risk assessment if patients required emotional support of a named relative. Staff we spoke with explained patient pastoral support needs could be accommodated following risk assessment.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

There were restrictions in place for relatives accompanying patients to pre-assessment clinic, due to Covid-19. However, staff we spoke with explained patients may be accompanied by a named carer following risk assessment. This provided patients and those close to them the opportunity to learn about the treatment they were going to receive and ask questions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service obtained feedback from patients through measures such as the friends and family test (FFT), electronic patient experience surveys, and face-to-face patient participation groups. All patient feedback is collated by the service into a customer focus report which is reviewed at the customer focus group. This is attended by representatives from across the service and members of the senior leadership team.

Staff involved patients in decisions about their care and treatment. All patients we spoke with told us they felt fully informed about their treatment plans and arrangements for discharge.

Patients gave positive feedback about the service. The most recent feedback from the friends and family test was positive. The patient overall satisfaction score for patient experience taken from the December 2021 Private Hospitals independent Network (PHIN) data was 95.3%. This was higher than the corporate average of 92.1%. We observed feedback from patients was shared with staff at the morning safety huddle, as well as displayed in communal staff areas.

Staff we spoke with gave us examples of how they used patient feedback to improve daily practice.

Are Surgery responsive?

Good

We rated it as good.

Good

Surgery

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The registered manager had worked hard to promote a positive working relationship with other health providers in the area. For example, a range of services were available for NHS patients where commissioners had identified capacity shortfalls or for patients who wished to exercise their rights of flexibility and choice, under the e-referral system (previously known as choose and book). The service had continued to work in collaboration with local NHS providers to address backlogs in elective procedures for patients waiting longer than 52 weeks.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Wards were designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities.
The service had developed a dementia friendly room, that had been decorated with a dementia friendly colour scheme, and all signs had been printed in larger fonts. Wards and departments were accessible for patients with limited mobility and people who used a wheelchair. Toilet facilities were available throughout the hospital for patients, carers and relatives including those living with a disability

We observed discussions between staff groups regarding reasonable adjustments that could be made for a patient attending the service with a learning disability. Adjustments were discussed and planned in advance to ensure staff awareness on the day and a positive experience for the patient.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Patients were provided with printed information regarding risks and benefits of surgery and could review this before their procedure. To comply with the accessible information standard, the provider had a contract for this information which was updated annually and could be downloaded to be available in different formats, to ensure patients of all abilities had access to important clinical information. This was referred to in the consent policy.
The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Pre-assessment staff identified individual needs such as hearing, sight or language difficulties or disabilities. Translation services were available by prior arrangement, for patients where English was not their first language.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment. We observed discussions between staff ensuring the service would have communication tools for a patient who was scheduled for the service and was unable to verbally communicate. This was discussed prior to the patient attending to ensure staff awareness of the patient's needs.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Patients were referred to the hospital by their GP, self-referral or NHS referral. Data was submitted monthly to NHS England and as at the end of January 2022, average percentage of patients treated within 18 weeks of referral was 99.6%

All patients were chronologically managed in accordance with the prevailing 18-week guidance, and were clinically prioritised in order of urgency. A single waiting list was managed at the hospital which consists of patients utilising the electronic referral service (ERS), inter-provider transfers from surrounding NHS organisations and privately funded patients. An allocation of theatre capacity was set aside for private patients.

The service regularly reviewed wait times through a Future Slot Utilisation Report. This report highlights the services have been utilised, any available slots, areas where additional capacity may be required. This enables the service to quickly respond to the demands of the services on offer and plan shifts accordingly.

The service received regular updates regarding their NHS electronic referral service (ERS) performance as part of a corporate reporting programme. We reviewed results for the November 2021 – January 2022 reporting period which demonstrated high performance

Theatre utilisation across both theatres at the time of the inspection was 62%, based on an estimation of 2000 cases being operated on per theatre per year for the November 2021 -January 2022 period . Leaders had outlined that utilisation had been impacted due to an increase of cancellations driven by the emerging new COVID-19 variant. Senior leaders outlined that work was ongoing with surrounding NHS organisations to aid and support the management of NHS waiting lists – which subsequently will increase utilisation.

At the time of the inspection, the service was in the process of recruiting additional ward staff to ensure the full capacity of both the inpatient ward and day ward could be utilised. This in turn would allow the service to further increase theatre activity, with ward staff available to provide the required pre and post-operative nursing care.

Managers and staff worked to make sure patients did not stay longer than they needed to. For example, data we reviewed for the current period showed the average length of stay for inpatients was 2.82 days and for all patients, against the hospital target of 2.0. The service had identified that the increase in average length of stay was due to the complexities of patients being received into the service who have been transferred from local NHS organisations who have multiple co-morbidities and waited an extensive period of time for treatment. As a result, these patients required additional time to mobilise after surgery.

Good

Surgery

Managers worked to keep the number of cancelled operations to a minimum. Reasons for cancellations were discussed routinely at governance meetings. We reviewed cancellation data for November 2021 – January 2022, which outlined 104 cancelled operations (average 17.3 per month) equating to 8.8% of total admissions in this same timeframe. 21% of cancellations were due to patients testing positive for COVID; 7% were staffing issues due to staff either being COVID positive or isolating; 14% patients chose not to proceed for non COVID reasons and 13% were medically unfit to be treated within the service.

Leaders we spoke with outlined that where possible, the service would look to implement measures to reduce the impact of cancellations such as theatre staff staying later than planned or delaying the start of theatre so the scrub team can run 2 lists consecutively.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discussions relating to discharge were undertaken with patients as part of their pre-assessment appointment, where appropriate. Where patients may require additional support, staff were able to make appropriate referrals during pre-assessment to ensure this would be available for patients at the point of discharge.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. All patients we spoke with commented they felt able to speak with staff to raise concerns. Patients had also been provided with a leaflet outlining the complaints process as part of their information package.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them in accordance with the complaints policy.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning was shared across the hospital in the daily morning huddle, head of departments meeting, medical advisory committee and departmental team meetings.

Good

Surgery

Are Surgery well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. 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 met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role.

The hospital was led by a newly appointed hospital director with prior hospitals management experience. They were supported by the head of clinical services, who was very experienced, and a broader senior leadership team.

The hospital was supported by the wider regional cluster and corporate management team.

All staff we spoke with considered the leadership team to be visible. For example, they attended departmental meetings, regularly walked round the hospital and spoke with patients and staff. Staff told us that the newly appointed hospital director had undertaken significant work to ensure their visibility within the service.

The Medical Advisory Committee (MAC) was proactive and engaged with the work across the hospital. The MAC chair met with the hospital director weekly and discussed any emerging risks and issues.

There were regular staff huddles and briefings across departments to ensure that frontline staff received all relevant information and improvement initiatives.

Staff we spoke with told us how management and senior leaders had supported them to take on more senior roles, strengthen existing leadership arrangements and held discussions relating to succession planning.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had a vision and strategy for what it wanted to achieve and workable plans to turn it into action, which the senior leadership and heads of departments shared with staff.

The strategy had three transformational goals and four key strategies that underpinned the overarching vision for the service. This linked into the strategic developments that had been set by the corporate provider Ramsay Health Care and the three-year business plan for the service. The hospital's strategy included a focus on building long term partnerships with stakeholders, which included local NHS hospital trusts and community in the support of their recovery activity.

Good

Surgery

Staff we spoke to understood the organisational strategy and vision and we saw this displayed in public and staff areas. Staff told us that they had been encouraged to submit ideas and to work collaboratively as to how the vision and strategy could be delivered, and that their contributions had been welcomed by the senior leadership team.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against strategy and plans.

Culture

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

All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. We saw there were suitable rest areas for staff. Staff we spoke with described staff wellbeing groups that were set up to support staff during the pandemic. Staff told us that they utilise group conversations on social media platforms to access informal support when required.

Staff could also access support from occupational health and an external counselling service if needed; there were posters that signposted staff to contact details.

Staff at all levels were actively encouraged to speak up and raise concerns. Staff we spoke with described an 'open' culture, and that this had significantly improved with the appointment of the new hospital director. Staff told us that the hospital director had worked to improve communications with staff and had pro-actively worked to improve the culture within the service. Staff told us that they felt more engaged, supported and valued as a result of this.

There was a policy to enable staff to 'speak up for safety' if they had concerns about colleagues professional behaviours. All staff we spoke with were aware of this, had received training and told us they felt empowered to challenge behaviours.

There was a violence at work policy to support staff. Violence and aggression were recorded as incidents and investigated.

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance arrangements were proactively reviewed using a board to ward framework and reflected best practice.

The hospital had a medical advisory committee (MAC) which met quarterly. Meeting minutes we reviewed followed a fixed agenda and were thorough.

There was a policy in place for management of consultant practising privileges. Review included General Medical Council (GMC) registration, appraisals, indemnity insurance, and disclosure and barring service checks. The MAC reviewed all applications annually. The service had established a dedicated credentialing committee that met regularly. The meeting followed a set agenda that reviewed all credentialing requirements for consultants working within the service.

Good

Surgery

The Chair of the MAC met regularly with the hospital director. These meetings included the review of serious complaints, clinical incidents and the provision of potential new services. The registered manager wrote formally to consultants to explain privileges would be suspended if required documentation was not submitted by the specified due date. Consultants with practising privileges where required were all listed on the GMC specialist register.

The clinical leadership team met at the bi-monthly clinical governance meeting. They discussed clinical incidents, accidents and near-misses, patient safety issues and reviewed new policies and procedures. Departmental managers also attended clinical governance meetings as well as monthly heads of department meetings. We reviewed minutes from January 2021 – November 2021. These followed the corporate agenda to ensure consistency. Minutes were detailed and cascaded to staff at departmental team meetings. Any actions arising from meetings were tracked on an action log.

Team meetings across departments used similar agendas to ensure consistency in what and how information was shared.

The hospital was a member of ISCAS, a nationally recognised organisation in the management of complaints in the independent health sector and followed their code of conduct.

Management of risk, 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.

The hospital had a risk management policy.

We saw a comprehensive electronic risk register. Risks were reviewed monthly and escalated appropriately.

Each department manager had an overview of their own risks and reviewed them regularly. These risks fed into the overall hospital and corporate risk register. Department managers demonstrated awareness of the key risks in other areas and outlined how departments worked in collaboration to mitigate against these.

The hospital had a major incident and business continuity plan and corresponding policy (BCP).

There was a full audit plan for the year which highlighted those that had been completed and those that were pending. These audit plans were in line with the wider group requirements. Audit results were presented to staff at departmental meetings. Individual areas for focus were highlighted with general findings and learning that had taken place.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Important information such as policies and minutes of meetings were held electronically on the hospital intranet and all staff we spoke with could access the system.

Staff viewed health records and diagnostic results electronically. Where records were not available electronically, these were stored securely.

We observed good adherence to the principles of information governance. For example, computer screens were password protected and closed when unattended.

Good

Surgery

Staff completed mandatory information governance training.

The service contributed to national audits and regularly submitted data electronically as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. The service held regular patient participation groups and staff forums to gain feedback as to how the service could be improved.

The service had a designated equality and diversity policy.

The hospital's website provided a wide range of information about the clinical services available. It also provided information about how to leave feedback. For example, by emailed satisfaction survey, comments on the social media page, NHS choices (search for the hospital and leave a review) and a search engine review.

Managers were visible in the departments, which provided patients and visitors with opportunity to express their views and opinions face to face.

Staff we spoke with told us managers engaged with them, were very supportive and visible. For example, they walked the departments daily and joined departmental huddles. Staff said they were encouraged to voice their opinions and speak with managers if they had any concerns. They told us they felt appreciated by their clinical colleagues and hospital managers.

We reviewed the most recent action plan following the staff engagement survey. This outlined two specific areas for action – communication and wellbeing. The action plan and subsequent actions is overseen by designated owners who maintained responsibility for actions listed. Senior leaders had implemented initiatives such as drop-in sessions to allow staff opportunities to discuss any thoughts of concerns as a result of the survey.

Staff used the morning safety huddles to share messages, patient feedback and good practice. Departments also held staff meetings and used a corporate fixed agenda to ensure continuity of items discussed.

Staff received a regular corporate newsletter containing business news, safety messages and 'unsung hero' nominations.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The hospital was committed to improving services by learning from when things went well or wrong, promoting training, and innovation. Staff we spoke with said they were supported to attend external training, to develop their career.

The service provided examples of innovative practice to improve service and experience.

Good

Surgery

For example, they developed pathways for patients identified as suitable for day case orthopaedic surgery. Patients were selected based on individualised risk assessment, support in the home following discharge and the patient's motivation to follow the pathway. These patients were followed to evidence patient outcomes. In addition, there was a virtual joint replacement patient education package, patients could access in advance of their surgery. This meant patients had a better understanding of their role in their own recovery.

Ramsay Health Care introduced remote consultations across all sites to enable patients to have remote consultations, during the COVID-19 pandemic.

Ramsay Health Care were recognised in national healthcare awards 2021 and presented with the 'healthcare outcomes award' for training all staff in 'speak up for safety' which was a national initiative, which focused on patient safety and improving patient outcomes.

The service at the time of this inspection was working towards accreditation as a centre for orthopaedic excellence. Ramsay Health Care had developed a set of standards and corresponding key performance indicators against which the service is assessed. The service reviewed performance against these standards as part of a quarterly orthopaedic centre of excellence meeting.

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

Please refer to 'Surgery' for further detail.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training; outpatients had 86% compliance for mandatory training.

Mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. The hospital had 100% compliance for safeguarding adults levels 1 and 2 training and 100 % compliance for safeguarding children levels 1 and 2 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Safeguarding updates were communicated through team meetings.

Good

Outpatients

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a designated safeguarding lead in place and staff were aware of details of local authority safeguarding teams.

Staff followed the chaperone policy to identify if patients were comfortable with a male/female nurse.

Staff followed safe procedures for children visiting the service and department.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE stations had been placed at the entrance and throughout the department, as well as hand sanitisers and hand washing facilities.

Staff completed COVID screening on the patient's entry to the building, doors were locked with camera-controlled entry.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service had an infection prevention and control lead in place.

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.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

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

Staff responded promptly to any sudden deterioration in a patient's health. A 'Recognition and Management of the Deteriorating Patient Policy' was in place, and a 'local safety standards for invasive procedures' (LocSSIPs) policy had been developed for the administration of a combined anaesthetic and steroid injection.

The Deteriorating Patient 'Track & Trigger 'poster is also uploaded as evidence. This poster is on display in all clinical areas as a quick reference guide for staff. Any patient suspected of sepsis is subsequently managed through the Sepsis Pathway which has been uploaded as evidence. Clinical staff undertake Acute Illness Management Training every 3 years.

Staff completed risk assessments for each patient on attendance, using a recognised tool.

Staff knew about and dealt with any specific risk issues.

Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

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

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The manager could adjust staffing levels daily according to the needs of patients. Arrangements were in place to support the service with staff from the ward if necessary.

The number of nurses and healthcare assistants matched the planned numbers.

The service had a low vacancy and turnover rate. The service had a higher than expected sickness rate. As of January 2022, the service had a sickness rate of 8.7% against a target of 3.5%. This included all Covid-19 related absence, which was the main cause of elevated sickness rate in the last twelve months.

The service had a low rate of bank nurse usage and did not use agency nurses. Managers limited their use of bank staff, and requested staff familiar with the service.

Managers made sure all bank staff had a full induction, understood the service and received the same training as permanent staff.

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.

Patient notes were comprehensive, and all staff could access them easily.

Good

Outpatients

Records were stored securely. A back-up system was in place to ensure the security of electronic patient records. Appointment and clinic letters were stored on the electronic system, although consent was recorded in paper format and scanned into the system.

Record keeping audits were completed. We reviewed 14 sets of patient records that were all complete. They were detailed, with appropriate risk assessments and individualised care plans.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. 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.

Staff knew what incidents to report and how to report them, for example the misfiling of letters, clinics running late and the cancellation of clinics due to COVID-19.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

Staff reported serious incidents clearly and in line with the service's policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Feedback was given monthly following an audit of incidents.

Staff met to discuss the feedback and look at improvements to patient care. Recently, a patient had been invited to join a patient user group following an incident with the location of an appointment.

Good

Outpatients

There was evidence that changes had been made as a result of feedback. For example, improvements to communication methods including appointment letters had been made following patients arriving for clinics that had been cancelled.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Are Outpatients effective?

Inspected but not rated

We do not rate effective.

Please refer to 'Surgery' for further detail.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Managers and clinical specialists identified changes to national guidance, and these were incorporated into policies following discussion at monthly clinical governance meetings.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. An induction booklet had been developed for new starters, complemented by an induction day and a meeting with the senior leadership team.

Good

Outpatients

Managers supported staff to develop through yearly appraisals of their work. These were all up to date and complemented by six monthly reviews.

Managers supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

The service accommodated patients with additional needs. For example, a patient who lacked capacity was accompanied by a member of staff experienced in learning difficulties on the ward, in recovery and throughout their treatment.

Consultants, nurses and healthcare staff worked together to care for patients, provide a clean environment and equipment and provided effective clinical care. Lead clinicians ran user groups where consultants and staff attended meetings relevant to their specialty.

Consultants were able to make appropriate referrals to other teams such as physiotherapy and social services if patients required additional support.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Good

Outpatients

Staff clearly recorded consent in the patients' records.

Patient notes were comprehensive, stored securely on an electronic system and although consent was recorded in paper format it was scanned into the electronic record.

Are Outpatients caring?

Good

We rated it as good.

Please refer to 'Surgery' for further detail.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said they were '…happy with the treatment received', '…consultants give the opportunity to ask questions' and they don't '…have to wait to be seen'.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The service ran a 'Friends and Family' test feedback tool, Patient Participation Groups and Customer Focus Groups. These were used to improve the quality of patient experience.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Restrictions were in place due to COVID-19 and the service had made adjustments to waiting and visiting arrangements; these were fully explained to patients, family and carers.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Good

Outpatients

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Customer focus groups and patient participation groups were in place.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Are Outpatients responsive?

Good

We rated it as good.

Please refer to 'Surgery' for further detail.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Evening clinics had been introduced to increase availability for patients. The service at the time of inspection was in the process of establishing weekend clinics to further increase availability.

Facilities and premises were appropriate for the services being delivered. Arrangements were in place to manage the numbers of patients waiting inside the building and in the car park.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The department was designed to meet the needs of patients living with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. A closed loop was in place for patients with hearing difficulties.

Carers were allowed with patients and a patient lounge was available.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers worked to keep the number of cancelled appointments to a minimum.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. We saw a member of staff talking to a patient and a family member to resolve an issue before it could escalate to a complaint.

Managers investigated complaints and identified themes. Complaints were discussed at team meetings and a standard template had been developed for recording complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

A formal complaint had been received identifying the need to improve signage to the service; a patient had been directed to various locations, as a result plans had been developed to improve the appointment letter, signage and visibility at the front of the building. Some patients raised the issue of not easily finding the service location and were observed having difficulty in finding the correct location during this inspection.

Staff could give examples of how they used patient feedback to improve daily practice.

Good

Outpatients

Are Outpatients well-led?

Good

We rated it as good.

Please refer to 'Surgery' for further detail.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. 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.

Please refer to 'Surgery' for further detail.

Staff told us leaders and managers were visible and an 'open door' approach was taken by the head of department.

The senior leadership team visited the department each week.

Staff we spoke with told us how management and senior leaders had supported them to take on more senior roles, strengthen existing leadership arrangements and held discussions relating to succession planning.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Please refer to 'Surgery' for further detail.

The vision to grow the business, caring for people, achieving a centre of excellence, and increase the availability of minor procedures had been shared with staff.

Staff told us a five-year vision for the service had been developed and communicated to them. This included the commissioning of new equipment and expansion of services.

Staff we spoke to, understood the organisational strategy and vision and we saw this displayed in public and staff areas. Staff told us that they had been encouraged to submit ideas and to work collaboratively as to how the vision and strategy could be delivered, and that their contributions had been welcomed by the senior leadership team.

Good

Outpatients

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients and staff could raise concerns without fear.

Please refer to 'Surgery' for further detail.

Staff told us the service had a positive, friendly and supportive culture. This had resulted in a focused team that had produced good service and care to patients despite a challenging period due to the pandemic.

We saw there were suitable rest areas for staff. Staff we spoke with described staff wellbeing groups that were set up to support staff during the pandemic. Staff could also access support from occupational health and an external counselling service if needed; there were posters that signposted staff to contact details.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Please refer to 'Surgery' for further detail.

Governance arrangements were proactively reviewed using a 'board to ward' framework and reflected best practice.

The hospital had a medical advisory committee (MAC) which met quarterly. Meeting minutes we reviewed followed a fixed agenda and were thorough.

Management of risk, 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.

Please refer to 'Surgery' for further detail.

The hospital had a risk management policy and a comprehensive electronic risk register. Risks were reviewed monthly and escalated appropriately.

Leaders and staff were able to discuss key areas of risk that may affect the service. There was a clear process for the identification, discussion and management of risk.

Staff were able to identify current risks, for example the impact of COVID-19, car park facilities and lift improvements.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were

integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Please refer to 'Surgery' for further detail.

Staff viewed health records and diagnostic results electronically. Where records were not available electronically, these were stored securely.

We observed adherence to the principles of information governance. For example, computer screens were password protected and closed when unattended.

Staff completed mandatory information governance training.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Please refer to 'Surgery' for further detail.

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The service used a 'Friends and Family' test feedback tool, Patient Participation Groups and Customer Focus Groups to improve the quality of patient experience.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Please refer to 'Surgery' for further detail.

Good

Diagnostic and screening services

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic and screening services safe?

Good

Please refer to 'Surgery' for further detail.

Mandatory training

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

The Ramsay Health Care UK core mandatory training matrix (v6.2) confirmed the mandatory training subjects and frequencies for each healthcare professional, for example, radiographer staff completed three-yearly health and safety, two-yearly equality, workplace diversity and human rights, annual basic and immediate life support and annual Ionising Radiation Medical Exposure Regulations (IRMER)and radiation protection training for operators.

Staff told us and their training records confirmed completion of mandatory training subjects in 2020/21. Mandatory training sessions completed included: - dementia, customer care, children's and adult safeguarding training sessions. The safeguarding training records confirmed radiographers had completed level three adults safeguarding training and level two children's safeguarding training was completed by four radiology staff.

Staff were introduced to and had read the diagnostic and interventional x-ray equipment local rules on induction to the service and following updates to the local rules.

Sepsis training was covered in Immediate Life Support (ILS) training as a clinical scenario.

One hospital manager monitored mandatory training compliance throughout the hospital. The manager reminded staff and alerted managers when uptake and compliance was less than required. Staff had also been reminded at the January 2022 radiology departmental meeting they were responsible for checking their mandatory training was up to date.

Medical staff completed mandatory training at their employing NHS Trust.

Resident medical officers (RMOs) were employed through a national agency and completed mandatory training with their agency. The hospital received confirmation of the training and kept a record of attendance.

Good

Diagnostic and screening services

Safeguarding

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

A member of the Executive Board had lead responsibility for safeguarding.

The Head of Clinical Services was responsible for ensuring the local hospital safeguarding pathway was followed and the hospital safeguarding lead retained responsibility for acting as the initial contact in the event of a safeguarding concern raised by the diagnostic staff.

Safeguarding incidents were reported through the risk management system and reviewed monthly and quarterly.

Staff knew how to make a safeguarding referral, identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

Comprehensive safeguarding adults and children's policies and procedures were in place and due for review in 30 December 2024. The policies outlined the objectives, explained the terminology of various types of abuse, identified the training requirements, duties, roles and responsibilities of staff.

Disciplinary policies and procedures were in place.

Recruitment practices included completion of disclosure and barring (DBS) checks. At inspection we reviewed the five radiology staffs DBS status and noted that the DBS checks had been completed and were in date.

Staff said patients were protected from discrimination including discrimination in relation to protected characteristics under the Equality Act. The Equality Act covers the same groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. Equality, Diversity and Human Rights training statistics confirmed all radiology staff attendance from February 2021 to January 2022.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ramsay Health Care had identified a corporate infection prevention and control lead. Staff were aware of this person and identified them by name. A network of specialist nurses and infection control link nurses operated across the Ramsay organisation to support good networking and clinical practice.

The service had adapted its Infection, Prevention and Control policy and introduced COVID-19 standard operating procedures to keep staff and patients safe. Staff received the COVID-19 Ramsay Recovery plan by email, to ensure they had the latest guidance. Staff followed Public Health England guidance on personal protective equipment. Control measures included staff completion of twice weekly lateral flow tests, hand washing facilities, hand gel, masks, aprons and gloves were available. Staff were bare below their elbows.

Staff and staff training records confirmed completion of infection, prevention and control training.

Good

Diagnostic and screening services

The Covid 19 risk mitigation checklist was completed on the 28 January 2022. Some of the areas included within the checklist were employees, ventilation assessment, cleaning and catering. The document was not signed and dated, and accountable person's and timescales were not identified.

The unit was visibly clean, furnishings were clean and well-maintained, and staff cleaned equipment after patient contact. Hand wash instruction above sinks instructed on effective hand washing techniques.

The department cleaning audit dated 16 November 2021 confirmed compliance at 93.5%. The shortfalls related to a brown patch on the ceiling and furniture and fixings high surfaces cleanliness. An action plan was not provided to show the progress made to-date against the two shortfalls. Cleaning schedules were recorded daily and were divided into daily and weekly tasks.

Full compliance was noted against the monthly hand hygiene audits; the last hand hygiene observation and hand hygiene technique audit took place on the 25 January 2022.

Legionella testing took place on the 7 November 2021 and identified an overall risk rating as high due to the controls in place. A further inspection was identified for 7 November 2023. Once the actions identified were implemented the risk level would be as low as reasonably practicable.

The hospital legionella action plan identified the previous 22 risk assessments actions rated low to medium priority from the 7 November 2021 report were not progressed. Dates for completion against the 22 areas ranged from the 31 January 2022 to 1 December 2022. Fourteen actions completion dates were identified from 31 January to 28 February 2022. The provider had not identified how they would ensure all the recommendations were actioned on time.

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.

CCTV operated at the entry to the main reception of the hospital and access into the different areas was by a swipe card.

The design of the environment followed health building note (HBN 6) national guidance.

The service had enough suitable equipment to help staff care for patients safely.

Staff said the existing x-ray department on the hospital site was due to be updated in 2022 and this also included the purchase of new x-ray equipment and a fixed scanner. We saw the plans for this, and work was due to commence in April 2022.

Service facilities included two fixed x-ray-controlled areas; both located in the outpatient areas. General radiography procedures were carried out within this department, for example, x-rays. Equipment present included x-ray tubes, capture devises, couch and a stand-up cassette holder. A controlled area was in each x-ray facility / room and a mobile x-ray was available for use.

The ultrasound room on the main hospital site also had a toilet / changing area which could be accessed by the patient direct from the ultrasound room if needed.

Accessible toilet facilities were located throughout the department.

Radiology signs were displayed on the doors accessing the x-ray area.

Out of hours specialist support was available for scanner problems and unit maintenance.

Seven diagnostic X-Ray equipment acceptance/commissioning checks, radiation safety and performance report records were seen. Two mini c-arm reports (theatre and outpatients) identified checks took place in November 2020 and were due to be repeated in November 2021, however, no reports were provided to confirm that these checks had taken place.

Service record data for five pieces of x-ray equipment confirmed services had taken place and the dates of the 2022 planned services. Service records were not provided for two pieces of equipment identified on the hospital service data sheet. The missing records related to the mini c arm equipment with the following serial numbers: 99243MCAA2 9081004 and 99243MCAA3 20031508.

Staff did daily safety checks of specialist equipment and records confirmed this.

The local rules were approved by the radiation protection adviser on the 24 October 2018 and contained information which identified the radiation protection adviser (RPA) and the radiation protection supervisor (RPS). The names of staff were documented once they had read the local rules. We observed that the local rules were present in a folder in each x-ray-controlled area.

A radiology risk assessment register confirmed yearly reviews of risks took place. Examples included, operational safety, anaphylactic shock management, Interventional procedures, Lone worker, staff pregnancy, the use of mobile imaging on wards, consent and skin marking. Risk assessments were due to be reviewed at intervals throughout the coming year. Gaps were noted in the risk assessments reviewed as the action by whom, action by what date, sign when complete fields were empty. This shortfall was raised with the diagnostics manager and governance assistant whilst on site.

Staff said they could access these radiation risk assessments which were printed in hard copy and stored in files in both x-ray-controlled areas.

The last staff film badges monitoring report confirmed ongoing monitoring took place and staff film badges showed exposure to radiation was at a acceptable range. Following the inspection, the provider confirmed that film badges were replaced monthly regardless of Covid.

Resuscitation equipment was shared with the outpatient department which was adjacent to the x-ray area. The outpatient nursing staff completed the daily resuscitation trolley and equipment checks and the contents checklist confirmed all was in order. Random checks of the equipment confirmed all equipment checked was in date.

Control of Substances Hazardous to Health (COSSH) substances were stored securely.

Spillage kits, arrangements and decontamination procedures were in place. Discussions with staff confirmed a knowledge of how to deal with spillages. Staff confirmed the spill kit located in the outpatient's area would be used within the radiology department when needed. When asked about the frequency of monitoring of the spill kit, the inspector was told the spill kit although monitored this was not documented.

We saw a bottle of undated ultrasound gel stored with the ultrasound machine. We raised this with staff as the ultrasound gel did not appear to be single use. Staff said they would raise this with staff to ensure going forward that single use ultrasound gel sachets were used. The following morning staff showed the newly produced standard operating procedure guidance document for the use of ultrasound gel in the radiology department.

Staff disposed of clinical waste safely and arrangements were in place for waste management and collection.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

A critical care service level agreement with the local NHS Trust existed for the transfer of a patient requiring level 1/2/3 care urgently. In a medical emergency staff would alert the registered medical officer, onsite anaesthetist and put out the crash call. If required, an ambulance was called, and the patient transferred to the local NHS Trust.

Recognition and management of the deteriorating policies (v10) were available for staff to access whose guidance included the sepsis pathway and anaphylaxis algorithm.

Morning safety huddles included attendance by the heads of department. Staff told us that safety huddle discussions included staffing, the mobile scanner's presence on site, sickness, who the radiologist on call was and the management lead for the day.

Staff said, and training records confirmed, that trained clinical staff had completed yearly immediate life support training; whilst reception staff completed basic life support training. The diagnostics manager was also advanced life support trained. Discussions with staff confirmed they were confident about their resuscitation skills.

Clifton Park Hospital undertook bi-monthly emergency resuscitation scenarios, of which anaphylaxis was one. Staff said these scenarios were carried out in different departments within the hospital including the radiology department. Following the emergency scenario training, a full debrief for the staff involved and a report is produced and circulated. Emergency scenario reports were discussed at the resuscitation committee and clinical governance committee and cascaded to staff via team meetings.

The service could access a medical physics expert and radiation protection adviser (RPA). The RPA was based at an NHS Trust and was easily accessible. The last onsite visit was 15 April 2020. Due to Covid future visits were by zoom calls. The last zoom call meeting was held on the 17 August 2021 and resulted in some recommendations which were being worked on.

Staff said they had not needed any advice over the last 12 months from the RPA or medical physics expert, however, they knew they could easily access these people if needed.

The head of department had just completed their radiation protection supervisor course. In addition, another radiographer had completed the RPS course previously. We saw evidence that their advice was followed through local rules procedures, risk assessments and minutes of joint service review meetings with the trust three monthly.

Pregnancy checking procedures were in place. We saw a radiation risk assessment dated December 2022 for staff pregnancy and the use of mobile imaging on the wards.

'Pause and check' procedures which correctly identified individuals exposed to Ionising Radiation were in place. This process was observed during the initial conversation between the radiographer and patient prior to their x-ray being taken.

The National Safety Standards for Invasive Procedures (NatSSIPs) audits for radiology identified 94.3% compliance in February 2021 and 100% compliance at the November 2021 audit.

Patients completed a patient health questionnaire so that a decision whether a pre-operative check was required prior to admission to the hospital. When we reviewed the electronic patients' records system with a staff member, we saw sections present which captured information on patient's medical history, safeguarding and other patient's needs.

Patients with more complex needs were notified by the referrer.

A new process introduced in October 2021 with associated guidance called significant pathology policy (December 2023) was available for staff to access. This guided staff on how to ensure that referrers acted on urgent or unexpected findings. Staff completed the significant unexpected pathology form with patient details, following which one radiologist would review all the plain film imaging. Staff said this radiologist acted quickly and could be contacted through the lead radiologist.

Interventional radiology took place at the main hospital outpatient department for patients with arthritis type conditions who required joint injections, local anaesthetic and steroids. Staff said these patients signed consent forms prior to injections. The Ramsay proforma checklist was checked by the team at the beginning of the list. The national safety standards for invasive procedures audit in Radiology scored 100% in October 2021.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service operated five days per week and was staffed by a diagnostics manager who was the lead radiographer, a radiographer who was the radiation protection supervisor, two part-time radiographers and one radiology administrative assistant and receptionist. The January 2022 radiology rota also confirmed that a healthcare assistant now worked in the department. Staff said that staffing had improved since the diagnostics manager had come into post two years ago and currently staffing was appropriate to meet demands.

Staff were deployed across the two x-ray rooms which were in the outpatient areas, theatre and the ward when required.

An out of hours rota identified radiographers who provided cover for the service.

Lone working guidance and risk assessments were in place.

Seasonal pressures were managed centrally by the bookings department and the safety huddles alongside daily calls assessed capacity.

Staff said the only temporary staff used was a bank radiographer.

Qualification checks such as General Medical Council, Allied Health Professionals checks were carried out prior to employment. Checks of staff personnel records confirmed radiographers and doctors' qualifications.

Induction training was provided to all staff including temporary and bank staff. Staff said a one-day corporate induction was introduced in the last year. New staff completed an induction pack over a three-month period. We reviewed one staff members induction pack and noted that the staff member had completed their induction pack. Staff said new staff had weekly meetings recorded with their manager throughout their induction period.

Three radiologists had practising privileges at the hospital. One radiologist was new to the hospital and we observed their information was being collected. The other radiologists personnel file was complete and some of the information we saw confirmed the relevant checks against areas such as qualifications, DBS, registration, appraisal, medical defence union were present.

Records

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

Records were stored securely.

Ramsay Health Care UK (Ramsay) had recently rolled out an Electronic Patient Record (EPR) across all Ramsay hospital sites. Staff said this new system had been introduced recently.

Information security standards were met, and password protected systems were used.

The electronic records system meant all images were processed and stored digitally. Images could be shared between Clifton Park Hospital and the local NHS trust when consultants needed to view images if they were off site or if images needed a radiologist report or opinion. Business continuity plans were in place in case of digital systems failure.

We saw a mix of paper records and electronic records in use. Patients records were recorded electronically on the hospital information system which allowed sharing of information.

Radiology results were reported via the radiology imaging system.

We reviewed six patients' records which we observed to be completed with full patient details.

The records audit on the 21 September 2021 confirmed 93% compliance and included checks on 30 patient referrals and 10 patient records. Some shortfalls were identified; however, it was not evident what actions and progress had been made since this audit as an updated action plan was not provided as evidence.

The radiology information system audit of 20 patient records against nine areas identified five patients' records did not have the examination times correctly completed and one patient record did not have the radiographer correctly identified as operator.

Good

Diagnostic and screening services

Medicines

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

The service worked in conjunction with the outpatient department for the prescribing, administering, recording and storage of medicines. See "Outpatients" for further detail.

The medicines optimisation policy (CMM-001) outlined the pathway and process of medicine management, and respective roles and responsibilities.

Additional support was provided by the group chief pharmacist who provided professional leadership for the pharmacy staff. The group chief pharmacist undertook governance activities to ensure compliance, strategy and development within medicines optimisation so that patients received the best possible outcomes from their medicines.

The last medicines audit was undertaken on the 17 August 2021 and identified some improvements to access controls and security. This related to the restriction of key holding responsibility to authorised staff only. The radiology manager was seen to hold these keys on the day of inspection. The second point related to the use of a digilock and it being changed every three months.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

The radiology department kept medicines for procedures including local anaesthetic for use during ultrasound-guided aspirations and ultrasound guided injections into joints. Medicines were stored securely with a key control process in place. The radiographer was the accountable person for checking the local anaesthetic and steroid drugs with the consultant radiologist prior to administration which was part of the National Safety Standards for Invasive Procedures checks. The responsibility for ordering drugs, stock control and key security was with the radiographers and was overseen by the visiting pharmacist.

A separate sealed anaphylaxis kit was held in the radiology department and was collected by the staff on the visiting mobile diagnostic units on arrival to site. These kits were issued by pharmacy to the radiology department with a visual inspection and checking of expiry date by staff. We saw this anaphylaxis kit was in date.

The anaphylaxis kit was on the resuscitation trolley, located on the ground floor near to the radiology department and was checked and audited as part of resuscitation trolley audits. The provider confirmed that the audits were conducted six-monthly and the results and action plans discussed in the resuscitation committee meeting. The audits conducted in 2021 demonstrated full compliance and identified no actions. However, the resuscitation trolley audits received did not specifically identify anaphylaxis kits were checked as part of this audit. Following the inspection additional evidence provided in the form of the February 2022 resuscitation trolley checklist identified that anaphylaxis kit checks were documented and had taken place. However, the resuscitation checklist provided did not specify the actual location of which resuscitation trolley was checked.

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.

Good

Diagnostic and screening services

Ramsay Health Care UK Operations Ltd central governance oversaw trends and incidents through the clinical advisory committee and quality and risk team and lessons learnt were discussed at clinical governance and staff meetings.

Incidents were reported on the hospital incident reporting system. The diagnostics manager investigated lower rated incidents and shared any learning or changes to practice with the wider team. Higher level incidents were investigated and overseen by the corporate risk team.

The diagnostics imaging incident register dated from 1 January 2021 to 1 January 2022 identified 15 radiology incidents for the inpatient radiology service. Some of the themes included wrong side request, incomplete request form, incorrect patient on request form.

Staff described two referrer error incidents in December 2021. We reviewed one of these incidents and tracked it through the incident reporting process. The diagnostics manager had reviewed this incident and then sent it electronically to the Head of Clinical Services.

Staff said and we saw that incidents were discussed at staff meetings, clinical governance and head of department meetings. Learning was shared between Ramsay hospitals at professional meetings and through a monthly Ramsay "Clinical Services Monthly Update" newsletter.

We asked staff about 'Duty of Candour' and when it would be used. All the staff we spoke with had knowledge of the 'Duty of Candour'. The radiology service had no incidents which required 'Duty of Candour' in the last 12 months.

Clifton Park Hospital received alerts regarding key safety messages relating to drugs and equipment via an electronic Central Alert System (CAS). Safety alerts, medicine / device recalls, and new and revised policies were cascaded in this way to the registered manager who cascaded this information to relevant staff.

Safety alerts were received by the department managers and all relevant alerts were emailed to all staff, displayed in the staff office and discussed at team meetings.

Are Diagnostic and screening services effective?

Inspected but not rated

Please refer to 'Surgery' for further detail.

We currently do not rate effective for diagnostic screening services.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Radiology staff adhered to and kept up to date with changes in clinical guidance through national Ramsay Health Care UK policies in accordance with Radiology Protection Association (RPA) and Ionising Radiation (Medical Exposure) Regulations IR(ME)R guidance and requirements.

Where people were subject to the Mental Health Act (MHA) the service ensured compliance with the MHA through support from their referring clinician. In these cases, more time was given to support the patient and escorts accordingly.

We observed that the local rules were dated 2018 and asked the staff why a more recent date was not on the local rules. Staff told us that the Radiation Protection Adviser advised the local rules would be updated again once the new x-ray equipment was in place. We were told there were plans for this upgrade to take place in June / July 2022.

We reviewed the risk assessments and guidance in place for radiography staff and saw that these were all in date.

Dose reference levels were displayed on the wall in the x-ray room for staff guidance. Staff when asked were aware of what the dose should be.

The radiology service review document was created as a quality improvement tool within RHC UK to support the radiology managers to understand the information and evidence needed to support compliance against policies and regulatory standards. The audit tool offered guidance to prioritise tasks, track progress against compliance and to be able to provide documented evidence of the review to aid continuous improvement and compliance against regulatory standards and guidance. Annual reviews take place and if compliance was below 95% regular monthly reviews were required to monitor progress against areas of non -compliance with an action plan with actions in order of priority based on a RAG rating. The radiology service review took place in February and March 2021 with a compliance score of 96%. Five areas of non-compliance were identified, one was resolved, and the remaining four actions are in progress. The next service review is due in March 2022.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Staff considered patients individual needs where food or drink were necessary for the procedure.

Diabetic patients' diagnostic investigation was carried out at the beginning of lists.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

To alleviate any discomfort staff positioned patients to ensure they were comfortable and ready to proceed. We observed one patient prior to their x-ray and saw the radiographer checked the patient was comfortable before proceeding with the x-ray.

Patients were administered local anaesthetic during ultrasound-guided biopsy procedures which took place in the ultrasound room in the x-ray department of the main hospital. No biopsies are taken, and the Consultant Radiologist and Radiographers delivered this service.

The Ramsay Health Care UK audit programme in 2021/22 did not include a pain audit. However, as part of this CQC inspection this was raised corporately and the audit programme for 2022/23 will include measures on pain management.

Good

Diagnostic and screening services

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements and achieved good outcomes for patients.

Ramsay Health Care staff said decisions were being made as to how to commence the accreditation process for the Quality Standard for Imaging (QSI) which was a quality improvement initiative for imaging services. It articulated the expectations of good imaging, interventional radiology and teleradiology services. It reflected wide consultation and valuable comments and suggestions received from professional colleagues and relevant UK government agencies and regulatory bodies.

The Medical Physics Expert completed yearly audits; the December 2021 audits for the Radiology department - x-ray room 1 identified no actions were required.

The radiation protection supervisor report November 2020 to March 2021 identified compliance within the radiology service as good.

Annual dose reference level audits took place and the dose reference levels were displayed in the control area. We reviewed the dose reference levels and noted that some were above the national dose reference levels. The hospital said they had a policy for action should the dose go above the local dose reference level, however, we saw no evidence of this policy.

The service submitted dose reference level audits in line with the recommendations of the Radiation Protection Advisor. Staff said that all dose reference levels submitted were within range. If the service was advised dose reference levels were out of range by the RPA, the service acted in accordance with the relevant advice given. Within 24 hours of the inspection a new Ramsay policy, employer procedure 7, including a Standard Operating Procedure and log for radiographers to follow should the local dose reference levels be exceeded was implemented.

Staff said all images were quality checked by radiographers before the patient left the department. The image quality scores audits which took place in March and April 2021 confirmed image quality. One audit of 10 sets of knee images were randomly selected for analysis by the department's radiographers. The audit detail showed from the knee reject analysis confirmed whether the x-ray film was acceptable or needed to be repeated. The audits confirmed that improvements were required. Two actions resulted from this audit, one of which was to repeat the audit.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Corporate and local induction training was provided to all staff including temporary and bank staff.

New staff completed an induction pack over a three-month period and had a probation period of six-months. A comprehensive local induction checklist took new staff through key milestones. As the new staff member progressed through their competency sheets these were signed off. Familiarisation with equipment formed part of the induction. We reviewed one staff members induction pack and noted that the staff member had completed their induction pack. New staff had weekly meetings with their manager throughout their induction period.

A new staff member confirmed they were supported by working closely with another radiographer and as they were new to the service did not take part in on call rotas.

Staff were encouraged to undertake continuous professional development and given opportunities to develop their clinical skills and knowledge through training relevant to their role. For example, one radiographer had completed their radiation protection supervisor course in October 2021. Radiation protection supervisor certification was seen for the existing staff member who had completed this course.

Staff said informal daily staff supervision took place.

Staff appraisals were conducted annually in line with a review of the hospital strategy and the annual planning process. The appraisal process commenced with the hospital director's completion of appraisals of the senior leadership team who conducted appraisals of the heads of department. Appraisal compliance rates were discussed in senior leadership team and heads of department monthly meetings. In 2020/21 staff appraisal documentation confirmed the appraisal process was completed for all radiology staff.

To help staff understand patients' needs in areas such as dementia staff completed this training as part of their mandatory training.

Monitoring of staff registration was through relevant professional bodies. We saw the registration status of the radiography staff and radiologists was in date.

There was a process in place to monitor whether consultants were up to date with revalidation. Medical revalidation and appraisals were carried out by the employing trust. Appraisal documentation was shared as part of the radiologists practising privileges agreement.

IRMER training certificates were seen for the consultant staff who used the mini-c-arm image intensifiers.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The radiology manager described good working relationships with orthopaedic consultants, radiologists and staff at other local imaging departments.

The radiology image exchange portal meant that images could be viewed at other sites and there was a facility for a blue light exchange in case of emergency.

Service level agreements were in place with other local hospitals to provide some radiology investigations and reciprocal arrangements were in place in case of equipment breakdown. Radiologists at the local Trust could be approached by consultants at Clifton Park Hospital if they wanted a second opinion on a diagnostic image.

The introduction of six-monthly radiology meetings in the North East cluster commenced in the last year. The minutes of the Regional Radiology Radiation Protection Committee (North) for the May, September and November 2021 meetings confirmed discussions included risk, dose reference levels, radiation protection adviser updates, recruitment updates and training needs.

The service could access a medical physics expert; a radiation protection adviser and radiation waste adviser.

Good

Diagnostic and screening services

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff said all in-patients could access diagnostic services seven days a week. Access to the services can be provided to meet the needs of the patient, within one hour for critical patients, 12 hours for urgent patients, and 24 hours for non-urgent patients. All requests are made by the RMO or Consultant and always reviewed and reported by the Consultant.

Radiographer cover was provided 24 hours a day, seven days per week.

Night and weekend on-call was organised by a rota system.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

If patients required further guidance, they were advised to discuss directly with their radiologist / referrer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff training records confirmed that two staff had completed annual mandatory training in consent processes. Discussions with the staff confirmed their understanding in these areas.

Mental Capacity and Deprivation of Liberty training was included as part of Safeguarding Adults Level 1 and Level 2. Mental Capacity Act & Deprivation of Liberty Training was also delivered as a 'Lunch & Learn' face to face training session.

Consent was obtained from the patient or respective power of attorney representative at the time of the booking and at the time of the appointment.

Where an adult attended a scan and lacked capacity or the radiographer was concerned the patient may lack capacity and there was no clear directive from the clinician regarding consent, the examination was delayed until consent was verified.

Interventional radiology took place at the main hospital radiology department for patients with arthritis type conditions who required joint injections, local anaesthetic and steroids. Staff said these patients signed consent forms prior to these injections and treatments taking place.

We observed that verbal consent was obtained as part of the 'Pause and Check' guidance when a radiographer asked the patient for their consent prior to the diagnostic procedure. One other patient confirmed the 'Pause and Check' process was followed when they were asked to consent to their diagnostic procedure.

Good

Diagnostic and screening services

Weekly and six-monthly consent audits for 2021 / 2022 confirmed high levels of compliance which ranged from 78.1% to 98.8%.The steroid injection cooling off period aspect of this audit scored 100% when audited on three occasions. The six-month audit dated 4 February 2022 confirmed 100% for healthcare workers completion of stage one and stage two training in consent

Are Diagnostic and screening services caring?

Good

Please refer to 'Surgery' for further detail.

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with three patients who were satisfied with their experiences throughout their diagnostic experiences. One of the patients had attended the hospital and used the diagnostic service on several occasions said their experiences had always been positive.

Patients described the staff as very friendly and caring. One patient said staff 'take all worries away'.

Patients said, and we observed, that their dignity had been maintained throughout the diagnostic process and inpatient stay. We observed two patient interactions from admission to the unit to their discharge. Staff ensured patients were comfortable, completed pre-investigation checks and explained what was happening. Staff were respectful and the patients' dignity was maintained.

Patient engagement feedback allowed reflection on outpatient comments with a view to improve the imaging service delivery. Patients said they were given a family and friends card on arrival to their diagnostic appointment should they want to provide further feedback about their diagnostic experience.

Patient feedback was captured through identified tools. The quarter three patient summary dashboard identified the hospitals ratings in terms of patient experience and identified two similar themes from two different patient surveys around better communication at discharge and how you would rate your post discharge follow up call. Privacy and dignity results were rated at 95.8% for Clifton Park Hospital against the Ramsay Group average of 96.7%.

Staff said patients' additional needs were considered and this information was included on the imaging request form. The imaging request form contained an additional / booking information section which was completed by staff at the time of booking the patient's appointment. In this section staff could include additional measures to support the patient. For example, a patient with learning disabilities could be accompanied by a responsible adult.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Good

Diagnostic and screening services

We observed four patient interactions from admission to the diagnostic unit to the completion of their diagnostic test. We observed staff kept patients informed about the process and explained what was going to happen.

Staff gave patients and those close to them help, emotional support and advice when needed.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their diagnostic procedures.

Following an explanation of the procedure and its aim patients were asked to consent for the diagnostic procedure.

Ramsay Health Care UK had an external contract to provide up to date patient information leaflets available in alternative formats including different languages; easy read large print, braille or email. This information could be provided at different points of the patient journey.

Patients could access frequently asked questions on the hospital website.

COVID-19 information, pregnancy and other information were available for patients to read on arrival at the unit. Information was available in different languages.

Patients could request a chaperone and the use of chaperones poster was displayed to inform patients of this option.

Are Diagnostic and screening services responsive?

Good

Please refer to 'Surgery' for further detail.

We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital had supported the local NHS Trust through the pandemic with equipment, staff, step down care, relocation of outpatient clinics, activity and subsequent return to elective surgery in a Covid free environment. Radiology services were planned around outpatient and theatre activity.

Clifton Park Hospital had arrangements in place with the local hospitals to ensure timely access to CT and bone scans.

Additional x-ray capacity is to be added by extending the day to 8pm on a Tuesday, Wednesday and Thursday evening from March. A trial offering x-ray imaging on a Saturday was due to commence March 2022.

Ultrasound capacity had increased since December 2021 as another consultant radiologist joined the team. Further options were to be discussed to increase this capacity further.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The patients who required additional support to access information and services policy enabled staff to ensure that they had the tools and training to ensure patients' needs were met.

Patients with additional needs information was saved in the reception information and booking information section of the booking screen. In addition, patients' additional needs were flagged on their electronic booking information, for example, safeguarding needs were recorded in the safeguarding section of the screen.

Accessible information standards were applied to the service.

Patients were offered a variety of location options based on their address location and appointment choices.

The facility was Disability Discrimination Act compliant.

Staff wore clear face masks so patients with impaired hearing could lip read; hearing loops were available for use.

Interpreter services supported communication face to face or language line could be accessed.

Patients with additional needs including complex communication needs had additional time factored into the appointment.

Visually impaired patients and any patient requiring assistance could be escorted.

Use of chaperones information was displayed in the main corridor and available to patients.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

The Ramsay Health Care UK Ramsay access policy and the waiting list policy and management of patients accessing NHS Treatment (v7.2) was comprehensive and provided guidance on the management of elective patients on 18-week referral to treatment (RTT) pathways. From a diagnostics perspective this meant that patients were seen within 41 days of the decision to refer.

The average wait time for ultrasound scans (USS) was seven to eight weeks. Currently 77 patients were waiting for USS, and (as of 22/02/2022) 36 patients had waited less than six weeks and 41 patients had waited more than six weeks with the longest wait being 10 weeks. Of the 41 patients who had waited more than six weeks, six were due to appointments being deferred due to patient choice. Waiting times increased during the Covid-19 pandemic due to several reasons including a lack of consultant radiologist time; patient choice to delay their appointments; suspension of non-essential services during Covid and the additional consent requirements for patients receiving steroid injections.

The service responded to this increase in USS waiting times by recruiting an additional consultant radiologist in December 2021 so now there are three consultant radiologists with practising privileges at Clifton Park Hospital.

The service had delivered additional sessions between January 2022 and April 2022 to reduce the waiting list and to ensure patients were not waiting more than the RTT of 41 days. Once this backlog has cleared staff said there was capacity with the three consultant radiologists to maintain RTT for USS at less than six weeks. If in the future, demand for USS services increased, options would be considered to address any capacity gaps which may include the use of sonographers or the appointment of an additional consultant radiologist.

Waits for patient x-rays did not exist as they were carried out on demand in the out-patient department and for the ward patients for post-operative x-rays.

Clifton Park worked in partnership with the NHS, under the Choose and Book e-referral system which allowed GPs to refer to a hospital of their choice.

Referral data for diagnostics from November 2021 to January 2022 confirmed 427 referrals.

The process included: patient contact by phone, an appointment letter was sent, and the patient was booked in and their details entered onto the radiology information system. Staff rechecked the referrals and booking list on the morning patients were due.

The Ramsay waiting list and access policy (v7.2) identified that patients (except for paediatrics and vulnerable adults) who do not attend (DNA) their outpatient appointments had a second appointment booked within two weeks. A second DNA resulted in a clinical review by the patient's consultant with a view to them being potentially discharged back to their GP. All DNAs (new and follow-up) were reviewed by the clinician at the end of clinic for a clinical decision to be made regarding next steps. Vulnerable patient DNAs were managed in line with the safeguarding policy.

The Radiographer contacts the referrer if it is indicated in the report that they need to see the report urgently.

Most report turnaround times from January to December 2021 were reported on the day. Data for some x-ray procedures identified x-ray reporting times ranged from approximately 3 days to 27 days. Two x-rays were reported at 24 and 27 days post diagnostic test in March 2021.

Six patients' records we reviewed included information of the x-ray taken and when reported. Five x-ray films were reported on the day of x-ray; one x-ray film was reported two days later.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

If patients wished to provide feedback the complaints procedure leaflet informed them how to verbally or formally log their feedback with any member of staff. Complaints were recorded in the incident management system for investigation. The results of a complaint investigation were shared with the complainant by letter. Staff said complaints were discussed at forums which included the clinical governance committee; customer focus group and medical advisory committee.

Good

Diagnostic and screening services

Comments boxes were in the outpatient's areas.

The hospital complaints register (2021) identified part of one complaint related to a patients wait for an x-ray. The learning from this complaint identified that the delay was caused by the mobile x-ray machine being used in theatre.

Are Diagnostic and screening services well-led?

Good

Please refer to 'Surgery' for further detail.

We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. 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.

Please refer to 'Surgery' for further detail.

Senior leaders said there had been no impact on leadership capabilities during COVID.

A diagnostics manager was on site five days a week. The days they were not present a clinical radiographer was on site.

Staff said talent maps were completed for heads of department and senior leadership team level. Following appraisal and talent mapping, heads of department had attended various programmes and a leadership development course. Bespoke training to support the development of the heads of department and senior leadership team included an Insights Team Building Day held in September 2021. A change management workshop was scheduled for the 16 February 2022 which supported the hospital strategy for site development and to help the heads of department consider their response to change. A communication workshop was planned for March 2022 to support the delivery of one of the key action areas from the staff survey.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

Please refer to 'Surgery' for further detail.

Culture

Good

Diagnostic and screening services

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Please refer to 'Surgery' for further detail.

Staff said there was a freedom to speak up guardian (FTSUG) and said the hospital director sent weekly communications to staff in which they asked staff to contact them with any concerns.

Staff were encouraged to raise concerns with their line manager and speak out.

We observed that the team were a cohesive team who worked well together.

Staff said they felt supported by their manager and there had been an increased recruitment of new staff to the service since this manager was appointed to post.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Please refer to 'Surgery' for further detail.

Ramsay Health Care UK had a group of relevant specialist advisors and users of ionising radiation as a sub-committee of the clinical governance committee. The committee's remit was to review and advise on the implementation of the relevant radiation protection legislation and on other health and safety matters in connection with both ionising and non-ionising radiations. The committee informed the clinical governance committee, for board level escalation of the state of protection arrangements in force.

Lead apron checks took place on the 23 and 26 April 2021 and were rated good or ok. No detail was provided as to what had happened to one piece of equipment rated poor. The lead gowns were checked by touch rather than using x-ray. We raised this practice with the Head of Department who confirmed that his Radiation Protection Advisor had agreed this method of checking lead gowns was satisfactory. The lead gowns were also checked by the Radiation Protection Adviser when onsite. Documentation from the Radiation Protection Adviser advised visual checks were satisfactory unless there were concerns about the integrity of the apron.

Following the inspection, the radiology manager at Clifton Park Hospital highlighted concerns raised by the inspectors which related to visual inspection of aprons with the radiation protection advisor and discussion was now underway to determine the process for inspection under x-ray. Lead aprons will be inspected annually using x-ray as agreed by radiology manager and radiation protection supervisor; auditing of the aprons commenced in February 2022.

Staff reported incidents through the incident reporting system and all incidents were recorded. In 2020/21 the hospital radiology service identified 15 incidents against the inpatient radiology service.

Clinical guidance was followed, and local policies and procedures reviewed to ensure guidance was current.

A service level agreement was in place until the 31 July 2023 with an NHS Trust to access expert advice through a radiation protection adviser and medical physics expert.

Management of risk, 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

Please refer to 'Surgery' for further detail.

The hospital risk register - summary on a page was updated in January 2022 identified one risk for the radiology service in respect of the risk of a potential failure of ageing equipment (>15 years old) in the x-ray room.

Annual reviews of radiology risk assessments by the head of department, radiation protection supervisor and the radiation protection adviser took place. The latest meeting notes (17 August 2021) confirmed checks made on previous actions were complete.

Both radiation protection and medical exposure committee meetings in 2021 were attended by a wide membership which included representatives from NHS Trusts and Ramsay Health Care.

The corporate annual infection prevention and control strategy developed through the infection prevention and control committee and group policy was revised every two years. Ramsay UK had introduced a robust Infection prevention and control board assurance framework (v1.6) and action plans which confirmed no gaps in assurance. The Clifton Park Hospital IPC action plan identified five areas as an amber rating, none of which were specific to the radiology service.

Infection prevention and control committee meeting minutes from February, March and May 2021 confirmed reviews of identified actions, policy ratification, risk register entries, Covid -19 data and outbreaks had formed part of the discussions.

The corporate annual Infection prevention and control audit programme informed the Ramsay UK board. The July 2021 hand hygiene observation and technique assurance inspection summary confirmed compliance at 100% for the radiology service. The facilities July 2021 assurance inspection summary confirmed compliance at 99%.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Please refer to 'Surgery' for further detail.

Engagement

Good

Diagnostic and screening services

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Please refer to 'Surgery' for further detail.

Radiology departmental meetings were attended by staff. The last meeting minutes from January 2022 confirmed some of the staff discussions included: the risk register, audits, complaints updates and the new radiology rooms and equipment.

The 2021 staff survey results identified areas of strength and improvement specific to Clifton Park Hospital. The outcome resulted in an action plan (undated) which identified two actions related to communication and wellbeing.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Please refer to 'Surgery' for further detail.

A business case was submitted to replace the x-ray facility on the main Clifton Park site. This would bring the equipment fully up to specification by replacing old equipment with full Digital capacity. This would allow for a faster throughput and higher quality images. Staff told us that the work on this improvement was due to commence in February 2022.

Key achievements during 2020/21 included: Delivery of Speak up for safety programme training for all staff and consultants and anaesthetists.