Ramsay Health Care UK Operations Limited

Clifton Park Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, review of information we hold and information given to us from patients, the public and other organisations. This location has been awarded a shadow rating. Shadow ratings apply to inspections which are undertaken during the development of our approach and before our final methodology is confirmed and published.

Ratings

Overall rating for this hospital	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Clifton Park Hospital is operated by Ramsay Health Care UK Operations Limited. It primarily serves the communities of York and North Yorkshire and accepts patient referrals outside of the catchment area. The hospital has two theatres and 24 beds configured into one ward which is used for day cases and inpatients. It provides elective orthopaedic surgery and care for adults including diagnostic services, outpatient facilities and physiotherapy. The hospital does not treat children or young people under the age of 18 years. Referrals were received primarily for NHS patients, treated under standard NHS contract, although there were some self-funding patients.

There were over 20 clinical staff (both nursing and physiotherapists) who were employed by the hospital and 34 consultants working at the hospital under a secondment agreement with York Teaching Hospitals Foundation Trust. There were a small number of these consultants who undertook private practice under practicing privileges. The senior leadership team comprised of a general manager, an operations manager, a matron and a finance manager. The hospital was supported by other professionals within the Ramsay Health Care UK.

We inspected the hospital on the 27 and 28 January 2015 and undertook an unannounced inspection on 10 February 2015. We inspected this hospital as part of our second wave independent hospital inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

Overall the care and treatment patients received at Clifton Park Hospital was good for the safe, effective, caring, responsive and required improvement in the well led domain.

Our key findings were as follows:

Medical and nurse staffing levels were adequate on the ward, theatres, outpatients and diagnostic services. Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.

Arrangements were in place to manage and monitor the prevention and control of infection. We found that all areas we visited were visibly clean. There were no hospital acquired infections reported from October 2013 to September 2014.

Some patients fasted pre-operatively for longer periods than necessary before their surgery. This had been identified by the hospital and an interim measure had been put in place to address this. Interim measures had improved the situation regarding prolonged fasting. Patients gave positive feedback about the choice and quality of food they received.

There was sufficient equipment to ensure staff could carry out their duties. Processes were in place for monitoring and maintaining equipment.

The majority of records we viewed across both core services were well maintained and documents were completed to a good standard including completion of patient risk assessments, however there were gaps in some records.

Staff understood their responsibilities to raise concerns and record patient safety incidents and near misses. There was evidence of a culture of learning and service improvement.

Overall the hospital responded to the Central Alert System (CAS). However we noted it had not fully implemented the National Patient Safety Agency alert "Emergency support in surgical units: Dealing with haemorrhage" Reference number 1025, dated10 September 2007. Clifton Park Hospital had not assured itself that blood products could be transported in a timely manner should an emergency arise.

Medicine management arrangements were in place. Medicines were stored securely and staff were competent to administer medicines.

Summary of findings

There were systems for the effective management of employed staff which included an annual appraisal, however, not all staff had received an appraisal.

The monitoring system to ensure the consultants' safety to practice within the hospital was not robust at the time of the inspection. For a significant number of the doctors information regarding: DBS checks; appraisal information from the employing organisation and; professional indemnity insurance arrangements, was out of date or had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured. When this issue was raised with the hospital management team the employing trust was contacted immediately to provide this assurance. Information provided by the hospital on the 10 February 2015 indicated that the figures for appraisal and indemnity insurance had improved.

The hospital undertook a programme of clinical audits. These covered a range of areas including infection prevention and control, medicines management and nutrition and were acted upon.

There was no secure access to the theatre suite to prevent patients or other people inappropriately accessing this area

Leaders were aware of their responsibilities to promote patient and staff safety and wellbeing. Leaders were visible and there was a culture which encouraged candour, openness and honesty.

Governance arrangements enabled the effective identification and monitoring of clinical risks and action was taken to improve performance. Progress on achieving improvements was reported and measured through the relevant committees with oversight and scrutiny from the provider's quality governance committees with ultimate responsibility resting with the Ramsay Health Care UK chief executive and board. It could be seen through the results from the audit programme that where a need for improvement had been identified this was actioned and subsequent audit demonstrated the progress made.

In addition to the above, we saw areas of good practice:

Patient information leaflets within outpatients were of a very high standard and had recently been developed and improved by members of the outpatient team. The radiology manager told us that the information tools developed were to be showcased within the Ramsay hospital group.

The radiology manager had been recognised by the Head of Diagnostics for Ramsay Health Care UK for her audit work regarding use of "C arm" equipment and had been asked to present her work to the Ramsay Radiology group.

The governance structures enabled national learning from other hospitals within Ramsay Health Care UK.

Patients were positive about their care and experiences. They felt involved in the decisions about their care and treatment and records were completed sensitively.

However, there were some limited areas of poor practice where the provider needed to make improvements:

Action the hospital MUST take to improve

1. The provider must take action to ensure that the appropriate checks and records are in place and recorded for the doctors working at the hospital including Disclosure and Barring Service DBS checks, indemnity insurance and appraisals.
2. The provider must take action to ensure that there is an effective system in place for the timely delivery of blood products from the local provider should an emergency arise and that emergency transport procedures are tested on a regular basis.
3. The provider must improve the security of access to the theatre suite to prevent patients or other people inappropriately accessing this area.

Action the hospital SHOULD take to improve

Summary of findings

1. The provider should ensure that the timings of theatre lists were agreed in advance to avoid patients unnecessarily fasting for an excessive number of hours.
2. The provider should ensure that all staff received an appraisal each year.
3. The provider should ensure that all medical records are fully completed and signed.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Service	Rating
Surgery	Good

Why have we given this rating?

Incidents were reported and dealt with appropriately and themes and outcomes were disseminated to staff. Patient areas were clean and we saw staff wash their hands and use hand gel between patients.

The hospital had not fully implemented the National Patient Safety Agency alert "Emergency support in surgical units: dealing with haemorrhage". The hospital had not fully assured itself that blood products would be transported in a timely manner should an emergency arise.

Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required. Effective medicine management arrangements were in place and effectively followed. Nursing staff were knowledgeable about what actions they would take if they had any safeguarding concerns. There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Nursing, medical and other healthcare professionals were caring and patients were positive about their care and experiences. Patients were risk assessed appropriately and effective pain relief arrangements were in place. Staff were able to recognise and respond to warning signs of rapid deterioration of a patient's health.

Service planning, delivery to meet the needs of people and access and flow arrangements were in place.

There were very few complaints arising from patient experiences in surgical services. There were two negative comments relating to the abrupt manner of a particular doctor who did not introduce themselves. prior to marking the operation site. Information about the hospital's complaints procedure was available for patients and their relatives. The service reviewed and acted on information about the quality of care that it received from complaints.

Staff were aware of the hospital's vision and there were arrangements for monitoring the service at a local level. The hospital had only recently recruited to its full leadership team.

The monitoring system to ensure the consultants' safety to practice within the hospital was not robust at the time of the inspection. At the inspection we found that for a significant number of doctors, the information regarding DBS checks, appraisal information from the

Summary of findings

employing organisation and professional indemnity insurance arrangements was out of date or had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured. This had not been identified as a risk on the hospital risk register.

Outpatients and diagnostic imaging	**Good**	Patients were happy with the care they received and found the service to be caring and compassionate. The positive themes from patient feedback were: caring staff attitude, being listened to and being treated with dignity and respect, cleanliness, the environment and feeling safe. There were also positive comments relating to food. Staff were well trained, provided with good support and worked within nationally agreed guidance to ensure that patients received appropriate care and treatment for their conditions. Patients were protected from the risk of avoidable harm by adherence to policies and procedures and by competent use of clinical risk assessments which ensured care needs were managed appropriately. Staff listened to and engaged with patients to actively seek their opinions. Services were delivered in a way which responded to patients' needs and ensured the departments worked effectively and efficiently. The monitoring system to ensure the consultants' safety to practice within the hospital was not robust at the time of the inspection. We found that for a significant number of doctors, the information regarding DBS checks, appraisal information from the employing organisation and professional indemnity insurance arrangements was out of date or had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured.

Good

Clifton Park Hospital

Detailed findings

Services we looked at
Surgery; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Clifton Park Hospital

Clifton Park Hospital is operated by Ramsay Health Care UK Operations Limited. It opened in 2006 as a purpose built hospital originally contracted to deliver NHS activity for a five year period. The hospital secured a further three year standard acute contract (SAC) in 2010 to deliver orthopaedic services. In December 2014 the hospital was awarded the contract to provide NHS services for the next five years with options to extend a further two years.

Clifton Park comprised 24 inpatient beds, day case facilities, x-ray, theatres, outpatient and diagnostic facilities. The theatre department has a seven bay day care facility, two laminar flow operating theatres, a four bay stage1 recovery, one point of care testing facility and a Theatre Sterile Services unit (TSSU) department. There was also a small physiotherapy gym and a restaurant providing food for patients, staff and visitors. The hospital provided a wide range of elective orthopaedic surgical procedures covering the sub specialities of hands, knees, hips, shoulders, feet and ankles. Referrals were received primarily for NHS patients although there were some self-funding / insured patients (approximately 3%). There was an MRI mobile scanner which visited the hospital every two to three weeks.

Clifton Park primarily serves the communities of York and North Yorkshire and accepts patient referrals outside of this catchment area.

There were no special reviews or investigations of the hospital by the CQC at any time during 2013/14. The hospital has been inspected three times, and the most recent inspection took place in October 2013 which showed the hospital was meeting all standards of quality and safety it was inspected against.

For this inspection, the team inspected the following two core services at Clifton Park hospital:

- Surgery
- Outpatient and diagnostic imaging

Our inspection team

Our inspection team was led by:

Inspection Manager: Karen Knapton, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultants in surgery and anaesthetics, a senior manager from another independent provider, nurses, and an expert by experience who had experience of using healthcare services.

Detailed findings

How we carried out this inspection

We carried out the announced inspection on the 27 and 28 January 2015 along with an unannounced visit at the hospital on 10 February 2015. We talked with patients and members of staff, including ward managers, nursing staff (qualified and unqualified) medical staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patients' clinical records.

Prior to the announced inspection, we reviewed a range of information we had received from the hospital. We also asked the local clinical commissioning group to share what they knew about the hospital.

Facts and data about Clifton Park Hospital

Activity

Between October 2013 and September 2014, the hospital had:

- 3,059 visits to the operating theatre including: 440 hip replacements; 469 knee replacements and; 2,149 other limb surgeries.
- 1229 overnight inpatients
- 1840 day care inpatients

Staffing

At 31 January 2015 the hospital had:

- 34 doctors working under the rules of practising privileges (No doctors were employed)
- 12.5 whole time equivalent (WTE) nurses in inpatient departments, 15.1WTE in theatres and 3WTE in outpatients.
- 4 Physiotherapists
- 1 Occupational therapist (14 hours per week)
- 4.1 WTE healthcare assistants in inpatient departments and 1.5 in outpatients
- A visiting pharmacist and pharmacy technician (for eight hours a week)
- Plus management and administrative staff

Outsourced services

- Pathology services
- Transfusion services
- X-ray services that cannot be provided at Clifton Park Hospital

Our ratings for this hospital

Our ratings for this hospital are:

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

Surgery

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

Information about the service

Clifton Park Hospital comprises 24 inpatient beds, including one isolation room plus a day room. There was a theatre department with a seven bay day care facility, two laminar flow operating theatres, a four bay stage one recovery area, one point of care testing facility and a fully compliant TSSU (Theatre Sterile Services Unit) department. Each theatre is utilised for orthopaedic surgical procedures and operates Monday – Friday from 8.30AM to 9.30PM.

We visited the ward, theatres and day case unit. We talked with 23 patients and relatives and 23 staff, including nurses, allied healthcare professionals, the Resident Medical Officer (RMO), consultants, support staff and managers. We observed care and treatment and reviewed nine clinical records. Prior to the inspection, we reviewed performance information about the hospital.

In addition to the patients we spoke to during the inspection, we received feedback from 34 other patients via comment cards and some who had communicated directly with the CQC.

Summary of findings

Incidents were reported and dealt with appropriately and themes and outcomes were disseminated to staff. Patient areas were visibly clean and we saw staff wash their hands and use hand gel between patients.

The hospital had not fully implemented the National Patient Safety Agency alert "Emergency support in surgical units: Dealing with haemorrhage" Reference number 1025, dated10 September 2007. Clifton Park Hospital had not assured itself that blood products could be transported in a timely manner should an emergency arise.

Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required. Effective medicine management arrangements were in place. Nursing staff were knowledgeable about what actions they would take if they had any safeguarding concerns and had an awareness of the hospital safeguarding systems and processes.

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Nursing, medical and other healthcare professionals were caring and patients were positive about their care and experiences. Patients were risk assessed appropriately and effective pain relief arrangements were in place. Staff were able to recognise and respond to warning signs of rapid deterioration of a patient's health. Some patients fasted pre-operatively

Surgery

for unnecessarily long periods before their surgery. This had been identified by the hospital and an interim measure had been put in place to address this. Interim measures had improved the situation regarding prolonged fasting.

Service planning, delivery to meet the needs of people and access and flow arrangements were in place.

There were very few complaints arising from patient experiences in surgical services. Information about the hospitals complaints procedure was available for patients and their relatives. The service reviewed and acted on information about the quality of care that it received from complaints.

Staff were aware of the hospital's vision and there were arrangements for monitoring the service at a local level. The hospital had only recently recruited to its full leadership team.

The monitoring system to ensure the consultants' safety to practice within the hospital was not robust at the time of the inspection. We found that for a significant number of doctors the information regarding Disclosure and Barring Service (DBS) checks, appraisal information from the employing organisation and professional indemnity insurance arrangements were out of date and had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured.

The hospital recognised the importance of patient and staff feedback and there were mechanisms to hear and respond to patient views. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Are surgery services safe?

Good

Incidents were reported and managed appropriately and themes and outcomes were disseminated to staff. The ward used the NHS Safety Thermometer audit tool for monitoring and analysing harm to patients and 'harm free' care. Patient areas were clean and infection prevention and control procedures were adhered to by the majority of staff.

Effective medicine management arrangements were in place. The patient records we reviewed were detailed and stored securely. There were safeguarding policy and procedures in place to protect vulnerable adults and children from abuse and these were effectively followed by staff. The majority of staff had received safeguarding training. However, the hospital could not provide us with evidence that 20 of the 34 doctors had a current DBS (Disclosure and barring service) check, in line with the hospital's policy.

There were processes in place for staff to recognise and respond to changing risks for patients, including responding to the warning signs of rapid deterioration of a patient's health. Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.

Incidents

- Nursing staff were knowledgeable about the reporting process for incidents using the electronic hospital incident reporting system. Staff said they were encouraged to report all incidents.
- The hospital has reported one unexpected death in the 12 months prior to the inspection, which occurred after discharge from the hospital. The correct authorities were informed and an appropriate investigation took place. There were no actions that the hospital was required to take as a result of this.
- The hospital has reported one serious incident requiring investigation and 15 clinical incidents reported. The rate of all clinical incidents has been consistent over time from January to September 2014.
- There were no themes or trends in the incidents reported although three incidents related to pre-assessment and resulted in postponement of

surgery. One of these was due to delayed MRSA results and a patient needed to have treatment for decolonisation, one patient had not stopped medication as required prior to surgery and one patient had not disclosed a medical concern during pre-assessment which was subsequently picked up by the anaesthetist on the day of surgery.

- The hospital has a current policy for incident reporting and staff were able to explain arrangements for the review of clinical incidents.
- The hospital did not hold separate mortality and morbidity meetings. Incidents and adverse events such as unplanned returns to theatre, transfers out and unplanned readmissions were discussed at the Clinical Governance & MAC (Medical Advisory Committee) meetings. Minutes of the four meetings held in 2014 showed cases were presented and clinical aspects of care discussed. These included a review of an unexpected death that had occurred. Findings of the investigation were disseminated to staff through team meetings and briefings.

Safety thermometer

- The hospital used the NHS safety thermometer which is a local implementation tool for measuring, monitoring and analysing harm to patients and 'harm free' care. Monthly data was collected on pressure ulcers, falls, urinary tract infections (for people with catheters) and blood clots / Venous Thrombo-Embolism (VTE).
- Safety Thermometer information was not displayed in public areas for the patients and public to view. The matron confirmed that a patient information notice board was to be erected and this would include displaying information regarding compliance with patient safety measures.
- There was a high rate of compliance with the VTE risk assessment for the period October 2013 up to September 2014. The hospital carried out VTE risk assessments for 100% of its non NHS-funded adult inpatients in this reporting period (87 adult inpatient admissions). It exceeded the 95% quality requirement for NHS Standard Contract for each quarter in the reporting period. The hospital carried out VTE risk assessments for 99.4% of its NHS funded adult inpatients in the reporting period (2953 adult inpatient admissions).
- The hospital had reported five cases of a hospital-acquired VTE from October 2013 to September 2014, all of which were investigated.
- We saw care records which showed all patients had been assessed and treated against a national surgical VTE pathway as part of an NHS CQUIN (Commissioning for Quality and Innovation) initiative. The hospital also audited the VTE assessments to review what happened as a result of the risk assessment, i.e. what was prescribed, administered and the timescales. Compliance against this audit was 99% in November 2014.
- The hospital had reported four falls between 1 April 2014 and 30 September 2014. There were no pressure ulcers or catheter associated urinary tract infections reported during this time period.

Cleanliness, infection control and hygiene

- The hospital had reported no cases of hospital-acquired infection: Methicillin-Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C. difficile) or Methicillin-sensitive Staphylococcus Aureus (MSSA) for the period from October 2013 up to September 2014.
- The hospital had reported one case of surgical site infection for orthopaedic procedures for the period October 2013 to September 2014.
- Patients who attended the pre-assessment clinic prior to surgery were screened for MRSA and given appropriate treatment if their MRSA screening was found to be positive.
- The service carried out infection control audits; these included hand hygiene, environment, mattresses, Peripheral Venous Cannula Care Bundle and surgical site infection.
- The latest hand hygiene audit (December 2014) for Clifton Park Hospital demonstrated 100% staff compliance with hand hygiene.
- The annual Patient-Led Assessments of the Care Environment (PLACE). In 2013-14 Clifton Park scored 95.5% for the four areas of cleanliness, food, privacy and dignity and the condition of the hospital.
- The Peripheral Venous Cannula Care Bundle audit showed 100% compliance in September 2014.
- Surgical site infection audit showed 92% compliance, documentation of evidence was the area where improvements needed to be made. This had been discussed with relevant staff.

Surgery

- Our observations during the inspection confirmed the majority of staff wore appropriate personal protective equipment (PPE) when required, and staff adhered to 'bare below the elbow' guidance in line with national good hygiene practice.
- All areas we visited had antibacterial gel dispensers at the entrances and by bedside areas. We observed staff washing their hands correctly and using gel appropriately.
- Appropriate signage was on display regarding hand washing for staff and visitors.
- The ward area had facilities for isolating patients with an infectious disease. Appropriate containers for disposing of clinical waste and sharps were available and in use.
- There was an in-house Theatre Sterile Supply Unit (TSSU) for the decontamination requirements of the hospital.
- There was a link nurse for infection control who worked in this role 15 hours a week with support and advice being provided by Ramsay Health Care UK and a local NHS hospital. The matron was the designated hospital lead for infection control.
- There were clear systems and structures for infection control management within Ramsay Health Care UK which were being effectively inplemented.
- Staff were required to attend infection prevention and control training. Records showed staff had completed this training.
- Infection control reports were presented to the hospital's Clinical Governance meetings which included items on infection, prevention and control including audit results and areas for improvements.
- The premises and equipment was visibly clean. Results of the November 2014 environmental audit of equipment stated 100% compliance of equipement cleaned before storage.We saw some equipment on the ward had 'I am clean' labels on. Not all equipment was labelled in this way. Staff told us that although the commodes were not labelled they were cleaned after every use.
- We saw cleaning schedules for most areas and spoke with housekeeping staff. We were told that staff had the correct equipment to carry out their jobs. Not all cleaning schedules were signed to indicate that they were complete; for example, schedules in four of the patient rooms were not signed.

Environment and equipment

- The ward area had single and double rooms each with suction equipment, piped oxygen, a nurse call bell and an emergency button.
- We checked emergency equipment, including equipment for resuscitation, in the ward area, theatres and recovery area and noted that contents were in date and were recorded as checked daily, weekly or monthly dependent on the type of equipment. The resuscitation call system was checked weekly as were the cardiac bleep systems. Emergency equipment was kept in a prominent place, so it could be quickly accessed if needed.
- Staff working in theatres had sufficient theatre instrumentation to enable them to undertake their operating lists.
- In theatre, there were maintenance records of checks made at regular intervals to prevent the failure of equipment before it actually occurred and staff carried out their own equipment checks and logged the result. Records showed checks had been completed.
- In-service and testing of electrical equipment (PAT) had been recorded in the ward and theatres.
- The theatre doors were not locked at any time which meant that patients or other people could access the theatre suite. We raised this with senior management who told us they were aware of this risk and had obtained a quote in 2014 for swipe cared activated locks to be fitted. However, this had not happened. At the unannounced inspection, the manager told us that new quotes were being obtained to fit the locks.
- There was a CCTV monitor showing the main entrances with a phone connected to the ward so staff could see and speak with people wanting to enter the building out of hours.

Medicines

- Medicines were appropriately stored and there were systems in place to check and manage medicine stock. All areas we visited had appropriate lockable storage facilities for medicines.
- A pharmacist from Ramsay Health Care UK visited the hospital three times a week to undertake: audits, policy review and updates, destruction of controlled drugs CDs, recording of stock wastage, stock checks and rotation, patient visits and education.
- The hospital employed a pharmacy technician for eight hours per week over two days to support the pharmacist and clinical team.

- There was a stock list on the ward which was recorded as being checked on a weekly basis. Stock was ordered electronically and delivered to the stores department in sealed packages.
- Records showed drug fridge temperatures were checked daily and included minimum and maximum temperatures which were within range.
- The controlled drug register and other medication registers confirmed there was a checking process in place. Records showed regular monitoring and audit of the management and use of controlled drugs in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006. An audit carried out in December 2014 showed 99% compliance.
- Prescribing and medicines management audits were in place and routinely completed. The December 2014 controlled drug audit showed 99% compliance with all actions and the November 2014 prescribing audit showed 90% compliance. The matron had spoken to medical staff regarding the areas where improvements needed to be made. The prescribing audit was to be repeated May 2015.
- Any medication to take home was dispensed by the RMO from stock held onsite
- We observed nurses administering medication and this was in line with the Nursing and Midwifery Council (NMC): Standards for Medicines Management.
- Protocols were in place regarding stopping anticoagulants and other medication pre-operatively and had been laminated and displayed for staff to refer to when advising patients during pre-assessment.
- Where appropriate, medicine protocols were in line with the Trust which seconded the consultants to the service.

Records

- There was a current medical records management policy.
- The hospital had an integrated care record system that included key health questions, pre-assessment, risk assessments, anaesthetic room care, care during the procedure, recovery care, and post-operative care and discharge arrangements. All healthcare professionals including consultants, nurses and the RMO documented care and treatment in the booklet.
- We reviewed nine patient records. Almost all records were completed correctly.
- Most pre-operative assessments were completed however there were some gaps in the records we looked at. Each record had at least one gap; they all related to different areas. It was noted that certain observations such as temperature, respirations or blood pressure were missing from the pre-assessment documentation and no rationale was given for the omissions. In two records there were missing initials from nutritional and or infection prevention and control assessments so it was unclear whether these assessments had been carried out.
- In one patient's notes, there was a change to protocol which was recorded within the nursing notes but there was no medical decision-making recorded to support the change and the rationale.
- Health record keeping standards were audited twice a year and actions taken. The July 2014 Pre admission / Discharge Planning audit showed 96% compliance and indicated that actions had been taken to further improve this. However, the completeness of the records was not included as part of the audits.
- The medical records / deteriorating patient audit September 2014 had an 'Amber' flag (compliance level in the range from 80 to 89%): and an audit score of 80%. A further audit In January 2015 indicated a significant improvement with an audit score of 99%.
- Current patient records were available on site in a dedicated medical records storage room.
- All other records were stored off site by an accredited provider with the facility of the scanned records being available electronically, if required, for an unexpected patient attendance.
- We were told that consultant staff did not remove patient records from the site.

Safeguarding

- Patients reported that they felt safe within the hospital.
- There were leaflets available for patients, staff and visitors "Keeping people safe from abuse" throughout the hospital which included who to contact if people were concerned.
- There were safeguarding policies and guidelines in place for the protection of vulnerable adults. Staff had access to a flowchart to aid with decision-making and reporting safeguarding concerns.
- The hospital matron was the named lead for adult safeguarding and was supported in this role by ward and outpatient leads.
- No safeguarding alerts or concerns had been raised in the last 12 months prior to the inspection.

- Nursing staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and had an awareness of the hospital safeguarding systems and processes.
- All staff undertook Level 1 safeguarding adults and children as part of their corporate induction and on-going mandatory training. The training compliance rate was 78% in April 2015 (which was mainly due to new staff who still had to complete the training).
- All clinical staff were required to undertake Level 2 adults and this was being set up corporately.
- Both Clinical and non-clinical staff also undertook Level 2 children's safeguarding by e-learning.
- In addition, all staff who have patient interaction (65 staff), have undertaken a DVD based training programme which covered safeguarding/DOLS/MCA. This was to be repeated in May 2015.
- There were also 10 "safeguarding champions" who have undertaken an online safeguarding vulnerable adults course
- At the time of the inspection, the hospital could not provide us with evidence that all the doctors had a current DBS check as required by the hospital's policy. The hospital could verify that 14 of the 34 consultants had current DBS checks. The secondment agreement did not provide any detail regarding regularity of DBS checks. This issue was raised with the hospital management team at the time of the inspection and the employing trust was contacted immediately to provide this assurance.

Mandatory training

- We saw a copy of the hospital's mandatory training matrix setting out the training that should be delivered to staff and the frequency of this.
- Compliance with mandatory training levels was good. Nursing staff told us they had received mandatory training. The mandatory training for ward staff included: blood transfusion, basic life support, immediate life support, health and safety, safeguarding, fire, infection control, manual handling, food hygiene, customer services data protection and security. Records indicated that all staff had completed these for 2014.
- The hospital had processes in place to ensure all staff received mandatory training and where required additional training sessions were provided to fit around staff shift patterns.

Assessing and responding to patient risk

- As part of the NHS contract, there were clear acceptance criteria in place to determine which patients could be treated at Clifton Park Hospital. This was part of the risk assessment process for each patient.
- Patients were assessed in a nurse-led pre-assessment clinic, usually at least a week prior to their surgery, with referral to a consultant anaesthetist if required.
- There was an effective process in place at the hospital for screening of patients to establish level of anaesthetic risk and appropriateness of referral. Prior to attending the hospital for a pre-assessment, a medical questionnaire was completed by patients or their carer and was triaged by the hospital Matron or senior nurse to allocate them for the appropriate pre-assessment.
- Anaesthetic risk was determined using the American Society of Anaesthesiologists (ASA) grades which describe fitness to undergo an anaesthetic. Predicted risk was used to determine the level of pre-operative assessment required i.e. ASA 1: no further assessment required, ASA 2: a pre-assessment telephone call or face to face assessment, ASA 3: a face to face nurse assessment, ASA grade of more than 3: consultant anaesthetist assessment. All patients undergoing major orthopaedic surgery were scheduled for a face to face assessment regardless of the ASA predicted risk.
- Pre-admission assessment followed a clear pathway incorporating a number of patient risk assessments. Pre-operative tests were undertaken according to NICE guidance and patients also underwent a comprehensive pre-operative physiotherapy assessment.
- Further assessments of patients were conducted on admission; these included a pressure care risk assessment, patient handling, a risk assessment for VTE and a nutritional assessment. We reviewed medical records that confirmed pre-assessment and other risk assessments were conducted.
- Staff we spoke with told us the anaesthetists did not leave the hospital until recovery staff were confident that all the patients were in a satisfactory condition.
- There were systems in place for the management of deteriorating patients. The hospital used an early warning score system (EWS). EWS ensured standardisation of acute illness severity in hospitals.

EWS scores were incorporated in the routine observations and we found these were comprehensively completed to ensure patients were being appropriately assessed for any signs of deterioration in their condition.

- Dependent on the nature of the deterioration, patients were managed in different ways. The hospital had agreements in place with the local NHS Trust and patients were transferred there, either to the orthopaedic wards or other services if required.
- Should a patient deteriorate and require an intensive care bed then the hospital worked with the local NHS Trust as part of the Critical Care Network to identify a bed.
- Medical and nursing staff told us they were able to manage a deteriorating patient within the recovery area in theatres. An anaesthetist and/or a consultant would manage a deteriorating patient until the patient was transferred to an NHS facility.
- Staff were trained to manage the sudden deterioration of patients. Qualified nursing staff had acute illness management (AIM) training every three years. All staff received immediate life support (ILS) training annually. The RMOs were certified as having received training and achieved the required standard in advanced life support (ALS). We saw individual certificates for this and it was explicit within the contract with the company that provided the RMOs.
- There was a policy and protocols in place for the management of adult medical emergencies.
- There was a policy for blood transfusions. Two units of O negative red cells were stored in the hospital for emergency use. An audit for safer blood transfusion (October 2014) showed compliance of 100%; however there was only one patient receiving a transfusion at the time of the audit.
- We observed the theatre team undertaking the 'Five steps to safer surgery' procedures World Health Organization (WHO) checklist. All processes from the sign-in before induction of anaesthesia to the sign-out when the patient left theatre were completed correctly.
- Information for August 2014 showed 100% of the WHO checklists had been completed and 92% for November 2014. An action for November was to ensure that the checklist was always competed at sign-out. A further audit was due in February 2015.
- Staff said they discussed any patient risks or abnormal test results pre-operatively with consultant anaesthetists to decide whether surgery needed to be postponed or the patient transferred to the NHS as a higher risk case. This was corroborated in a set of records we had reviewed where a nurse had concerns regarding a patient's medication at pre-assessment.

Nursing staffing

- Ramsay Health Care UK have recently introduced a new rostering management system which allows heads of departments to manage rotas, skill mix, and staff requirements including senior cover requirements. We were told it also monitored safety and effectiveness of staffing levels and allows heads of departments to manage sickness and annual leave absences.
- At the time of the inspection there were minimal vacancies: one registered nurse (RN) and a healthcare assistant (HCA) post for two nights a week. There were no vacant theatre posts.
- Nurse staffing levels on the ward were linked to the number of patients. If there were over 18 patients then there was usually three RNs and two HCAs during the day and two RNs and one HCA overnight. The sister informed us that depending on the needs of patients, additional nursing staff could be rostered for any given shift.
- From October to December 2014 there were always a minimum of two RNs on duty overnight with one HCA on a Tuesday to Friday. On the day shifts, the rotas indicated that there was a minimum of two RNs on duty at weekends plus an HCA on a Saturday. During the week there were three RNs and at least one but usually two HCAs. In addition there was ward administration support between 8am to 12noon Monday to Friday and student nurses who were supernumerary.
- The day case unit was staffed by the ward team.
- Pre-assessment was staffed separately although two ward staff were trained to cover this area if required. Staffing for the pre-assessment of patients was adequate to meet patient need.
- Staffing in theatres was staged to accommodate times when there were three lists a day.
- Ideal and actual staffing numbers were not displayed on the ward.
- The rate of sickness for all nursing staff reported by the hospital had fluctuated between 0 and 10% over the reporting period from October 2013 to November 2014. There was no clear trend (rising or falling rate of sickness absence) and the rate of sickness peaked in December 2013 (12%) and July 2014 (11%).

- The requirement for the use of agency staff by hospital inpatient and theatre departments has been consistently low. The hospital used the same agency when it required additional staff. We were told it was usually the same nurse that covered shifts which meant they were familiar with the hospital and its procedures. The hospital also had its own bank staff that were used as required.
- Three staff commented that on the days with three theatre sessions they often did not know when their shifts would finish: "It could be 6.30pm or 9pm".

Surgical staffing

- The local NHS Trust was the substantive employer for the consultants who worked at Clifton Park Hospital under practicing privileges. Surgeons were seconded from the local NHS trust to work two to three sessions per week.
- All patients were admitted under the care of a named consultant. Consultants visited and reviewed their patients on a daily basis. Out of hours they were available to be contacted by the Resident Medical Officer (RMO). Staff and the RMO we spoke with raised no concerns about the support they received from consultants or their availability.
- Specialist registrars and registrars supported the consultants as part of the arrangements with the local NHS Trust.
- There was 24-hour on-site medical cover by an RMO. The hospital contracted with an agency to provide RMOs who lived on-site for a continuous seven or 14 day period. The hospital used regular RMOs with one being contracted for the previous three years. We saw that the RMOs had current advanced life support training.

Major incident awareness and training

- The hospital had a major incident plan which identified the roles and responsibilities of the senior management team and staff. The hospital recognised the importance of external major incidents; however as a private healthcare provider its capabilities fell outside the areas of services that would normally respond to an external major incident.
- Staff told us they participated in training for emergency scenarios such as fire evacuation, loss of vital services and responding to a cardiac arrest. We saw evidence of the resuscitation practice runs being carried out at least once every two months. There was learning and action plans in place. In addition we were told there was a Ramsay Health Care UK audit completed after each practice.
- Desk top scenario/simulation exercises were run by though senior management. The last exercise one was in January 2014 with a further one planned for February 2015.
- Business continuity plans for surgery were in place. These included the risks specific to each clinical area and the actions and resources required to support a return to normal services.

Are surgery services effective?

Good

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes.

Patients received care and treatment from competent staff, patients were risk assessed appropriately and effective pain relief arrangements were in place.

Some patients fasted pre-operatively for unnecessarily long periods before their surgery. This had been identified by the hospital and an interim measure had been put in place to address this.

The consultants' appraisals were completed by the local trust from which they were seconded. However, at the time of the inspection, the hospital could not provide evidence that all of the 34 consultants had been appraised by the Trust in the past twelve months. On the 10 February 2015, the hospital submitted figures to CQC which had improved and demonstrated that the hospital had evidence that 26 of the 34 consultants had been appraised.

Evidence-based care and treatment

- Care pathways were detailed and staged. Evidence based care and treatment was carried out in line with National Institute for Health and Care Excellence (NICE) guidelines and other recognised organisations, such the Royal College of Anaesthetists and the Association of Perioperative Practice.

Surgery

- Pre-assessment staff were seen to be following the NICE guidance relating to preoperative tests and the prevention and treatment of surgical site infection.
- The hospital had specific pathways / care records for each surgical procedure; for example, "Day case pathway under local anaesthetic" and "Hip replacement rapid recovery care pathway – 3 day".
- Overall the hospital responded to the Central Alert System (CAS). However we noted it had not fully implemented the National Patient Safety Agency alert "Emergency support in surgical units: Dealing with haemorrhage" Reference number 1025, dated10 September 2007. The hospital received its blood products from the local NHS hospital. It held two emergency units of blood on site but any further blood requirements had to be transported from the NHS hospital. Clifton Park Hospital had not assured itself that blood products could be transported in a timely manner should an emergency arise. We raised this with the matron and they confirmed that they would put the necessary checks in place. The hospital submitted evidence that they had completed a blood loss scenario and all blood products were received within 30 minutes. Also an external audit of the blood transfusion service had taken place on the 25 March 2015 and an action plan developed to ensure compliance with this requirement.
- Policies and procedures were developed by Ramsay Health Care UK and implemented locally. We saw that staff had signed to say they had read any new or changed policies that had been issued, for example a pre-operative urinalysis policy had been issued in December 2014 and 15 staff had signed to say they had read this.
- Ramsay Health Care UK ran a clinical review programme which Clifton Park Hospital participated in. We saw the report for a review of both operating theatres and physiotherapy. This included assessing compliance with the critical checks to safety during the patient pathway from the ward area, through theatre to recovery. Clifton Park Hospital was one of the four top performers out of the 29 Ramsay sites reviewed.
- We saw a copy of the hospital's current audit programme. The majority of audits scored 90% or over, however two of the audits completed had an 'Amber' flag (compliance level in the range from 80 to 89%): September 2014 – Medical records / Deteriorating patient (audit score of 80%). No new audit has taken place yet based on information available to CQC.
- The second amber audit was also in September 2014 and was in relation to Medical records / Nutrition and hydration – see section below.

Pain relief

- Patients were asked about pain relief and given medication when required. Patients' comments included "I've not had much pain and when I had, I was given tablets" and "I've had no pain to date as I had a spinal".
- We reviewed a number of patient records and saw pain scores and pain relief for patients undergoing a variety of procedures was documented.
- An enhanced recovery pathway was planned for patients in 2015/16 who were admitted for surgery. It would ensure patients were provided with defined pre-operative, peri-operative and post-operative analgesia, which meant early patient mobilisation, independence and earlier hospital discharge.
- The most recent patient satisfaction survey (2013) showed 92% of patients said "Staff did all they could to help control pain" compared to the Ramsay Health Care UK average of 93%.

Nutrition and hydration

- Patients reported that they had a choice of food and that the food was "good and nutritious"
- The hospital's food preparation facilities have received a rating from the Foods Standard Agency (FSA). The FSA reported a rating of 5 in September 2014 – the best rating possible – and CQC assessed the hospital to be 'Much better than expected' compared to the other independent acute hospitals we hold this type of data for.
- The Malnutrition Universal Screening Tool (MUST) was in place and documented within patient records. Records showed these had been completed accurately.
- A medical records audit during September 2014 highlighted recording of Nutrition and hydration as having an 'Amber' audit score of 82%. A new audit was carried out in December 2014 and an improved score of 93% was recorded –'Cool Amber' flag, compliance level in the range from 90 to 99% was reported.

- Nausea and vomiting was formally assessed and recorded during recovery and post-operative care. The patient records we reviewed confirmed this had been carried out.
- A variety of food was available that included vegetarian options, gluten-free, lighter options and multi-cultural food choices. Patients said, "The food was good", and "There was plenty of choice".
- The hospital did not directly employ dieticians but staff told us they could access advice when required.
- There was a pre-operative starvation policy in place which was last reviewed in 2007 and due for review in 2016. It set out the minimum fasting times for solid food and drinks.
- Some patients fasted pre-operatively for unnecessarily long periods before their surgery. We spoke with three patients on the 27 January 2015 who had not eaten since the previous evening and had not gone to theatre until between 4-5pm the following afternoon. We raised this concern with the Matron and general manager. They told us this issue had already been identified internally and discussed at a recent clinical governance meeting. The hospital was reviewing its procedures and would amend processes so it was clear to staff and patients from what point patients were not allowed food or drink.
- We noted at the unannounced inspection that an interim measure had been put in place to decrease the times that patients had to fast. The anaesthetist reviewed the theatre list on a daily basis and recorded what time each patient had to fast from. This was discussed at the theatre "huddle" meeting each morning and fasting times then recorded and shared with the ward staff. This meant that patients who were not being operated on until the afternoon were offered a light breakfast and fluids up to the agreed time. Patients we spoke with on the unannounced inspection confirmed that this was in place.

Patient outcomes

- The hospital makes submissions to the National Joint Registry (NJR) and has been referenced as an outlier for its revision rate for hip replacement in the NJR Annual Report 2014. These were higher than normal due to a national alert regarding a specific prosthesis that required a recall of patients for revision surgery. Although Clifton Park hospital undertook a large number of revisions the original surgery had taken place at a number of other providers in addition to those originally performed at Clifton hospital. . Evidence indicated that the rate was decreasing year on year from over 80 revisions in 2012, to 62 in 2013 and 31 in 2014.
- The rate of unplanned transfers of an inpatient to another hospital is consistently low; there were nine cases of unplanned transfer to another hospital from October 2013 to September 2014.
- There were two cases of unplanned return to theatre for the same time period which was similar to expected compared with other independent health hospitals.
- For NHS-funded patients only, the emergency readmission rates from April 2013 to March 2014 for hip and knee replacement by the hospital was compared to the other independent acute hospitals for which CQC holds this data type. This data indicated that the hospital was similar to expected for its emergency readmission rate following a hip replacement procedure and similar to expected for its emergency readmission rate following a knee replacement procedure.
- The hospital had reported only one unplanned readmission.
- The hospital participated in the Patient Reported Outcome Measures (PROMs) for its NHS patients having hip replacements. The outcomes for the PROMS 2013 /14 (provisional) showed the percentage of Clifton Park Hospital patients that declared a health gain following a primary knee replacement procedure was better than reported nationally and that following a primary hip replacement it was slightly below the national average.

Competent staff

- There were formal induction processes for all employed staff. These had been revised by Ramsay Health Care UK in July 2014. Agency staff underwent local induction and the hospital tended to use its own bank staff or regular agency staff so they could be assured of competency.
- The hospital reported that in 2013/14 there was 67% of nursing staff, 90% of AHPs, 57% of ancillary staff and 63% of administrative and clerical staff who had received an appraisal. Apart from nursing staff the appraisal rates had worsened for the period April to November 2014. For nursing staff it was up to 69%, however for AHPs it was 75%, ancillary staff 42% and for administrative and clerical it was 57%.
- We saw training and development files for staff on the ward area. These were up to date and comprehensive.

Surgery

- We saw examples of competency packages for staff including RNs, HCAs and ODAs (Operating Department assistants) which were in line with the guidance from the Association for Perioperative Practice (AfPP).
- Staff told us they were supported to take further training. For example, the pre-assessment lead had attended a 3 day specialist training course in pre-assessment and was booked for an additional course in March 2015.
- The key skills / competency framework for pre-operative assessment was clear and contained robust and comprehensive assessment criteria. The framework covered key skills such as; communication and information giving, history taking, clinical examination, ordering and interpretation of investigations required for preoperative assessment, altering medications to maximise surgical safety, airway assessment and preoperative assessment outcomes.
- Staff undertaking phlebotomy in the pre-assessment or outpatient area had all received competency based training and assessment provided by the pre-assessment and blood transfusion lead.
- Revalidation was completed via the employing organisations with input from Clifton Park.
- The RMOs were appraised by the company providing the RMOs to Clifton Park Hospital. This company also managed the revalidation process for the RMOs. The hospital had submitted a six monthly appraisal for each RMO to this company and received copies of relevant documentation.
- There were arrangements in place for the sharing of information between the service and the substantive employer of consultants working at the hospital under practicing privileges. The secondment agreement stated that "The Employer warrants that each member of the Seconded Staff; holds the relevant qualifications required to fulfil his role…" and "are not currently subject to an alert letter notifying the National Health Service or any of its bodies of a Secondee whose performance or conduct could place Host staff, Seconded Staff or patients at risk." It also stated that the employer should provide Clifton Park hospital with copies of appraisals. However, the agreement did not provide any detail regarding on-going assessment of competence or appraisal, regularity of DBS checks or whether seconded staff held personal indemnity insurance.
- The hospital supplied the consultants with revalidation information for the purpose of their appraisals which were completed by the local trust. In return a copy of the appraisal summary should be forwarded to the hospital to be included in the consultants' personnel files. Although the consultants and managers we spoke to were confident all medical staff were up to date with appraisals, the documentary evidence to support this was incomplete. At the time of the inspection the hospital could not provide evidence that 20 of the 34 consultants had been appraised. We raised this concern with the manager who sent further reminders to the consultants. On the 10 February 2015 the hospital submitted to CQC figures which had improved; the hospital had evidence that 26 of the 34 consultants had been appraised.
- As part of the secondment agreement with the substantive employer of the consultants, any HR issues or concerns were to be communicated by both parties.
- All of the doctors and nurses in post had their registration status verified by the hospital.

Multidisciplinary working

- Records showed details of referrals, including those made to community nursing teams and occupational therapy services. The hospital employed its own physiotherapists. This meant that multidisciplinary team support was available if patients required it.
- Effective team working between ward and theatre staff was observed; interactions, interventions and treatment were recorded.
- Electronic discharge letters were sent to the patient's general practitioner (GP) and a copy of the letter provided to the patient.
- There were specific agreements in place for working with the local NHS trust, for example, there were service level agreements in place for blood testing, blood transfusions, pathology, transfer of critical patients, CT scanning and long bone radiography.

Seven-day services

- An RMO was available and onsite 24 hours a day seven days a week.
- Consultants provided 24 hour on-call (off site) cover for patients.

Surgery

- There was no on-site hospital pharmacy. The hospital was supported by a Ramsay Senior Pharmacist. There was a corporate contract with a pharmaceuticals company for provision of pharmaceutical products.
- Radiographer and physiotherapy cover was provided 24 hours a day and seven days per week to meet the needs of inpatients and theatres. Night and weekend on-call was organised by a rota system.
- Theatres were available 8am to 9.30pm Monday to Friday.
- There were arrangements in place for the management of 24/7 consultant on-call cover. As part of the secondment agreement with the local NHS Trust, the hospital had the provision of 24-hour on call cover from both consultant orthopaedic surgeons and anaesthetists.

Access to information

- The care pathway records contained all of the information staff needed to deliver effective care and treatment and included information on risk assessments, care plans and medical notes.
- There was evidence of clinical discharge information being provided to receiving healthcare professionals with a copy given to the patient.
- There was a visible patient board which clearly indicated at a glance key information for staff including the named doctor, named nurse, and whether the patient was pre or post-surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The care pathway contained several sections where consent was discussed with the patient and had been obtained for treatment and care. We reviewed consent forms and found these were completed appropriately and in line with Department of Health guidelines.
- Patients confirmed they had received sufficient information regarding the risks and benefits of surgery to enable them to make an informed choice.
- There was information visible and available for staff about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The hospital confirmed that staff who had patient interaction (65 staff), had undertaken a video based training programme which included DoLS and MCA. This training was due again in May 2015.
- The hospital did not admit patients with advanced dementia, although patients with mild dementia could be admitted for surgery and their care planned so their individual needs were met. Pre-assessment information showed planning took place to accommodate patients with mild confusion. An multi-disciplinary approach was undertaken which included family or carers. A room near to the nurse's station was provided and staffing levels increased if one to one care was required.

Are surgery services caring?

Good

Nursing, medical and other healthcare professionals were caring. We observed staff interacting with patients in a respectful and considerate manner. Patients were positive about their care and experiences. They felt involved in the decisions about their care and treatment and records were completed sensitively.

Feedback from Friends and Family Test (FFT) and NHS choices were extremely positive and the latest Ramsay Health Care UK patient survey of the hospital indicated that 88% of patients felt they got enough emotional support from staff compared with a Ramsay Health Care UK average of 89%

Compassionate care

- The hospital had a policy for staff regarding maintaining people's privacy and dignity.
- Almost all the patients we spoke with told us they were very happy with the service they had received from the hospital. Patients said that staff were caring, friendly and courteous.
- Patients told us "The staff should have full marks", "I even had music in headphones to listen to during the operation", "The care was wonderful, like a five star hotel" and "I've not been in pain". Other patients told us staff were very quick to answer call bells and they were treated with dignity and respect.
- NHS England reported high overall quality scores for the Friends and Family Test (FFT). Between November 2013 and October 2014 the hospital had consistently scored above 95% for overall quality of care from the 1,457 NHS patients that responded to the survey.

Surgery

- Patient feedback about the hospital via the NHS Choices website overall aligned with the FFT scores reported above.
- The latest Ramsay Health Care UK patient survey of the hospital indicated that 88% of patients felt they got enough emotional support from staff compared with a Ramsay Health Care UK average of 89%

Understanding and involvement of patients and those close to them

- Patients told us they were involved in their care and that information about their treatments was given and explained to them. Patients were routinely contacted by phone pre-operatively as well as receiving written information about their procedure. There was a specific pre-op phone call check list for staff to use which covered a number of areas including checking patients had read information about the operation, any particular dietary requirements and discharge arrangements. One patient said "I had all my questions answered. I feel well prepared. They rang me to confirm the booking and what times I had to fast from".
- Patients told us staff spoke to them about their care and treatment in a way they were able to understand.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers for the hospital to ensure they had adequate support on discharge.
- The hospital's patient satisfaction survey showed that for the important questions 96% of doctors and 94% of nurses answered them in an understandable way.

Emotional support

- Hospital visiting hours were Monday to Friday 1.30pm to 7.45pm and Saturday, Sundays and Bank Holidays 11am to 5.45pm, which meant patients could have access to their family and friends for support if they chose to do so. A patient told us they thought visiting hours at the hospital were "very flexible".
- For patients who needed further emotional support, staff told us they had the time to offer reassurance when required. We spoke with one patient who had been concerned about their operation and recovery. They felt staff had been very supportive and had planned an extended stay to suit their needs.
- Staff were aware of a range of counselling services where patients could be signposted if required.
- Pre-assessment staff gave examples of how they listened to patients and made a holistic assessment of patient's well-being and readiness for surgery.

Are surgery services responsive?

Good

We found the service was responsive. Service planning, delivery to meet the needs of people and access and flow arrangements were in place.

There were very few complaints arising from patient experiences in surgical services; the main one being in relation to extended periods of fasting and lack of staggered admission times, which were being addressed by the hospital. Information about the hospital's complaints procedure was available for patients and their relatives. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- The hospital had a contract with the NHS for orthopaedic surgical procedures and associated care. The contract set out various exclusions, which included not allowing the hospital to admit patients whose pre-existing medical condition was not deemed stable.
- All admissions for surgery were planned in advance and included private patients and NHS patients.

Access and flow

- Access and flow was linked to the hospital's booking system and surgery was elective other than those patients who had to return to theatre unplanned.
- We found that theatre staff had an on-call arrangement to manage any unexpected returns to theatre. This arrangement included night and weekend cover.
- There was a low rate of cancellation of operations.
- Records showed there were no theatre cancellations between January 2014 and 30 September 2014 for non-clinical reasons.
- There were 19 operations cancelled for clinical reasons between January 2014 and 30 September 2014; all of which were reviewed by the Clinical Governance & MAC Meeting. There were no particular themes or trends.

- The staff acknowledged there were some issues in relation to the patient wait times from admission to theatre caused by a mixture of block admissions and reshuffling of theatre lists. See section below re meeting people's individual needs.
- Discharge planning commenced at the pre-assessment stage. Planning for discharge continued during admission with specialists such as social services being identified and arranged for while the patient was in the hospital.

Meeting people's individual needs

- Patients told us that their individual needs were met. However five inpatients we spoke with commented that they did not understand why they had been asked to attend the hospital at 7.30am but were not being operated on until the late afternoon. Clifton Park Hospital had also identified these issues in its "Quality Accounts" 2013/14 and was working towards putting improvements in place.
- One of the few pieces of negative patient feedback from post-operative patients interviewed in the outpatient department was again in relation to extended periods of fasting and lack of staggered admission times.
- To reduce delays and problems on the day of surgery, such as extended fasting, the pre-assessment staff were telephoning patients 24-48 hours prior to admission to ensure all arrangements were in place for admission, that medications had been stopped as appropriate and that fasting instructions were fully understood. This would offer the opportunity to change fasting instructions if the order of theatre lists had changed or to tailor instructions to the individual's needs.
- Staggered admission times were gradually being introduced and the management team were exploring with consultants ways of ensuring theatre lists could be managed to reduce the need for extended periods of fasting for patients.
- Staff informed us patients' individual needs were assessed at pre-assessment clinic.
- The hospital did not routinely screen for dementia. All patients were risk assessed prior to surgery and patients with more complex needs were not usually admitted. Patients who required extra care, such as those living with mild dementia or a learning disability would be assisted by ensuring there was extra staff available and arrangements were made for their carers to help if required.
- Staff responded promptly to call bells and undertook their nursing duties in an unhurried manner. Patients we spoke with said staff responded promptly when they needed them.
- Staff knew how to access interpreting services if required.
- Some patient information leaflets were available in large print for patients with visual impairment. Patient information was not kept in alternative languages but staff explained they had a process in place to translate leaflets as and when necessary.
- There were systems and procedure in place should anyone require end of life care. Staff we spoke with were aware of the procedures and showed us a bereavement folder which contained all the relevant information. The hospital did not admit patients at end of life care but had appropriate procedures in place for the escalation and transfer of patients who may unexpectedly deteriorate.

Learning from complaints and concerns

- Complaints were handled in line with the hospital policy. Information was given to patients about how to make a comment, compliment or complaint.
- The general manager was responsible for the management of complaints. Dependent on the nature of the complaint received, this was forwarded to the relevant head of department or team leader for investigation. The complaints were handled according to hospital policy. Complaints were tracked both by the Ramsay Health Care UK corporate system and also at a local hospital level.
- The overall complaint rate was very low: six in 2013/14 and six from April to November 2014. Of the complaints received: four were concerns about surgical outcome, further consultations were arranged with consultants to reassure patients. Three were regarding delay from admission to surgery. This was being addressed through Clinical Governance and discussions with surgeons and anaesthetists. The remaining five were a variety of issues with no common theme.
- The Matron did a daily walk round which included checking if patients were satisfied with the care and treatment they had received.
- Complaints were discussed at the hospital's Quarterly Clinical Governance / MAC meetings.

Surgery

- NHS complaints were discussed with the local Clinical Commissioning Group (CCG) which then determined sign-off and closure.
- Complaints were reported to the Ramsay Health Care UK corporate team in a monthly report.
- Patients were given a "We Value Your Opinion" leaflet to complete, and leaflets were displayed throughout the hospital regarding how to make a complaint.
- Learning from complaints was disseminated via heads of department meetings and team meetings.
- Examples of changes made as a result of learning from complaints were: ensuring patients received "aids" e.g. raised toilet seats, at pre-assessment groups where possible. Complaints received highlighted that equipment and aids occasionally were missed at discharge (particularly at weekends). This was now also included in the discharge checklist.
- In response to complaints and other patient feedback, the hospital was working towards staggering admission times to reduce the patient waiting time between admission and surgery. The pre-admission telephone call was seen to be enabling a more individualised approach to fasting instructions for patients. It was recognised by the hospital management team that this was a work in progress and patient feedback still indicated some patients were having longer than necessary periods of fasting.
- One complaint was tracked through the process and it was seen that the hospital had taken the complainant's concerns regarding assessment of readiness for discharge seriously. The complaint handling was appropriate and the patient had been given the opportunity to discuss his concerns face to face with the hospital manager. Awareness had been raised with staff regarding the thoroughness of discharge assessment and the need to ensure the patient's views were actively sought.

Are surgery services well-led?

Requires improvement

The monitoring system to ensure the consultants' safety to practice within the hospital was not robust at the time of the inspection. At the inspection we found that for a significant number of doctors, the information regarding DBS checks, appraisal information from the employing organisation and professional indemnity insurance arrangements was out of date and had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured. This had not been identified as a risk on the hospital risk register.

The hospital had not fully implemented the National Patient Safety Agency alert "Emergency support in surgical units: Dealing with haemorrhage" Reference number 1025, dated10 September 2007. Clifton Park Hospital had not assured itself that blood products could be transported in a timely manner should an emergency arise.

Staff were aware of the hospital's vision and there were good arrangements for monitoring the service at local level. There was a new local leadership team in place.

The hospital recognised the importance of patient and staff feedback and there were mechanisms to hear and respond to patient views. Staff were encouraged and knew how to identify risks and make suggestions for improvement. Quality of care and patient experience was seen as all the staff's responsibility.

Vision and strategy for this service

- There was a clear mission and vision for the hospital and for Ramsay Health Care UK: "The Ramsay Way" included being caring and progressive as well as valuing people through personal and professional development.
- Staff could tell us what the vision and strategy for the hospital was. They were aware of a clear strategy which focussed on Delivering a cost effective, high quality service to patients to ensure business sustainability

Governance, risk management and quality measurement

- There were systems and processes in place for assessing risks. However the risk risk register did not include all the risks indentified at the inspection. Management were aware of the risks and responded promptly when we raised our concerns.
- The hospital had a Clinical Governance structure which due to the small size of the hospital had combined a number of other committees including the Medical Advisory Committee (CGMAC) and the infection prevention and control group. We saw copies of the last

four CGMAC meetings and noted that its members reviewed the quarterly Clinical Governance report which included a summary of the hospital key performance indicators.

- Agendas for the CGMAC were set corporately, but included local issues, which helped to ensure compliance with Ramsey Health Care UK requirements. The chair of the Clifton Park CGMAC reported to the corporate MAC.
- There was a proactive approach to monitoring and measuring various aspects of quality and safety. This included external assurance and challenge from both Ramsay Health Care UK and the local CCGs. There was a corporate governance team which reviewed all the Clifton Park hospital audit results, actions taken and improvements made as demonstrated in subsequent audit.
- There were monthly meetings with the CCG which included discussions on performance, quality and complaints.
- The hospital provided a copy of its current audit programme which included for each audit: references to national standards and best practice; the audit criteria and outcomes; follow up comments from any previous audit's action plan; conclusions/comments; action plan, person responsible and timescale for completion.
- Ramsay Health Care UK used a balanced scorecard approach to give an overview of audit results across the critical areas of patient care. The indicators on the Ramsay scorecard were reviewed each year. The scorecard was reviewed each quarter by the hospital's senior managers together with regional and corporate senior managers.
- All incidents were reported up to Ramsay Health Care UK through the national governance system. Governance arrangements enabled the effective identification and monitoring of clinical risks and action was taken to improve performance. Progress on achieving improvements were reported and measured through the relevant committees with oversight and scrutiny from the provider's quality governance committees with ultimate responsibility resting with the Ramsay Health Care UK chief executive and board.
- Ramsay Health Care UK sent monthly information to Clifton Park Hospital which included any CAS alerts and any required actions.
- There was evidence of national learning including from other hospitals in Ramsay Healthcare UK. Staff gave examples of attending Ramsay-wide meetings, for example regarding infection control where new best practice and learning was disseminated.
- External Commissioning for Quality and Innovation (CQUIN) framework measures had been agreed for 2014/15. The measures were negotiated to improve local quality and were in line with the strategic quality aims of the hospital. Measures included VTE risk assessments, completion of the NHS Safety Thermometer, nutrition and hydration, implementation of the Friends and Family Test (for staff and patients); and electronic discharge letters to GPs.
- CQUINs were currently being agreed for 2015/16 based on previous performance. Priorities were likely to be enhanced recovery, nutrition and hydration and managing the deteriorating patient.
- There was a risk profile within the "Business Unit Plan Clifton Park 2014" which measured impact against likelihood to indicate the level of risk. On-going risk trends were routinely reviewed by the hospital committees. The risk register was maintained and reviewed by the senior management team and the heads of department. It was also discussed at each Clinical Governance & MAC Meeting.
- There was a Hospital Health & Safety (H&S) committee which met bi-monthly and the minutes were sent to the Ramsay Group Health & Safety Manager. There was an annual H&S audit and an annual report produced.
- The hospital used an electronic system which monitored the current status of professional registrations of all employed staff. There were safeguards within the system which would not allow a person to be rostered for duty if their registration had expired. All of the hospital's employed professional staff had their registration status verified.
- Procedures were in place through Ramsay Health Care UK for granting practicing privileges to enable doctors to work privately at the hospital. The hospital used a database which monitored the current status of DBS checks, appraisals, GMC registration and professional indemnity insurance arrangements for the consultants working at the hospital. The matron and general manager reviewed the information and sent reminders to doctors whose details had potentially lapsed.
- However, at the time of the inspection, records of the relevant checks were not up to date regarding DBS

checks, appraisals and professional indemnity insurance. For a significant number of doctors the information had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured. This had not been identified as a risk on the hospital risk register.

- At the time of the inspection there were 16 of the 34 consultants whose professional indemnity insurance had potentially expired. We raised this concern with the manager who sent further reminders to the consultants. On the 10 February 2015 the hospital submitted revised figures to CQC; there were 11 doctors where there was a lack of evidence that their insurance was current.
- Also the hospital could not confirm if 20 of the 34 doctors had a current DBS check as required by the hospital's policy. The sevice level agreement with the Trust stated that "The Employer warrants that each member of the Seconded Staff; holds the relevant qualifications required to fulfil his role…" and "are not currently subject to an alert letter notifying the National Health Service or any of its bodies of a Secondee whose performance or conduct could place Host staff, Seconded Staff or patients at risk." However, it did not provide any detail regarding on-going assessment of competence or appraisal or regularity of DBS checks or whether Seconded Staff held personal indemnity insurance. When this issue was raised with the hospital management team the employing trust was contacted immediately to provide this assurance.

Leadership of service

- The general manager had been in post since June 2014, the operations manager started in December 2014 and the Matron had been in post for a number of years. The finance manager covered three Ramsay locations. The senior management team meetings had recently been reinstated.
- There was local leadership of the service. The matron and general manager were seen by staff on a daily basis.
- Staff told us they felt well supported by their managers and peers. Staff made positive comments about the new management, for example, "There was focus on the needs of the business" and "They wanted staff to be happy".
- Nurses were being encouraged to become clinical champions and take responsibility for aspects of clinical care and sharing knowledge within teams. As an example of this, the lead nurse for pre-assessment also took responsibility for blood transfusion and phlebotomy by providing training and competency assessments for other staff.
- There were ward meetings where issues were raised and addressed.
- Staff said they could report any concerns they had about the service or practice and said it would be listened to and addressed.
- Consultants felt there was a good working relationship with the hospital management team and the staff.

Culture within the service

- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and all of the staff groups' responsibility.
- Openness and transparency was the expectation and was encouraged at all levels. Staff we spoke with told us they worked well together and there was obvious respect for others across disciplines.
- The hospital staff were aware of the new regulations relating to Duty of Candour. Staff spoke about an open culture regarding reporting and responding to incidents and complaints and understood the need to inform and involve patients when incidents resulting moderate harm occurred. Staff felt that this principle was adhered to in relation to all incidents not just those resulting in moderate harm or above.
- The hospital reported that for the period from April to November 2014 nursing staff turnover was 6% and the previous year it was 4%. The stability of nursing staff within inpatient departments was high (95% of staff employed at the hospital in November 2013 were still working there one year later)
- The turnover for all other staff groups had reduced compared to the previous 12-month period.

Public and staff engagement

- Ramsay Health Care UK completed national in-patient surveys. The latest survey was January to August 2013 and 600 surveys were completed for Clifton Park Hospital (a response rate of 81%). Out of the 58 questions asked, the patients' responses were equal to or better than the Ramsay average for 39 of the questions. Action plans were then monitored to improve care.

Surgery

- The hospital also had an action plan in place to improve care based on PROMs (Patient Reported Outcome Measures). PROMs measure health gain in NHS patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England based on responses to questionnaires before and after surgery
- There was a Ramsay Health Care UK staff survey. We saw the results from the hospital 2014 survey and the associated action plan. It compared positively to other Ramsay locations.
- Staff had led a "Productive Ward" initiative which had resulted in changes to practice including providing more clinical space, protected drug rounds and the RAG rating (red, amber, green) of patients pre and post-operatively.
- There were regular ward meetings which included agenda items such as patient care, audit requirements and infection control updates.

Innovation, improvement and sustainability

- Staff said they felt encouraged to learn and improve.
- There were systems in place to improve performance which included the collection of national data, audit and learning from complaints and incidents. A number of action plans had been developed and these were monitored on a regular basis.
- Changes were being made to improve the overall experience for patients, for example, the work on reviewing and reducing fasting times.

Outpatients and diagnostic imaging

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

Information about the service

Clifton Park Hospital has an outpatient and radiology department providing single speciality orthopaedic services to NHS and privately funded patients over the age of 18 years. The department consisted of seven exam rooms, a doctor's office, minor procedure room and two vital signs/pre-assessment bays. It provided diagnostic testing including blood testing, x-rays, ultrasound investigations and preoperative assessment. Radiology services included an X-ray department with plain x-ray room, mobile x-ray unit, ultrasound and a Magnetic Resonance Imaging (MRI) hook up. Computerised Tomography (CT), bone scans and long limb x-rays were undertaken at the nearby hospitals.

The physiotherapy services provided assessment and treatment to patients attending the hospital for surgery as part of their orthopaedic pathway. Services included access to a modern gymnasium and shock wave therapy. Self-paying patients could also refer themselves for physiotherapy assessment and treatment.

Pathology services were provided externally through contracts and service level agreements with other providers. Transfusion services were provided by the local NHS Hospital.

During the inspection we visited the outpatient, physiotherapy and radiology services. In the outpatient and diagnostic imaging department we spoke with 19 patients, four nurses, one orthopaedic consultant, two receptionists, one house-keeper, two physiotherapists, one out patient department manager, one radiographer / radiology manager, one student radiographer and two healthcare assistants (HCAs). We observed the outpatient environment, checked equipment and looked at patient information. We also reviewed five patient medical records as well as performance information from both the hospital and public sources.

In addition to the patients we spoke with during the inspection, we received feedback from 34 other patients via comment cards and who had communicated directly with the CQC.

Outpatients and diagnostic imaging

Summary of findings

Patients were happy with the care they received and found the service to be caring and compassionate.

The positive themes from patient feedback were: caring staff attitude, being listened to and being treated with dignity and respect, cleanliness, the environment and feeling safe. There were also positive comments relating to food. There were two negative comments relating to the abrupt manner of a particular doctor who did not introduce themselves prior to marking the operation site for surgery.

Staff were well trained, provided with good support and worked within nationally agreed guidance to ensure that patients received appropriate care and treatment for their conditions. Patients were protected from the risk of harm by adherence to policies and procedures and by competent use of clinical risk assessments which ensured care needs were managed appropriately.

Staff listened to and engaged with patients to actively seek their opinions. Services were delivered in a way which responded to patients' needs and ensured the departments worked effectively and efficiently.

The monitoring system to ensure the consultants' safety to practice within the hospital was not robust at the time of the inspection. We found that for a significant number of doctors, the information regarding DBS checks, appraisal information from the employing organisation and professional indemnity insurance arrangements was out of date and had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured.

Are outpatients and diagnostic imaging services safe?

Good

Medical records were available for outpatient clinics. There were policies and procedures in place to protect vulnerable adults or those with additional support needs. The majority of staff had received their mandatory training.

Incidents were reported, investigated and lessons learned. Learning was shared within the hospital and across the wider Ramsay Health Care UK company. The cleanliness and hygiene in the department was of a good standard and sufficient personal protective equipment was available to protect patients and staff from cross-infection and contamination. Clean and well maintained equipment was available.

Incidents

- Between 1 October 2013 and 31 September 2014 there were three incidents relating to diagnostic imaging. All incidents were low or no harm.
- All staff were aware of how to follow the hospital's policies and procedures for reporting incidents and had easy access to an electronic system to log incidents and view the progress of investigations. Incidents were reported and investigated in line with trust policies.
- The two managers within outpatients and radiology told us they provided staff with verbal feedback from incidents at monthly team meetings. Staff we spoke with confirmed the managers fed back the learning from incidents and discussed how they could do things differently to improve.
- Learning was shared between Ramsay hospitals at professional meetings and via a monthly Ramsay "Clinical Services Monthly Update" newsletter.
- The radiologist explained how learning which had been reported in the December 2014 newsletter by another Ramsay hospital, had been implemented at Clifton Park Hospital. The incident involved a wrong drug being transferred to a mobile unit and administered. In response, the radiology department at Clifton Park Hospital had introduced a separate box to store and separate the drugs needed by the mobile unit from the substances needed in the x-ray department to prevent similar incidents.

Outpatients and diagnostic imaging

- Managers and staff told us about a reflective session held following an unexpected clinical emergency. The session enabled the staff to think about the management of the situation, highlight what went well and what could be improved should such an incident occur again in the future. It also gave the staff the opportunity to debrief following a distressing experience. The staff reported that the reflective exercise had been extremely valuable in terms of learning and emotional support.
- 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 General Manager who then 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.

Cleanliness, infection control and hygiene

- Clinical and non-clinical areas in outpatients and diagnostic imaging appeared clean, were dust free and tidy with equipment stored appropriately.
- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments. It was noted that two sharps bins were full; these were immediately replaced when it was drawn to the attention of nursing staff.
- We saw staff adhering to the trust's bare below the elbows policy and observed hand hygiene practice which was performed to a good standard.
- We saw that staff wore protective aprons and gloves when required and regularly used hand gel between patients.
- Hand washing signage was clearly displayed and supplies of hand gel, hand soap and paper towels were available throughout the department.
- The outpatient and diagnostic imaging departments were part of regular hospital wide infection control audits, such as compliance with hand hygiene. The latest hand hygiene audit (December 2014) for Clifton Park Hospital demonstrated 100% staff compliance with hand hygiene.
- The housekeeping team were responsible for co-ordinating annual Patient-Led Assessments of the Care Environment (PLACE). In 2013-14 Clifton Park scored 95.5% for the four areas of cleanliness, food, privacy and dignity and the condition of the hospital.

Environment and equipment

- Staff told us they had sufficient equipment to meet the needs of patients.
- The radiology manager told us that they were waiting for approval of a business case to upgrade the current ultrasound scanner and also that there was a need to replace a fixed height bed (with a high / low bed) in the ultrasound room. The current situation made it difficult for some patients to get on and off the bed and posed a potential manual handling risk to staff.
- We looked at equipment and refrigeration and found they were appropriately recorded as being checked, cleaned and maintained. Labels were in place showing date of last maintenance check.
- Maintenance contracts and service level agreements were in place with an external provider to service, maintain and repair equipment, including radiological equipment. Staff told us that requests for service and repairs were met quickly and effectively by contractors. Equipment was labelled with the dates of when last checks were made and maintenance records were kept.
- The Ionising Radiation (medical exposure) Regulations IR(ME)R annual audit from March 2014 showed that all equipment met national requirements for safety. There were three actions from the audit which had all been fully implemented.
- There were processes in place to monitor radiation exposure, dosage and number of exposures. Consultants were benchmarked to highlight any issues which needed addressing individually and all consultants received IR(ME)R training every five years. All consultants were up to date with training at the time of the inspection and there were no current concerns regarding practice.
- MRI scanning was provided and managed separately by Ramsay Health Care UK. There was an agreement with the local NHS Trust MRI unit for support in case of emergency or failure of the MRI equipment or process.
- Records showed resuscitation equipment and defibrillation machines were checked daily in the outpatient department.

- Physiotherapy services had a fully equipped gym for rehabilitation and therapeutic regimes.

Medicines

- Medicines were kept in a locked cupboard in the treatment room and the key kept by the nurse in charge.
- We observed medicine keys were kept on the same ring as other cupboard keys and that the key ring was given to a member of maintenance staff to access another cupboard. When it was pointed out to the nurse in charge that this was a risk to the secure storage of medicines, action was taken immediately to separate the keys.
- Safe temperatures for fridges were recorded and a log of medication contents was maintained.
- A Ramsay Health Care UK pharmacist visited three times a week to undertake; audits, policy review and updates, destruction of controlled drugs, recording of wastage, stock checks and rotation, patient visits and education.
- Records showed regular monitoring and audit of the management and use of controlled drugs in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006. An audit carried out in December 2014 showed 99% compliance.
- Prescribing and medicines management audits were in place and routinely completed. The December 2014 controlled drug audit showed 99% compliance with all actions and the November 2014 prescribing audit showed 90% compliance. The matron had spoken to medical staff regarding the areas where improvements needed to be made. The prescribing audit was to be repeated May 2015.
- The radiology department kept a supply of relevant and appropriate medication for the procedures carried out including local anaesthetic for use during ultrasound-guided biopsy procedures. This was stored safely and securely in the medicines cabinet and overseen by the visiting pharmacist.
- Clifton Park Hospital employed a pharmacy technician for eight hours per week over two days to support the pharmacist and clinical team.
- Medications required for patients leaving the hospital were dispensed by the RMO from stock held onsite.
- The hospital matron was the “Accountable Officer” for controlled drugs.
- The general manager was responsible for destruction of controlled drugs.

Records

- Current patient records were available on site in a dedicated medical records storage room. All other records were stored off site by an accredited provider with the facility of scanned records being available electronically if required for an unexpected patient attendance.
- At the time of inspection, we saw personal patient information and medical records were held safely and securely. Staff we spoke with in outpatients, radiology and physiotherapy could not recall an instance where medical records had not been available for a clinic.
- Patients had a single set of records which held referral letters, medical and nursing notes / pathways, operation and anaesthetic records and discharge documentation. Pathway documents were evidence based, clear, easy to follow and facilitated comprehensive assessment and documentation.
- X-ray had an electronic records system which meant all images were processed and stored digitally. This also meant that images could be shared between Clifton Park Hospital and the local NHS trust when consultants (who also worked at the Trust) needed to view images if they were off site or if images needed a radiologist report or opinion. Staff in x-ray told us about business continuity plans in case of digital systems failure.
- We looked at the medical records of five patients attending outpatient clinics. We found that all records were legible and contained sufficient up to date information about patients to be able to safely assess care needs and provide treatment.
- All records contained a patient-completed medical questionnaire and pathway documents which showed assessments and care given so far.
- Records in the physiotherapy department were also reviewed and these were of a good standard.
- The last record keeping audit in physiotherapy from November 2014 showed 100% compliance against the tool used.
- The medical record audit in October 2014 showed 97% compliance. The area for improvement noted was that an entry must be made in the patient record by the doctor whenever they see a patient. Action had been taken to improve compliance.

Safeguarding

Outpatients and diagnostic imaging

- The hospital had safeguarding policies and guidance in place for both children and adults.
- All staff we spoke with were aware of safeguarding policies and guidance and could describe how to report and escalate a safeguarding issue. All staff knew who the lead for safeguarding was and said they would approach her for advice if needed.
- All staff felt well supported by senior staff who were readily available if they needed to escalate any safeguarding concerns.
- All staff had access to a simple flowchart to aid with decision making and reporting concerns regarding vulnerable adults.
- All staff undertook Level 1 safeguarding adults and children as part of their corporate induction and on-going mandatory training. The training compliance rate was 78% in April 2015 (which was mainly due to new staff who still had to complete the training).
- All clinical staff were required to undertake Level 2 adults and this was being set up corporately.
- Both Clinical and non-clinical staff also undertook Level 2 children's safeguarding by e-learning.
- In addition, all staff who have patient interaction (65 staff), have undertaken a DVD based training programme which covered safeguarding/DOLS/MCA. This was to be repeated in May 2015.
- There were also 10 "safeguarding champions" who have undertaken an online safeguarding vulnerable adults course
- The training lead was responsible for delivering safeguarding training using bespoke materials including DVDs and worksheets.
- At the time of the inspection the hospital could not provide us with evidence that all the doctors had a current DBS (Disclosure and Barring Service) check which was required by the hospital's policy. The hospital could verify 14 of the 34 consultants had current DBS checks.

Mandatory training

- Clifton Park Hospital had in place a comprehensive mandatory training programme.
- Staff reported that mandatory training was delivered by a combination of face to face training and eLearning.
- Mandatory training was undertaken by staff on a rolling programme throughout the year and the training matrix was updated by the team leader. Compliance at Clifton Park Hospital was 75% with all mandatory training at the time of inspection. The hospital was unable to provide detailed information regarding compliance rates across departments and by subject.
- The radiology manager was the nominated training and development lead for the hospital and monitored staff uptake and compliance with mandatory training, as part of this role. The training lead reminded staff and alerted managers when uptake and compliance was less than required.
- Medical staff completed mandatory training at their employing NHS Trust.

Assessing and responding to patient risk

- Clifton Park Hospital was equipped to take patients at a lower risk of anaesthetic or operative complications. Patients were referred by GPs, Muscular Skeletal Services (MSK) triage or, on occasion, by local NHS trusts when workload issues arose. Criteria were in place to ensure appropriate patient referrals.
- Staff were fully aware of the process for managing patients who became medically unwell. This included involving the patient's consultant, contacting the resident medical officer and transferring the patient to the Accident and Emergency department of York Hospital.
- There was a clear up to date policy relating to the "Management of Adult Medical Emergencies"
- There were emergency assistance call bells in all patient areas including consultation rooms, toilets, treatment rooms and x- ray. Staff confirmed that when used they were answered immediately.
- It was observed that the emergency call bell was wrapped around the hand rail in 2 of the disabled toilets which could potentially impede raising an alarm for someone who had suffered a fall. This was remedied when pointed out to staff.

Nursing staffing

- The outpatient department had a team of registered nurses, healthcare assistants, physiotherapists, radiologists, receptionists, house-keeping, administration staff and a pharmacy technician.
- Clifton Park Hospital used an electronic rostering management system which allowed Heads of Departments (HoDs) to manage rotas, skill mix, and staff

requirements including senior cover. We were told it also monitored safety and effectiveness of staffing levels and allowed HoDs to manage sickness and annual leave absences.

- Within the outpatient department, staffing levels were based upon a number of factors including the number of patients expected to attend and number, type and complexity of clinics to be held. However there was no specific acuity tool used.
- Staff and patients we spoke with, as well as our observations, confirmed that there was enough staff available to meet patient's needs.
- There were no vacancies within the nursing and health care assistant staff in the outpatient department at the time of inspection. A total of three whole time equivalent (WTE) nurses and 1.5 WTE HCAs were employed.
- There were systems and processes in place to request additional temporary staff when shortages were identified.
- The radiology department staffing consisted of two full time and one part time radiographers, however the part time position was vacant at the time of inspection.
- The physiotherapy team consisted of four full and one part time physiotherapists. There were no vacancies at the time of inspection.
- Physiotherapy and radiology were using bank staff on occasion to cover vacancies and sickness. The hospital used its own bank staff that worked at the hospital regularly and were familiar with the organisation, policies and procedures.
- The radiology manager told us that the bank staff used had been inducted and assessed as fully competent in the roles required of them. Data showing use of agency or bank staff across physiotherapy and radiology April 2014 -November 2014 indicated a peak in usage in June and July 2014; 15 % and 10% respectively. This dropped to 4% in August and then to 0% for the remainder of the time period.
- Induction training was provided to all staff including temporary and bank staff. Agency staff were given a local induction specific to the area of work they were covering. Reception staff told us that they had received a two week induction package and had also completed mandatory training in hand hygiene, customer care and record keeping.
- Sickness levels for nursing staff (all departments) was reported to be at 8% for November with allied health professionals (AHPs) showing sickness rates as 2% for the same time period.
- Managers and staff reported that sickness levels were usually low and the majority of cover could be provided by regular staff working additional hours when needed.
- Turnover rates for AHPs and nursing staff (all departments) were reported as 9% and 6% respectively for the period April 14 to November 2014.
- The vacancy position at end of November 2014 was: nursing staff (all departments) 4%; AHPs 9%; ancillary staff 0% and administration staff 11%.

Medical staffing

- The secondment agreement with the local NHS Hospital provided 24 hour cover, seven days a week to Clifton Park Hospital from both consultant orthopaedic surgeons and consultant anaesthetists.
- There was on-site RMO cover 24 hours a day, for seven days a week.
- There were 34 consultants employed by the local NHS Trust who were carrying out treatment, procedures and operations at this hospital under a secondment agreement. Some of the consultants also had practicing privileges to provide privately funded services of the same nature.

Major incident awareness and training

- There was a hospital major incident policy and staff were aware of contingency plans should major incidents occur. As an independent provider, the Clifton Park Hospital did not routinely become involved in major incidents external to the organisation.
- Business continuity plans were in place and senior managers operated an on call rota to ensure availability out of hours.
- Staff were clear how to escalate both clinical and non-clinical incidents of a serious nature.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We found the services provided by the outpatient department were effective. Care and treatment was

evidence based and patient outcomes were measured and within acceptable limits. Staff were involved in audit and were seen to take action when areas were highlighted as needing improvement. Staff in the department had undergone competency based assessments and there was evidence of multidisciplinary working. Staff gained patient consent before care and treatment was given.

The outpatient department was open 9am to 5pm Monday to Friday and support services such as physiotherapy and radiology were in place, as required, 24 hours a day, seven days a week.

The consultants' appraisals were completed by their employing trust. However, at the time of the inspection the hospital could not provide evidence that all of the 34 consultants had been appraised by the Trust within the last 12 months. On the 10 February 2015 the hospital submitted to CQC figures which had improved; the hospital had evidence that 26 of the 34 consultants had been appraised.

The radiology manager had been recognised by the Head of Diagnostics for Ramsay Health Care UK for her audit work regarding use of "C arm" equipment and had been asked to present her work to the Ramsay Radiology group.

Evidence-based care and treatment

- We saw staff in the departments were adhering to local policies and procedures. Staff were aware of how policies and procedures had an impact on patient care and they had easy access to policies, protocols and other clinical guidance on line. Hard copies of those documents in regular use were available for reference.
- Physiotherapists provided post-operative treatment to orthopaedic patients according to agreed, written consultant protocols and to the Chartered Society of Physiotherapy Standards.
- Radiology staff adhered to 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.
- Staff from all outpatient departments told us they took part in the local audit programme. Results of these audits either demonstrated compliance or included actions identified to improve practice. Actions had been taken where areas for improvement had been noted.
- Nursing staff were involved in peer audits and had access to online audit tools. Staff were able to demonstrate how these tools were used.

Pain relief

- There was a process in place to enable patients attending the outpatient department to access pain medication. Pain medication was dispensed via a personalised prescription and dispensed by the RMO.
- Patients were administered local anaesthetic during ultrasound-guided biopsy procedures.

Patient outcomes

- Patient outcomes in physiotherapy were monitored by well recognised outcome measures such as range of movement, pain scores and quality of life measures to establish effectiveness of treatment. Distances walked and numbers of repetitions were also used as measures of improvement where appropriate.
- Several people commented that the physiotherapy care was particularly good and that they were pleased with their outcomes.
- All images were quality checked by radiographers before the patient left the department.
- The radiology manager had been recognised by the Head of Diagnostics for Ramsay Health Care UK for her audit work regarding use of "C arm" equipment and had been asked to present her work to the Ramsay Radiology group.

Competent staff

- Managers told us formal arrangements were in place for induction of new staff and that all staff, including bank and agency staff, completed full local induction and training before commencing their role.
- We saw competency frameworks for staff outlining key skills for different roles. New members of staff had their key skills assessed by a competent person prior to working unsupervised and were given the opportunity to work towards accredited courses in appropriate areas of practice such as pre-assessment or interpretation of ECGs.
- The radiology manager told us how new staff were given support through a buddying system.
- All staff told us they were encouraged to undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. Staff

training and competency records were documented within individual "Clinical Skills Portfolios" and retained in HR files. Assessment of competence was on-going and revisited through annual appraisals and mid-year reviews. The portfolios provided evidence of induction, subsequent training and on-going assessment of competence.

- Staff told us that if they had attended training outside the hospital, they shared their learning through meetings or in clinical areas with relevant staff where appropriate.
- Staff we spoke with confirmed they had received appraisals and mid-year reviews in the last year. The appraisal rate for Clifton Park Hospital was 69% nursing (all departments) and 75% AHPs at November 2014. Ancillary and administration staff were less likely to have received an appraisal with rates of 42% and 57% respectively.
- 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. Although the consultants and managers we spoke to were confident all medical staff were up to date with appraisals the documentary evidence to support this was incomplete. Information for the purpose of consultant appraisals was supplied to the NHS Trust and in return a copy of the appraisal summary should have been forwarded to Clifton Park to be included in the consultants' personnel files. At the time of the inspection, the hospital could not provide evidence that 20 of the 34 consultants had been appraised. We raised this concern with the manager who sent further reminders to the consultants. On the 10 February 2015 the hospital submitted to CQC figures which had improved; the hospital had evidence that 26 of the 34 consultants had been appraised.
- The secondment agreement stated that "The Employer warrants that each member of the Seconded Staff; holds the relevant qualifications required to fulfil his role…" and "are not currently subject to an alert letter notifying the National Health Service or any of its bodies of a Secondee whose performance or conduct could place Host staff, Seconded Staff or patients at risk." However, it did not provide any detail regarding on-going assessment of competence or appraisal or regularity of DBS checks or whether Seconded Staff held personal indemnity insurance. When this issue was raised with the hospital management team the employing trust was contacted immediately to provide this assurance.
- Any HR issues or concerns related to medical staff were shared by both parties.
- The hospital was Deanery approved for training purposes and medical students and junior doctors accompanied consultants at times, when working in the outpatient department.
- During the inspection, we observed an x-ray guided injection of thumb and little finger which was carried out safely using appropriate x-ray protection and aseptic technique.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team. Staff were observed working in partnership with a range of staff from other teams and disciplines including radiographers, physiotherapists, nurses, booking staff, and consultant surgeons.
- Nursing staff reported that they had clear agreed protocols to follow in most instances; however where patient care needed to deviate outside of these protocols, they had good relationships with the medical, radiology and physiotherapy staff and were able to easily access specialist advice and support.
- The radiology manager described good working relationships with orthopaedic consultants, radiologists and staff at other local imaging departments. The 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.
- There were service level agreements in place with other local hospitals to provide a number of 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.

Seven-day services

- The main outpatient service operated Monday to Friday, 09.00 to 17.00 service.

Outpatients and diagnostic imaging

- Radiographer and physiotherapy cover was provided 24 hours a day and seven days per week to meet the needs of inpatients and theatres.
- Night and weekend on-call was organised by a rota system.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as x-rays, medical records and physiotherapy records appropriately through electronic and paper records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received adult safeguarding training which included the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) and basic awareness of the needs of people with dementia and learning disabilities .
- Staff could articulate a good understanding of informed consent.
- Staff reported if consent could not be obtained and/or the patient lacked capacity to consent, they would contact the hospital safeguarding lead for advice. There was a process in place for staff to follow when patients were not able to give consent because of fluctuating capacity.
- It was observed that verbal or implied consent was obtained from patients before care and treatment interventions such as obtaining specimens, routine diagnostic tests and the checking of height, weight and other physiological signs.

Are outpatients and diagnostic imaging services caring?

Good

During the inspection we saw and were told by patients that staff in the outpatients, physiotherapy and radiology were caring and compassionate at every stage of patients' journeys. Patients and relatives commented positively about the care provided from all of the outpatient's and diagnostic imaging staff.

We saw that people were treated courteously and respectfully and their privacy was maintained. Services were in place to emotionally support patients. Patients were kept up to date with and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions or treatment.

Patient experience feedback from multiple sources was in the main very positive and despite a small number of negative comments, all patients were pleased with their experience overall and gave good feedback as well as pointing out where care could have been better.

Compassionate care

- During our inspection we saw patients being treated respectfully by all staff. Staff were wearing name badges and were observed to introduce themselves to patients, politely and professionally.
- Reception staff were observed as providing a warm welcome to patients as they entered the hospital and giving clear instructions and advice in a helpful, caring and compassionate manner.
- We saw patients' privacy was respected Staff were observed to knock on doors before entering. Curtains were drawn and doors closed when patients were in treatment areas and consulting rooms.
- Notices offering chaperoning were in evidence and staff told us this was provided whenever requested.
- Staff endeavoured to make sure that patients were kept up to date with waiting times in clinics; staff could view if patients were waiting longer than expected on the computer system and took action where appropriate.
- We observed the reason for an unexpected delay being communicated to patients in outpatients by the hospital Matron. We saw patients and staff had a good rapport and staff put patients at ease. Some patients had visited the hospital a number of times and knew the staff well. New patients also confirmed they were put at ease and felt staff were caring towards them.
- The majority of patients we spoke with spoke highly of the care and treatment they received. There were two negative comments about the abrupt manner of a doctor who did not introduce himself.

Understanding and involvement of patients and those close to them

Outpatients and diagnostic imaging

- We observed staff spending time explaining procedures to patients using both verbal and written information. Patients were given time to ask questions and these were answered in a way patients could understand.
- We observed that staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.
- All of the patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about the care and treatment they could have. They all confirmed they were given time to make decisions and staff had made sure they understood the treatment options available to them.
- Two patients we spoke to in outpatients felt that information regarding post-operative activities and expectations of levels of pain and post-operative pain control and pain killers could have been better. Patients told us the pre-operative and post discharge telephone calls were very valuable.

Emotional support

- Staff were seen to take time and effort to talk to patients and enable them to feel comfortable and supported whilst in the department.
- We saw staff spend time talking to patients and showing empathy and encouragement to have tests completed.
- Physiotherapists were aware of the emotional impact of pain on patient well-being and this was an integral part of quality of life measures used to assess and evaluate clinical improvements and effectiveness of treatment. Patients reported the physiotherapy service as being "very good", "very professional", and "in fact excellent".
- Staff were aware of a range of counselling services where patients could be signposted should the need arise.
- Patients reported that they felt listened to and supported.

Are outpatients and diagnostic imaging services responsive?

Good

We found that outpatient services were responsive to needs of patients. Patients were able to be seen quickly for urgent appointments, if required and clinics were only rarely cancelled at short notice.

Mechanisms were in place to ensure the services were able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability, or those whose first language was not English.

Systems were in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- Staff and patients told us clinics seldom ran late however there was no data collected by the hospital about this. One comment was made by a patient in relation to clinics running late and not being kept informed.
- Clinics tended to run in a predictable pattern as determined by the numbers and type of patients booked and the busier time periods were staffed accordingly.
- Staff told us clinics were only rarely cancelled with short notice. Some clinics were occasionally cancelled with notice, we were told: to fit in with the NHS commitments of consultants.
- 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.

Access and flow

- All patients received their appointments within the 18 week target. Physiotherapy reported that most of their patients were seen 4-6 weeks from referral. Average waiting time for an ultrasound scan was around 4-6 weeks, CT scan around two weeks and MRI scans approximately four weeks.

Outpatients and diagnostic imaging

- Patients told us they had been very pleased with the short waiting lists and one person told us they had an appointment for their surgery which was within three weeks of seeing the consultant.
- As patients arrived at the hospital, they were logged onto the computer system which enabled staff in all areas to track where patients were as they moved through the department. This enabled staff to view if patients were waiting longer than expected and identify where they were held up and take any action needed to prevent delays.
- The radiology manager told us how they now accessed and downloaded images prior to a patient's attendance at the outpatient department, rather than at the time of appointment, to prevent unnecessary delays when the system was unavailable or slow.
- Patients were observed to be seen on time in the majority of cases however the hospital did not collect information about how long patients were waiting to be seen once they arrived.
- Most patients who used the hospital, whether as a private patient or an NHS patient were referred by their GP or from MSK triage.
- Patients could refer themselves to physiotherapy by calling the department directly.
- The hospital ran clinics for NHS and private patients; there was capacity within the service to see patients urgently if necessary.

Meeting people's individual needs

- The environment in the outpatient areas was uncluttered and well maintained.
- Patient waiting areas were tidy with comfortable seating for patients visiting the department. There was access to drinks and books / magazines for patients who were waiting.
- There were toilet facilities with disabled access available for patients.
- The environment in the outpatients department allowed for confidential conversations.
- A range of information leaflets were available, which provided patients with details about their clinical condition and treatment or surgical intervention. We saw staff used these leaflets as supportive literature to reinforce the verbal information they had been given.
- Some patient information leaflets were available in large print for patients with visual impairment. Patient information was not kept in alternative languages but staff explained they had a process in place to translate leaflets as and when necessary.
- Staff told us when patients with learning disabilities attended the departments; they allowed carers to remain with the patient if this was what the patient wanted. They also ensured that patients were seen quickly to minimise the possibility of distress to them.
- Staff we spoke with told us any patients who attended who were living with dementia were in the early stages of the condition and were generally accompanied by carers or relatives. Staff gave examples of how they had supported patients with dementia or learning disability by involving carers or relatives, adapting explanations and by allowing more time or by rearranging appointments. Staff told us they encouraged carers and relatives to support the patient as appropriate. Flexibility was offered around outpatient appointments where possible.
- Staff told us they were able to access interpreting and translation services if they needed to.
- Information signage was adequate within outpatients and diagnostic imaging and patients appeared to be able to make their way around both departments easily.

Learning from complaints and concerns

- The hospital reported to us that the total number of formal complaints for the period April 2013 to November 2014 was 12. Of the 12 complaints received: four were concerns about surgical outcome, further consultations had taken place with consultants to reassure these patients, three were regarding, delay from admission to surgery. This was being addressed through Clinical Governance meetings and discussions with surgeons and anaesthetists. The remaining five were a variety of issues with no common theme.
- Staff in all areas described how they would try to resolve a patient's concerns informally in the first instance if they could, but would escalate to a more senior member of staff as necessary.
- Staff we spoke with were confident in dealing with patients concerns as they arose.
- Staff were also aware of the more formal complaints process and policy as well as the mechanisms in place for reporting, investigation and feedback to departments.

Outpatients and diagnostic imaging

- Staff told us any comments and complaints were reviewed and discussed by the teams at monthly staff meetings. We saw the minutes of meetings that reflected this.

Are outpatients and diagnostic imaging services well-led?

Good

The monitoring system to ensure the consultants' safety to practice within the hospital was not robust at the time of the inspection. At the inspection we found that for a significant number of doctors, the information regarding DBS checks, appraisal information from the employing organisation and professional indemnity insurance arrangements were out of date and had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured.

Staff and managers had a vision for the future of their services and were aware of the risks and challenges faced by the department. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed. The department supported staff who wanted to undertake additional training, be innovative and try out new ideas in relation to services and treatments.

The hospital engaged with staff and patients were given opportunities to provide feedback about their experiences of the services provided and staff regularly engaged with patients waiting for appointments.

Staff in all outpatient areas stated they were well supported by their managers. They were visible and provided clear leadership. Staff and managers told us there was an open culture. They felt empowered to express their opinions and felt they were listened to.

Vision and strategy for this service

- The department managers we spoke with demonstrated a vision for the future of services. They were aware of the challenges faced by the departments they managed and had action plans in place to address these challenges. For example to ensure delivery of high quality services and maintenance of standards and competencies, managers were encouraging of clinical staff to become more involved with audit and peer review. Staff were also being encouraged to accept greater individual responsibility for any issues highlighted by internal audits, such as compliance with record keeping standards or infection control procedures, and the identification of solutions to improve performance .
- The staff we spoke with were aware of the Ramsay vision "The Ramsay Way" and the business unit strategy and were seen to display the behaviours expected of them. Staff were observed to be caring and with a desire to continuously improve how things were done. We observed good team relationships and a clear understanding of the need for high quality services to ensure business sustainability.
- The organisational objectives of quality standards and competent staff were integral to staff performance, development and appraisal.

Governance, risk management and quality measurement

- Clifton Park Hospital had a Clinical Governance team and committee that met quarterly to monitor quality and effectiveness of care. Clinical incidents, complaints and patient and staff feedback were reviewed to determine any trend that required further analysis or investigation. Recommendations for action and improvement were agreed with hospital management to ensure results are visible and tied into actions required by either the hospital or the organisation as a whole.
- Staff were aware of governance arrangements and feedback from governance meetings was given at team meetings. All staff had access to the minutes of governance and team meetings.
- Incidents, complaints and potential items for the risk register were discussed at Heads of Departments (HODs) and operational team meetings.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints at team meetings. Audits and quality improvement were also discussed.
- Clifton Park Hospital had systems in place through its parent company, Ramsay Health Care UK, for scrutinising all national clinical guidance including technology appraisals issued by NICE and ensuring recommendations for implementation are cascaded to the hospital.

Outpatients and diagnostic imaging

- Minutes of the corporate Drugs and Therapeutic Committee demonstrated that NICE guidance regarding intravenous fluids had been brought to the attention of medical and nursing staff at Clifton Park Hospital.
- There was a risk profile within the "Business Unit Plan Clifton Park 2014" which measured impact against likelihood to indicate the level of risk. On-going risk trends were routinely reviewed by the hospital committees. The risk register was maintained and reviewed by the senior management team and the heads of department. It was also discussed at each Clinical Governance & MAC Meeting.
- The hospital had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were managing them appropriately. For example, radiology had identified risks associated with IT and equipment failure. Staff were able to clearly articulate contingency plans in place should equipment failure occur.
- The hospital used an electronic system which monitored the current status of professional registrations of all employed staff. There were safeguards within the system which would not allow a person to be rostered for duty if their registration had expired. All of the hospital's employed professional staff had their registration status verified.
- Procedures were in place through Ramsay Health Care UK for granting practicing privileges to enable doctors to work privately at the hospital. The hospital used a database which monitored the current status of DBS checks, appraisals, GMC registration and professional indemnity insurance arrangements for the consultants working at the hospital. The matron and general manager reviewed the information and sent reminders to doctors whose details had potentially lapsed.
- However, at the time of the inspection, records of the relevant checks were not up to date regarding DBS checks, appraisals and professional indemnity insurance. For a significant number of doctors the information had not been provided to the hospital and therefore the consultants' safety to practice within the hospital was not assured. This had not been identified as a risk on the hospital risk register.
- The radiology manager described how there were audit systems in place to measure the quality and accuracy of work carried out within the department. For example staff completed regular audits of internal systems and routine practice against national guidelines. The latest audit in November 2014 showed 97% compliance against standards. Actions had been taken to make improvements to completion of patient type and legibility.
- Registration status had been verified for 100% of professional staff at the hospital.

Leadership of service

- We found there were clear lines of management responsibility and accountability within the outpatients' and diagnostic imaging services. Staff had clear roles and responsibilities and knew what their duties would entail on each shift. Communications between staff were observed as being clear regarding expectations of each other's roles and duties.
- Staff in all areas stated they were well supported by their managers; they were visible and provided clear leadership. Staff appreciated that they were able to access the Matron easily if needed and that she walked around the department on a daily basis.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes.
- Staff were encouraged to undertake professional development and received annual appraisals and mid-year reviews.
- Staff told us they would be confident to raise a concern with their managers and that this would be investigated appropriately.
- The hospital and department managers were seen on a daily basis throughout the hospital by all staff. Managers were known on first name terms and were approachable.
- Staff felt managers were interested in their work and encouraged them to express ideas for service development.
- Nurses were being encouraged to become clinical champions and take responsibility for aspects of clinical care and sharing knowledge within teams. As an example of this the lead nurse for pre-assessment also took responsibility for blood transfusion and phlebotomy by providing training and competency assessments for other staff.

Culture within the service

- Staff and managers told us the outpatient and diagnostic imaging departments had an open culture. They felt empowered to express their opinions and felt

they were listened to. An example of this was where a nurse had raised a concern regarding a patient being listed for surgery despite not having stopped a particular medication in line with the local protocol. The patient had requested the surgery go ahead and the consultant had agreed however, the nurse had been concerned that this would raise the risk of the patient suffering the post-operative complication of suffering a venous thrombus embolism (VTE). The concern had been raised with the departmental manager and investigated appropriately. The consultant had undertaken a risk assessment of the patient and the impact of delaying the surgery was judged to be greater than the risks of going ahead. Additionally the patient was given prophylactic medication to minimise the risk of VTE and the surgery went ahead as planned. The nurse was able to discuss with the patient and ensure that she fully understood the higher risk of VTE that the surgery posed due to the medication not being stopped as early as ideal and was reassured that the patient was giving a fully informed consent.

- Other staff told us of the above incident and that they were encouraged to report concerns and incidents and felt that these would be investigated fairly.
- They told us managers were open to comments and suggestions for improvements from staff and staff were encouraged to seek feedback from patients and take immediate action when issues or concerns arose.
- Managers and staff told us that they felt well supported by the organisation.
- All of the staff we spoke with were proud to work for Clifton Park Hospital. Staff received praise and recognition of good work and innovation.
- The hospital staff were aware of the new regulations relating to Duty of Candour. Staff spoke about an open culture regarding reporting and responding to incidents and complaints and understood the need to inform and involve patients when incidents resulting moderate harm occurred. Staff felt that this principle was adhered to in relation to all incidents not just those resulting in moderate harm or above
- The was a clear culture of innovation, improvement and learning.

Public and staff engagement

- The hospital actively sought patient feedback. Staff regularly spoke with patients waiting for appointments to gather their feedback. Feedback was discussed at team meetings.
- The Clifton Park Hospital had a continuous cycle of patient surveys as well as taking part in the national Friends and Family Test (FFT). Latest data for the national FFT showed Clifton Park Hospital to have a response rate of 78.8% and 100% of patients would recommend this hospital to their friends or family if they needed similar care or treatment. National data also showed that Clifton Park Hospital consistently showed a "would recommend" rate of over 90%.
- NHS choices showed seven reviews from April 2014 to November 2014 all of which indicated that reviewers would be extremely likely to recommend the hospital.
- All 19 of the patients we spoke with said they would recommend Clifton Park Hospital to family and friends and that they were happy with their care and treatment.
- A comments box was in place in reception with pen and paper for patients, friends and families to leave comments or suggestions for improvements to the service.
- Staff said they felt they had opportunities to approach and discuss with managers areas of work that were positive or where improvements could be made. Staff felt listened to and that they were encouraged to take up opportunities to develop their skills.

Innovation, improvement and sustainability

- Staff were encouraged to suggest ways to make departments run more effectively and efficiently.
- Staff and managers told us that the Clifton Park management team actively engaged in talent management and promoted retention of staff. We were given two examples of staff that had started with the organisation as housekeepers, who had received training and development and were now working as healthcare assistants.
- Patient information leaflets within outpatients were of a very high standard and had recently been developed and improved by members of the outpatient team. The radiology manager told us that the information tools developed were to be showcased within the Ramsay hospital group. Patients told us that "The written information is clear and comprehensible".

Outpatients and diagnostic imaging

- The radiology manager had also been recognised by the Ramsay Head of Diagnostics for her audit work regarding use of “C arm” equipment and had been asked to present her work to the Ramsay Radiology group.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The provider must take action to ensure that the appropriate checks and records are in place and recorded for the doctors working at the hospital including Disclosure and Barring Service checks, indemnity insurance and appraisals.
- The provider must take action to ensure that there is an effective system in place for the timely delivery of blood products from the local provider should an emergency arise and that emergency transport procedures are tested on a regular basis.
- The provider must improve the security of access to the theatre suite to prevent patients or other people inappropriately accessing this area.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The provider should ensure that the timings of theatre lists were agreed in advance to avoid patients unnecessarily fasting for an excessive number of hours.
- The provider should ensure that all staff received an appraisal each year.
- The provider should ensure that all medical records are fully completed and signed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** People who used the service and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity. This was in breach of Regulation10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(1) & (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must take action to ensure that the appropriate checks and records are in date and recorded for the doctors working at the hospital including Disclosure and Barring Service checks, indemnity insurance and appraisals. The provider must take action to ensure that there is an effective system in place for the timely delivery of blood products from the local provider should an emergency arise and that emergency transport procedures are tested on a regular basis. The provider must improve the security of access to the theatre suite to prevent patients or other people inappropriately accessing this area. We are making this requirement under regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity. This was in breach of Regulation10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must take action to ensure that the appropriate checks are in date and recorded for the doctors working at the hospital including Disclosure and Barring Service checks, indemnity insurance and appraisals. The provider must take action to ensure that there is an effective system in place for the timely delivery of blood products from the local provider should an emergency arise and that emergency transport procedures are tested on a regular basis. The provider must improve the security of access to the theatre suite to prevent patients or other people inappropriately accessing this area. We are making this requirement under regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who used the service and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to

Requirement notices

enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from carrying on the regulated activity. This was in breach of Regulation10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must take action to ensure that the appropriate checks are in date and recorded for the doctors working at the hospital including Disclosure and Barring Service checks, indemnity insurance and appraisals.

The provider must take action to ensure that there is an effective system in place for the timely delivery of blood products from the local provider should an emergency arise and that emergency transport procedures are tested on a regular basis.

The provider must improve the security of access to the theatre suite to prevent patients or other people inappropriately accessing this area.

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