The Yorkshire Clinic

Quality Report

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

Ratings

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

Overall summary

The Yorkshire Clinic Hospital is part of the Ramsay Health Care UK Operations Limited. The hospital has 56 beds and 12 ambulatory bays. Facilities include five operating theatres, a four-bed level two care unit, an endoscopy unit, angiography suite, physiotherapy, pharmacy, central sterile services department (CSSD) and X-ray, outpatient and diagnostic facilities. The Lodge is a separate building but still part of the hospital, which has one theatre, consulting and treatment rooms and is the dedicated ophthalmology centre.

The Yorkshire Clinic provides surgery, services for children and young people, and outpatients and diagnostic imaging. We inspected surgery, outpatients and diagnostics and services for children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 to 20 October 2016, along with an unannounced visit to the hospital on 3 November 2016.

Summary of findings

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

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

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

We rated this hospital as good overall.

We found good practice in relation to surgery, diagnostics and outpatient care and services for children and young people:

- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- Staff were encouraged to report incidents and we saw good sharing of learning following incidents. Staff were aware of the two never events and subsequent changes in practice.
- Mandatory training compliance levels were high and we observed good practice in relation to infection prevention and control and medicines.
- Documentation was good and patient care and treatment was evidence based. There were clear pathways of care and staff were able to recognise and respond to signs of deteriorating health.
- Patients were involved in their care and treated with dignity and respect.
- Service provision was focused around the needs of the people using the hospital.
- The provider met national indicators for referral to treatment (RTT) waiting times.
- Staff spoke positively about their leaders and managers.
- The governance arrangements in place ensured that quality, performance and risks were managed.

We found some areas of outstanding practice, these were:

- The pharmacy department had undergone external benchmarking of their aseptic department.
- The new senior children's nurse was building links to the local authority safeguarding children's board and had attended a recent link meeting.
- The senior registered sick children's nurse had started weekly two hour information and advice safeguarding children 'drop ins'. These had proved popular and provided a link between local and national developments and staff.

There were no breaches of regulations. However, there were areas where the provider should make some improvements, even though a regulation had not been breached, to help the service improve. These were:

- The provider should consider making designated areas more child focused.
- The provider should ensure that all staff receive an annual appraisal.
- The provider should ensure best practice guidance is followed in relation to mental capacity assessment and best interest's decisions.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led. High dependency care services were a small proportion of hospital activity. The hospital has a four-bed high dependency unit providing level 2 care. The main service was surgery. We have reported any findings specific to high dependency in the surgery section of the report.
Services for children and young people	Good 	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section of the report. We rated this service as good because it was safe, effective, responsive and well-led. We did not rate the caring domain.
Outpatients and diagnostic imaging	Good 	We rated this service as good because it was it was safe, caring, responsive and well-led. We did not rate the effectiveness of the service.

Summary of findings

Contents

Good

The Yorkshire Clinic

Services we looked at

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

Summary of this inspection

Background to The Yorkshire Clinic

The Yorkshire Clinic is operated by Ramsey Health Care UK Operations Limited. The hospital opened in 1982. It is a private hospital in Bingley, West Yorkshire. The hospital primarily serves the communities of the North and West Yorkshire areas. It also accepts patient referrals from outside these areas.

The hospital provides the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury
- Family planning (not inspected or rated)

The hospital has had a registered manager in post since 2010. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in November 2015.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 to 20 October 2016, along with an unannounced visit to the hospital on 3 November 2016.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors, and two specialist advisors with expertise in theatres and management at executive director level. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Why we carried out this inspection

The hospital has a day case ward (Ward 2) with 19 single en-suite rooms located on the second floor. The operating theatres and endoscopy are located on the first floor.

The in-patient ward (Ward 1) has 27 single en-suite rooms and six ambulatory bays. The high dependency unit was located on this floor. This unit was open one week out of each month for planned admissions. From the time of inspection to the end of the year it was only planned to be opened for one week. As a result of this it was not reported separately but included in the surgical report.

How we carried out this inspection

CT and MRI and pathology facilities were operated by another provider.

The hospital is registered to provide the following regulated activities:

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

During the inspection, we visited both wards, theatres and departments. We also visited the lodge. We spoke with 49 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 42 patients and relatives. During our inspection, we reviewed 30 sets of patient records and prescription charts. Before the inspection, we reviewed performance information from, and about, the hospital.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been

Summary of this inspection

inspected four times; the most recent inspection took place in January 2014. This found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016):

- In the reporting period July 2015 to June 2016 there were 16,608 inpatient and day case episodes of care recorded at The Yorkshire Clinic; of these 82% were NHS-funded and 18% other funded.
- 11% of all NHS-funded patients and 28% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 60,444 outpatient total attendances in the reporting period; of these 73% were NHS funded and 27% were other funded.

195 consultant surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Two regular resident medical officers (RMO) worked on a one week on, one week off rota.

The Yorkshire Clinic employed 54 whole time equivalent (WTE) registered nurses, 41.6 WTE care assistants and operating department practitioners. The accountable officer for controlled drugs (CDs) was in the process of being changed to the newly appointed matron.

Track record on safety in the reporting period of July 2015 to June 2016:

- There had been two never events
- 204 Clinical incidents; 166 no harm, 24 low harm, 9 moderate harm, 1 severe harm, 4 death
- 3 serious incidents
- 0 incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- 0 incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- 0 incidences of hospital acquired Clostridium difficile (c.diff)
- 0 incidences of hospital acquired E-Coli
- 1 complaint received

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department
- Joint Advisory Group on GI endoscopy (JAGS) accreditation

Services provided at the hospital under service level agreement:

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

Information about The Yorkshire Clinic

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Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Staff were encouraged to report incidents and we saw good sharing of learning following incidents. Staff were aware of the two never events and subsequent changes in practice.
- We observed good infection prevention and control practice and there had been no reported cases of hospital acquired infections
- Mandatory training compliance was high.
- We found good practice in relation to medicines management.
- Safeguarding policies were in place, staff were appropriately trained and aware of how and when to escalate concerns.
- There were robust systems in place for assessing patient risk and regular emergency simulations were run. The process for transferring patients, when it was no longer safe to provide their care at the hospital, worked well.
- Staffing was at planned levels and appropriate to meet the needs of patients in the different clinical areas.

However;

- Although unauthorised access to theatre was being addressed, we could not be assured at the time of inspection that access to theatre was limited or monitored.
- Within the physiotherapy outpatient department records were not always fully completed and we saw examples of care plans, risk assessment scores and allergy records not always being completed.
- We identified from records in outpatients, early warning scores were not always recorded following minor procedures. Following the inspection we were provided with new documentation which addressed this.
- We lacked assurance over staffs understanding and training on mental capacity and best interest decisions.
- We identified concerns in how private prescriptions were managed. These were resolved by the service by the time of our unannounced inspection.

Are services effective?

Good

We rated effective as good because:

- Care and treatment of patients was delivered in line with current best practice and guidance.

Summary of this inspection

- Pain levels were monitored and assessed; patients received pain relief in a timely manner.
- There was evidence of participation in local and national audit and within the service and showed good performance against audit targets.
- There was good support for new staff and training was comprehensive.
- There were good examples of multidisciplinary working within the service and the wider hospital.
- Informal clinical supervision took place via team and one to one meetings with staff.

However;

- We were provided with several figures in relation to staff appraisals. Appraisal figures for theatre staff were 60%.

Are services caring?

Good

We rated caring as good because:

- The majority of patients gave us positive feedback and told us that they received care that was compassionate and maintained their dignity.
- Friends and family test data showed good response rates with 100% of respondents recommending the service.
- Patients were involved in their care and treated with dignity and respect.
- There was good support for patients undergoing bariatric surgery.

However;

- Some patients told us that they felt that their dignity was not always maintained in the radiology waiting area.

Are services responsive?

Good

We rated responsive as good because:

- Service provision was focused around the needs of the people using the hospital.
- There was good patient flow through the hospital with proactive management of theatre lists and admission times.
- Those patients who had operations cancelled for non-clinical reasons were all rebooked within 28 days.
- The service was meeting referral to treatment indicators and imaging was reported within an appropriate timescale.
- Training was provided and staff sought to deliver individualised care.
- There was access to interpretation services available.

Summary of this inspection

- The service received a low number of complaints, with no particular trends or themes.

However;

- There were no dedicated areas in the hospital for children. However the challenge in relation to this was acknowledged due to the level of paediatric activity.

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the wider hospital and corporate vision and strategy.
- Staff spoke positively about their leaders and managers.
- The governance arrangements in place ensured that quality, performance and risks were managed. This enabled information to be shared between senior management and clinical staff.
- Staff representatives were able to engage with leaders via a monthly engagement forum.
- A new patient focus group had been set up for the hospital that could drive improvements and change within the service.

However;

- The arrangements and governance processes for children and young people's services were new and needed embedding.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Not rated	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We will rate effectiveness where we have sufficient, robust information which answer the KLOEs and reflect the prompts. We inspected but did not rate the caring domain for services for children and young people.

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as good.

Incidents

- In the reporting period of July 2015 to June 2016 there had been two never events at the hospital both were attributable to surgery. One related to wrong site surgery and the other related to a wrong site anaesthetic block. Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers.
- We reviewed the investigation reports for the never events and related action plans. They included a review of service delivery problems and contributory factors; a root cause was identified with associated recommendations and lessons learned. Areas of good practice were also noted and an action plan developed.
- The recommendations and action plans associated with the wrong site surgery event focused on full participation of the World Health Organisation (WHO) safety checklist. This included utilising senior theatre nurses to lead by example to reinforce the requirements of the surgical checks and stopping the use of abbreviations on the theatre booking forms.
- The investigation in to the never event related to the wrong site anaesthetic block identified that the 'stop before you block' process had not been used by the hospital. This guidance has been available since 2010. The associated recommendations and action plan following the investigation focused on embedding this into practice and ensuring visibility of surgical site marking. On ward two, we saw a monthly audit for surgical site marking for the current month (October 2016) as part of the action plan. Instructions were for 20 cases to be audited each month. At the time of inspection eight had been done. Five had been marked correctly; three had been identified as being incorrectly marked. Staff were asked what the process was for patients who had been incorrectly marked. We were told the consultant would be asked to come back to the ward and re-mark the patient. The audit sheet did not indicate if this had happened and we were unable to confirm this as the patient's notes were not available. However audit data provided on the WHO checklist showed good levels of compliance suggesting any incorrect surgical site marks were changed before the patient went to theatre.
- Other actions to prevent recurrence included organising theatre lists to perform all right sided procedures first. We observed the weekly clinical operations meeting. During this, checks relating to the order of the theatre lists and the names of the procedures were checked by the multi-disciplinary team.
- The staff we spoke with were aware of the never events and the changes in practice following this. Minutes from the Medical Advisory Committee (MAC) meeting evidenced shared learning of the never events as part of the clinical governance report.
- We also saw a letter which had been send to all theatre staff following the first never event identifying staff had not always felt able to challenge poor practice. Staff had been reminded of their code of practice and staff forums had been held to encourage sharing of learning.

Good

Surgery

- We saw six staff had completed human factors training in September 2016 in response to the never events. Human factors are the way individual characteristics combined with the work environment and organisation can influence behaviour and affect health and safety.
- From July 2015 to June 2016, there had been no unexpected deaths. Three serious incidents were reported by the hospital for the same time period. The number of serious injuries was not high when compared to a group of independent acute hospitals who submitted performance data to the CQC.
- The serious incidents related to, incorrect administration of a drug, a complication during surgery and a complication post operatively requiring a return to theatre. A root cause analysis (RCA) investigation was completed for each incident. RCA is a method of analysis that tries to identify the root cause of incident.
- We reviewed the investigations for these incidents and found they were robust and objectively looked at the reasons why the incident occurred. The associated action plans were thorough and aimed at preventing a reoccurrence. They also focused on staff training and the use of audits to evidence improved practice.
- From July 2015 to June 2016, a total of 204 clinical incidents had been reported by the provider. Of these, 166 were categorised as no harm, 24 as low harm, nine as moderate harm, one as severe and four were categorised as death (these were expected deaths).
- The assessed rate of clinical incidents in surgery, inpatients or other services (per 100 bed days) was lower than the rate of other independent acute hospitals that the CQC hold this type of data for.
- Incidents were reported on the provider's electronic system. There had been a focus within the hospital to increase staff awareness around incidents and improve subsequent reporting. Training had been provided in July 2016 for all staff. We were told the numbers of incidents reported had risen from an average of 14 per month to 50 in August 2016 and 58 in September 2016.
- There were 118 incidents that related to surgery and none for the high dependency unit (HDU). Staff told us a trend of falls had previously been identified. Following this, on-going training and a falls flow chart had been implemented. Other examples of incidents reported were operations being cancelled on the day.
- We saw evidence of changes made as a result of incidents. For example, within the Lodge we were told of an incident were a patient who fell in the toilet as they could not locate the light switch. Within 48 hours a sensor light had been installed to prevent a reoccurrence.
- Incident data from January 2016 to July 2016 indicated 12 incidents related to medications, all of which resulted in no harm. We discussed one of these regarding to the dispensing of Tramadol (a strong painkiller) to someone being discharged. The patient had been discharged home with a larger quantity of tablets than they should have been. We were told changes in practice had taken place following this. Examples included, stopping lone dispensing on a weekend and not stocking different quantities of the same drug. Following the incident the patient was also contacted and the additional tablets were returned to pharmacy.
- All staff had access to the electronic system to report an incident. We viewed the 'live' system which had drop down boxes for incident type. Once completed the incident went to the appropriate person for investigation depending on the type of incident. Heads of departments were able to view all incidents for their area and received an email when a new incident was reported. The quality improvement lead, hospital manager and the matron were able to see all reported incidents.
- Feedback of incidents was through clinical governance and clinical effectiveness committees. Ward meetings took place every two months, and monthly in the operating theatres, to further disseminate information. We reviewed meeting minutes and found incidents to be a standing agenda item. Staff also told us direct feedback may be given following an incident, or within theatres a meeting may be arranged for a particular team to provide feedback. Copies of meeting minutes and communication boards were in use for further sharing of information.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents'andprovide reasonable support to that person. This regulation was introduced to all NHS trusts in November 2014. Staff spoke about being open and

honest and we observed information for staff about the duty of candour displayed in clinical areas. The never events we reviewed, provided evidence this regulation was being met.

Clinical Quality Dashboard or equivalent

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thromboembolism (blood clots), and catheters and urinary tract infections (UTIs). The data was collected bi-monthly.
- From June 2015 to October 2016 data provided by the hospital showed, with the exception of April 2016 when the hospital scored 98%, patients received 100% harm free care. This was better than the average 97% score for a similar size independent hospital.
- For the same reporting period, there had been no pressure ulcers reported. VTE risk assessments were audited and information supplied to us showed the screening rates were above 95% between July 2015 and June 2016. The medical records we reviewed on the wards and HDU showed VTE risk assessments had been completed.
- No specific audit data was collected for HDU due to having low numbers of patients using the service.

Cleanliness, infection control and hygiene

- There had been no cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium difficile (C.diff) infections at the hospital for the period July 2015 to June 2016.
- Screening for MRSA was done at pre-assessment following a risk-based assessment following national guidance. This process was explained to us and seen in the MRSA screening policy.
- Data related to Surgical Site Infections (SSI) from July 2015 to June 2016 was reviewed. There were a total of 19 infections. The rate of infections during other orthopaedic and trauma, breast and urological procedures was above the rate of other independent acute hospitals. In response to this implementation of a surgical site 'care bundle' was a priority within the new infection control annual plan. As part of this, training on aseptic non touch technique would be rolled out in December 2016. Competency documents had been created to evidence practical application of this skill.
- The rate of infections during primary hip arthroplasty, gynaecology, upper gastrointestinal and colorectal procedures were similar to or lower than the rate of other independent acute hospitals. There were no surgical site infections resulting from revision hip arthroplasty, primary knee arthroplasty, revision knee arthroplasty or vascular procedures.
- We spoke with the infection control nurse about SSI's. There was a robust system for reviewing all potential infections. For example, if a wound was leaking it was clinically reviewed and recorded centrally on a spreadsheet. No themes had been identified in relation to SSI.
- There was a service level agreement (SLA) with a microbiologist from a local NHS trust who reviewed the spreadsheet and supported and advised, as required. An RCA investigation was conducted if the case met certain criteria.
- The HDU environment was visibly clean and tidy. Labels were in use to indicate equipment had been cleaned ready for use. Hand wash basins were available and alcohol gel was at each bed space. Personal protective equipment (PPE) was available.
- In theatres, arms bare below the elbows guidance was adhered to by all staff. There was also good access and supply of PPE including gloves, eye protection, masks and aprons within the operating theatres. We were told if staff came out of theatres coveralls should be worn over theatre scrubs. We observed this practice during our inspection.
- At the back of theatres, the flooring was cracked and uneven. Theatre staff were aware of this and we were told they were waiting for estates to rectify this. We were told about ongoing work to improve storage facilities within theatre. However, we observed the main corridors were free from clutter.
- All contaminated waste and equipment was appropriately managed.
- Ward areas were free from clutter and signs were placed on doors to indicate they had been cleaned ready for the next patient. We inspected seven of these rooms and, whilst visibly clean, six of them had dust under the beds, on the frame and on top of the hand towel dispensers.

- Clinical rooms and store rooms on the wards were tidy with nothing stored on the floor.
- We observed good hand hygiene and appropriate use of PPE. With the exception of one consultant, all staff adhered to arms bare below the elbows guidance. The patients we spoke with reported observing staff washing their hands and using alcohol gel.
- Most ward areas had carpeted floors. Carpets should not be used in areas where frequent spillage is anticipated (Health Building Note 00-09: Infection control in the built environment, 2013); however, facilities were available for the prompt and effective removal of any spillage. Carpets were cleaned regularly and staff said in the event of a spillage, the carpets were cleaned following the appropriate procedure.
- Rooms which had been recently upgraded had had carpets replaced with easy to clean flooring.
- In the Lodge, there were two consulting rooms. In room two, the hand wash sink was in the room. In room one; it was in an adjacent room. This meant patients may not see staff washing their hands. The two theatres in the Lodge had handwashing facilities and led into a sluice area for the disposal of equipment and rubbish.
- Cleaning manuals had recently been introduced and we saw these in the different areas we visited. These contained daily and weekly checks to be done, cleaning standards and methods and a copy of the cleanliness audit tool.
- Hand hygiene audits were completed monthly and had been changed to make them more objective by having staff from other areas completing them. Action plans were implemented for any scores at 95% or below. We reviewed audit data from January 2016 to April 2016 which showed compliance was 97%. Audit data could be accessed on the hospitals intranet site.
- Infection prevention link practitioners had been identified in each area. Interested parties had nominated themselves. Monthly meeting were held to share information and update any learning.
- Infection control was part of the hospitals mandatory training. It included a practical session and an e-learning package. On the ward, compliance rates were 100% and 93% respectively. Within theatres it was 100% and 97%.
- The endoscopy unit had achieved Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in October 2013 and endoscopes were decontaminated in line with national guidance.

Environment and equipment

- Visitors to the service were required to sign in and wear a visible identification badge. This made sure patients and staff were protected from unauthorised personnel.
- The main doors to theatres were next to the lifts and could be accessed by simply pressing a button next to the door. This posed a potential security issue as the door led directly into recovery, and the bay nearest the entrance was used for paediatric cases. We fed this back to the senior management team and were told plans were already in place to address this. Swipe access was being installed in the next two weeks which would resolve this issue. This was not on the hospitals risk register and no interim mitigating actions were in place.
- Within theatres, patients had to walk past the recovery area to get to the anaesthetic rooms for theatres one to three. Whilst this was not ideal, we had no evidence of patients expressing concerns or complaints in relation to this.
- Emergency buzzers were checked daily in theatre and we saw documented evidence of these checks being done.
- In April 2013, Patient Led Assessment of the Care Environment (PLACE) was introduced. This assesses the quality of the patient environment. The assessments are undertaken by local people and look at how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The scores for the hospital were around the England average for all domains apart from disability (73% against an England average of 81%).
- Staff told us that equipment was available when needed; this included moving and handling and pressure relieving equipment. The hospital replaced items or purchased new equipment when needed in a timely manner. Bariatric equipment was available, such as beds and hoists. When this equipment was in use rooms were utilised which were slightly bigger and had more spacious bathrooms.
- The estates manager held a list of service contracts and dates for servicing. They arranged routine servicing of equipment. In theatres, if equipment needed to go for repair there were systems in place to facilitate this and get replacements. We were told very occasionally equipment may not be available for a specific

operation. During a clinical operations meeting, we observed checks were made to ensure any equipment not usually stocked had been ordered and would be available.

- The hospital had an accredited sterile services department (SSD) for the cleaning of instruments.
- We checked various pieces of electrical equipment in the wards, theatres, the lodge and HDU and found evidence of in date safety checks being completed.
- In all areas we visited, resuscitation trolleys were easily located. There were separate trollies for adults and paediatrics which were clearly identified. Best practice is for resuscitation trolleys to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). We inspected resuscitation equipment in both wards, theatre, HDU and the Lodge and were assured that daily checks had been undertaken. Tamper proof seals were used to indicate when checks had been completed. With the ward sister's permission one seal was removed and a selection of the contents were reviewed. They were found to be sealed and in date.
- The anaesthetic machine checks were completed daily and records kept.
- The HDU had four bed spaces with the necessary monitoring and equipment to care for level two patients. Staff were in the process of putting together boxes for quick access. For example, for arterial lines and chest drain insertion.
- On the wards, we saw sharps injury packs and hypo and epistaxis kits for use in emergencies. These each had a contents list and guidance documents. The contents were in date and as listed.

Medicines

- Medicines management training formed parts of the trust's mandatory training. Compliance rates for surgery were 96%. We were not aware of a trust target; however mandatory training was red, amber and green rated (RAG). Medicines management was green indicating a good level of compliance.
- There was an on-site hospital pharmacy and there were procedures in place for staff to obtain patients medicines when it was closed.
- We reviewed 14 medication records 10 from HDU and four from the wards. There were fully completed including patients allergy status. We found three examples where it was difficult to read what had been prescribed. We asked ward staff about this and they said they would ask for it to be rewritten if they could not clearly read the prescription.
- We observed fridges for storing medications in each of the areas we visited and found these to be locked and temperatures recorded daily.
- Medications were stored in locked cabinets in clinical areas. A sample of the contents were checked and found to be in date.
- Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed the controlled drugs records on ward one and in theatre. Accurate records were maintained and balance checks were performed in line with hospital policy.
- During the announced inspection, the HDU was not being used so the controlled drugs had been returned to pharmacy. On the unannounced visit the HDU was open and the controlled drugs had been relocated with the appropriate checks having been completed.
- We spoke with a patient who had been administered morphine (a controlled drug) the previous day. They reported two staff came and checked their details and explained what a drug was before administering. This followed hospital policy.
- We reviewed a pharmacy error monitoring document. This report indicated how many errors had been avoided by the intervention of theatre staff. Whilst this only gave brief details, between June and July 2016, 64 errors had been avoided. Examples of these included medications being prescribed when there was a documented allergy and dispensing errors. We discussed this with the pharmacy team who stated the cluster of incidents related to allergies were discussed within the medicines management committee. No formal actions had been put in place following this.

Records

- We reviewed four sets of records on the surgical wards and we requested ten sets of notes for patients who had been on the HDU. With the exception of one set, we found them to be completed appropriately and each contained completed risk assessments on topics such as Malnutrition Universal Screening Tool (MUST), skin integrity and falls.

- Prior to admission, patients were asked to complete a medical questionnaire that detailed past medical history and any medications taken. This was kept in the patient's notes.
- Pre-operative assessments took place at an outpatient appointment so that clinical information was available for staff on admission.
- The nursing documentation consisted of paper records that were pre-printed as specific care pathways used by all disciplines of staff. These were in a checklist format, which required an initial from the nurse undertaking the check.
- Records were audited quarterly. The most recent audit from August 2016 showed compliance to be at 97%. An area for improvement was identified as countersigning entries by non-registered staff, and this information was shared through staff meetings.
- We also reviewed the results of a care pathway audit from May 2016. This looked at the completeness of ten care pathways. Compliance was 98%.
- Information security and data protection were part of staff's mandatory training. Compliance rates for the ward and theatre were between 87% and 98%. Records were stored securely in line with data protection procedures, preventing the risk of unauthorised access to patient information.
- Ward clerks were responsible for sending copies of patient's discharge letters to their GP's; most were scanned and sent electronically.

Safeguarding

- There was a designated safeguarding lead within the hospital. There had been one safeguarding concern reported to the CQC from June 2015 to July 2016; this was still being investigated at the time of our inspection. Records indicated this was being managed appropriately.
- The hospital had a policy for safeguarding adults at risk of abuse or neglect, which had been updated in January 2016. This included additions as required under the Care Act 2014 such as new definitions of adult risk, modern day slavery, female genital mutilation, self-neglect and institutional abuse.
- We saw flow chart information displayed in clinical areas on 'what to do if you think a vulnerable adult has been abused' and 'what to do if you think a child or young person may be at risk of harm'.
- Trust policies around safeguarding were easily accessible and staff were aware of what signs to look for and how to escalate any safeguarding concerns.
- Adults safeguarding training level one was completed by all staff with compliance rates for the wards and theatre between 97% and 100%.

Mandatory training

- The hospital had a comprehensive mandatory training programme which included both e-learning and practical (face to face) training. It included topics such as resuscitation, infection prevention and control, manual handling, fire safety, good communication, workplace diversity, and customer service.
- We viewed the 'training tracker' which was used to monitor compliance for theatre and the wards. This was RAG rated.
- Compliance rates for theatre were between 94% and 100%. Compliance rates for the ward were between 89% and 100%. Any staff requiring updates had dates scheduled.
- Staff reported no issues in accessing training and time was given for training to be completed.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- There was a clear admission criteria for patients planned to have surgery at the hospital and those who required high dependency care post operatively. This was identified at pre assessment. This helped to risk assess patients prior to agreeing any treatment.
- Following completion of a medical questionnaire patients were triaged. Some had face to face pre assessment. If no risks had been identified triage could be done by phone.
- Anaesthetic clinics ran each Friday morning with local NHS anaesthetic services to review patients identified as at risk. All potential HDU patients went through this service.
- Pregnancy testing was part of the theatre care pathway and prompted checks to be done prior to an operation.
- The national early warning score system (NEWS) was used as a tool for identifying deteriorating patients. This was used in ward areas and recovery. The documentation we reviewed across all ward areas showed accurate completion of NEWS scores and we saw evidence of raised NEWS scores being escalated appropriately. We did find an example of medical staff

not recording in the notes when they had had been asked to review a patient. This was raised with the senior management team who explained they expected any contact to be documented. They stated they would follow this up with the individual member of staff.

- Compliance rates for paediatric basic life support which was 38%. However, this training was only required for eight members of staff and training dates had been arranged for those who required updating.
- The HDU had the facilities to care for level two patients. There was a formal arrangement for patients to be transferred to the local NHS hospital if there clinical condition could not be safely managed. We were provided of an example when this situation occurred; a patient experienced a severe asthmatic attack. We spoke with staff who had been involved and they said the transfer process worked well.
- The practicing privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. Furthermore, they needed to be available to attend within an appropriate timescale if there was an emergency or significant deterioration in their patient's condition. The staff we spoke to raised no concerns in relation to this, saying consultants could always be contacted. There was an escalation process if there were any issues.
- There was an 'on call' rota for each department which we saw copies of. This detailed who to contact out of hours if advice or support was needed.
- The resident medical officer (RMO) was on site 24 hours a day and was trained in advanced life support.
- There was not an outreach team, however the HDU staff worked on the ward or in theatre when there were no patients in the unit. If any patients were causing concern, they would review them.
- The hospital had a pathway for the management of suspected sepsis. Sepsis is a potentially life threatening complication from an infection. There are national guidelines and care bundles on early recognition and management of sepsis. We saw information displayed on the sepsis six care pathway and the situation, background, assessment and reporting (SBAR) method of communicating.
- Sepsis was included in the policy for recognising and managing deteriorating patients. Training on sepsis was included in the acute illness management (AIM) course. 96% of qualified staff on the ward had attended this and four theatre staff.
- In the week prior to the inspection there had been a simulation for a paediatric emergency; this was led by the RMO. Staff reported having a lot of confidence in how the situation was managed.
- We saw evidence of scenarios simulating an emergency being run each month. One such example was a patient collapse at the bottom of the stairs. A blue light illuminated on the ward if the emergency call bell was pressed. In this event, the cardiac team, who carry bleeps, were contacted. The team consisted of the RMO, the nurse in charge on the ward and in theatre, the HDU nurse if the unit was open and a porter.
- The hospital followed the five steps to safer surgery procedures and WHO safety checklist. The hospital used separate checklists for local and general anaesthetic procedures. We observed sign in, the surgical pause and sign out. Each of these steps took place with the team fully engaged and the appropriate documentation completed. The checklist was complete in each of the patient records we inspected.
- The staff we spoke with understood the purpose of the safety checks and felt comfortable and empowered to challenge anyone if any issues were identified.
- Following the never events, there had been a focus on the WHO safety checklist and monthly audits had been undertaken by staff external to theatre. The audits looked at five patient records and five observations of the checks being undertaken. We reviewed audit data from March 2016 to July 2016; each observation was scored out of six. Comments were made where it was felt improvement could be made. For example, new staff members needing to be aware of the processes. The audit scores for the time period were between 54 and 57 out of 60.
- We were told plans were to continue with audit and make use of the theatre co-ordinators to ensure compliance and challenge any poor practice.
- There was a service level agreement in place for the provision of blood products.

Nursing and support staffing

- The hospital did not use an acuity tool to plan staffing levels on the ward. A dependency and capacity planning

tool, which was based on the Safer Nursing Care tool (SNCT), had been trialled but was found to more suited for NHS trusts than independent health and it did not meet their needs. We were told of plans to implement an integrated dependency and staffing tool later in the year.

- Duty rotas were arranged four to six weeks in advance using an electronic rostering system. Staffing levels were based on expected activity levels. This was done by looking at the number of patients planned to be admitted and the type of surgery. The ward sister told us staffing was continually reviewed and adjusted to meet the demands of the service. Staff were flexible if the staffing needs changed. Staff told us they may be asked to change shifts at short notice, but no concerns were raised with regards to this.
- The staff on the wards were divided into teams as the wards were single rooms on a long corridor. Each registered staff member was allocated to a group of patients. We were told the ratio was one staff nurse and one health care support worker to six or seven patients. On the day we visited ward one, the ratio was 1:8 as a two patients expected to be discharged the previous day stayed overnight.
- We were told the ward sister generally did not have a patient caseload as they had an oversight role. This included conducting ward rounds, checking documentation and controlled drugs. We were told the ward sister saw every patient and reviewed where they are on their pathway.
- There were currently nine permanent nursing staff and two bank staff on the endoscopy unit. The hospital were in the process of recruiting an additional nurse and healthcare assistant. This was with a view to taking pre-assessment work for the unit away from the designated surgical pre-assessment nurses.
- Data from July 2016 indicated there was one whole time equivalent vacancy (WTE) on the wards. There were four WTE vacancies for registered staff and five WTE vacancies for unregistered and operating department practitioners (ODP) staff in theatres. Recruitment was ongoing for these posts.
- Sickness levels within theatre from July 2015 to June 2016 were lower than other independent acute hospitals, with the exception of March which was higher. Sickness levels on the ward for the same time period were higher in the months of March, April and June 2016, but for the remaining were lower than other acute hospitals.
- Data showed there had been a significant reduction in staff turnover. For example, registered staffing turnover on the wards had reduced from 72% from July 2014 to June 2015, to 16% from July 2015 to June 2016.
- Agency staff were used in theatre; however, data from July 2015 to June 2016 showed registered and unregistered agency rates were consistently below those of other independent acute hospitals. April 2016 to June 2016 showed 100% of shifts had been filled. Staffing levels were discussed at the weekly clinical operations meeting. We observed staff being reallocated to cover any gaps in staffing.
- In theatres, the Association for Perioperative Practice (AfPP) was used to guide staffing. We were told the staffing structure had changed in theatre to include coordinators. This was a supportive role for the theatre teams; these staff were supernumerary to have oversight of activity. We received positive feedback from staff about these changes.
- At the time of inspection the HDU had opened one week out of every month for planned admissions. HDU staff were rostered to work for that week to ensure appropriate staffing levels with additional staff on call.
- We observed the nursing handover which was well structured and detailed the plan of care for each patient. The RMO attended the evening handover.

Medical staffing

- The service was consultant led and there were 195 doctors with practicing privileges at the hospital. All patients were referred under the care of a named consultant. Most of the consultants were employed by local NHS trusts and had practicing privileges to run clinics, carry out treatment and procedures and operate at the hospital.
- The registered manager held information for every consultant. There were robust systems in place with the management and the Medical Advisory Committee (MAC) for any new consultants wishing to practice. They also had an oversight role in monitoring consultant competence and revalidation. We reviewed minutes from the MAC meetings which evidenced discussions over how to ensure all consultants had up to date training in immediate life support.

- The RMOs were sourced from an agency. The arrangement for cover was two doctors working opposite to each other with one week on duty and one week off duty. A verbal handover took place at the changeover. Any sickness absence was covered by the agency.
- We were told of a situation where the RMO had been called to the ward several times during the night. To allow time to rest, six hours cover by another doctor was arranged for the following day.
- The hospital had two regular RMO's, so the system worked very well. We were told if a new RMO started they would be inducted by the other.
- The RMO reported good working relations with the consultants and anaesthetists. We were provided of examples where they had to be contacted and no concerns were raised in relation to this.
- The RMO would be involved with all patients on the HDU and would be briefed on their plan of care.

Emergency awareness and training

- The hospital had an overarching business continuity policy put in place by the wider Ramsay Health care group. This was noted to be past its date for review (August 2016).
- Staff knew where to access the policy and said in the event of an emergency would await advice from senior staff.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We saw the service used care pathways and patient care was carried out in line with national guidelines such as, the National Institute for Health and Care Excellence (NICE). Policies were accessed on the hospital intranet site and this was easy to navigate.
- We were told if any new guidance was issued, for example early recognition of sepsis from NICE, a policy gap analysis was done to identify aspects relevant for the hospital.
- The care pathways had an initial patient assessment and progressed through to patient discharge. The care pathways were multidisciplinary and allowed for variances for individual care. For example, if post-operative pain or nausea was an issue.
- Cataract care pathways were used in the Lodge and the HDU used a care pathway based on the various systems in the body, such as renal and neurological.
- The Intensive Care Society standards and policies were not applicable for the level of patient care provided on the HDU.
- The Health and Social Care Information Centre (HSCIC) has developed a breast implant registry on behalf of the Department of Health. The registry is designed to capture all breast implant surgery carried out both privately and by the NHS, and is being produced in response to Recommendation 21 of the Keogh Review of the Regulation of Cosmetic Interventions. The register allows patients to be traced in the event of an implant recall. The Yorkshire Clinic had registered with HSCIC-Breast and Cosmetic Implant Registry.
- The endoscopy service used HTM 01 – 06 Management and decontamination of flexible endoscopes to support the policies and procedures for endoscopy. This was in line with national guidance. The hospital had achieved and retained JAG accreditation since October 2013.
- We saw the annual audit programme for the hospital, which included the NHS safety thermometer. Audits were undertaken by two people; one from the department one from another area to aid objectivity. Any action plans as a result of audit findings were the responsibility of the head of that department.

Pain relief

- Pain scores were assessed using a score of 0 to 10 and recorded on NEWS charts. The patient records we reviewed showed pain scores had been recorded.
- The patients we spoke with confirmed that they had been offered pain relief in a timely manner and their pain had been controlled. One patient told us the nurse had explained if their pain had not reduced half an hour after administration of analgesia to let them know, so an alternative could be used.
- Pain was also assessed during 'comfort rounds' which took place two hourly.

- Patients on a three day rapid recovery pathway for joint replacements had a pain protocol in place. If pain control became an issue staff discussed this with the RMO or the anaesthetist.

Nutrition and hydration

- A Malnutrition Universal Screening Tool (MUST) assessment was completed during pre- assessments to identify patients at risk.
- The hospital had a policy for pre-operative fasting which was compliant with national guidance. Patients were provided with clear instructions over fasting times prior to their admission.
- On the wards, we saw patients were offered a variety of food options and alternative options to meet cultural needs were available. Jugs of water were seen in patient's rooms and were within patient reach. Staff were seen assisting patients with drinks.
- We received positive comments about the food from all the patients we spoke with, one described it as 'superb'.
- Nutrition and hydration was part of the annual audit plan. Ten records were audited in June 2016. This looked at whether fluid balance charts were completed and if nutritional screening had taken place. Data showed compliance at 94%; this was graded as amber.
- The fluid balance chart we reviewed had been fully completed, and with the exception of one, the total input and output had been calculated for the previous day.
- A specialist dietitian was available for patients undergoing bariatric surgery. They also attended weekly clinics.

Patient outcomes

- Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing surgery based on responses to questionnaires pre and post operatively. The hospital collected date for hip replacement, knee replacement, and groin hernia surgery for NHS funded patients.
- PROMs data from August 2016 showed that for the three procedures the hospital's adjusted average health gain was in line with the England average.
- The hospital also participated in the National Joint Registry and submitted information on all hip and knee replacement operations. This national audit monitors the performance of joint replacement implants and the effectiveness of different types of surgery.
- There was an extensive audit schedule for the hospital on an annual basis. This covered a wide range of areas from prescribing to consent. There was evidence of good levels of compliance and action plans where improvements needed to be made.
- The on-site pharmacy had an aseptic unit; a quality control lead from a local NHS trust had monitored and audited their practice. This was good practice as there was no requirement for the hospital to do this.
- The hospital did not submit data to the Intensive Care National Audit and Research Centre (ICNARC) as the information collected was not applicable to the patients cared for on HDU.
- Between July 2015 and June 2016, there had been 15 cases of unplanned readmissions within 28 days of discharge. The assessed rate of unplanned readmissions (per 100 inpatient and day case attendances) was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- There had been 16 unplanned returns to the operating theatre in the period July 2015 to June 2016. Senior managers were aware of this and no themes or trends had been identified.
- For the same time period, there were 23 cases of unplanned transfers of an inpatient to another hospital. This figure was lower than average for independent hospitals.
- Between July 2015 and June 2016, there had been four unplanned admissions to HDU and one readmission due to a poor urine output. No patients had been transferred from the HDU to an NHS intensive care facility.

Competent staff

- Practising privileges were managed on a database; information was received from the NHS organisation to confirm there were no concerns. The hospital provided us with information that demonstrated there had been validation of professional registration of all consultants with practising privileges. An annual request was sent to their NHS organisation asking what procedures they undertaken and how often, as well as information on any incidents or complaints they have been involved in. We looked at five staff recruitment files. All relevant paperwork was in place, appropriate documents and revalidation had been checked.

- The hospital had not removed practising privileges, suspended or placed any consultants on supervised practise in the 12 months prior to our inspection. However two Consultants had retired, two had moved away from the area and four ceased work at the Yorkshire Clinic. We were given an example of a consultant who was declined practicing privileges as they had retired from the NHS 18 months previously and had done no work since.
- Records showed 29 consultants had performed between one and nine episodes of care, 43 had carried out between 10 and 99, and 123 had carried out more than 100 episodes of care between July 2015 and June 2016.
- Data provided prior to the inspection indicated appraisal rates were 3% for inpatient areas and 11% for theatres. Further data indicated 0% of staff in inpatient areas had received an appraisal in the last 12 months. Information from the provider following the inspection showed 98% of staff in the inpatient areas had undergone an appraisal. Appraisal rates for staff working in theatres, the Lodge and endoscopy were 60%, 70% and 80% respectively. This is reflective of what staff told us. Senior staff on the ward indicated only two staff had not had their annual appraisal. In theatre, we were told less than 50% of staff had received an appraisal in the last 12 months.
- New staff confirmed they had competency booklets to enable them to do their job and we saw records of these in the staff files we inspected. New staff were given an induction pack which included a staff hand book; this contained a jargon buster and information on governance. They were booked on the next available mandatory training and were supernumerary for three to six weeks. A 'buddying' system was also used to support new starters. We spoke with a staff member who was new to the hospital and they felt well supported.
- Staff underwent training in basic and immediate life support, compliance figures across the wards and theatre were between 92% and 100%. Acute illness management (AIM) training had also been completed by five staff in theatres and several staff on the wards.
- We saw a clinical skills portfolio document which included competencies on various topics such as administration of post-operative pain relief. These appeared to be new documents as in the eight staff files we checked they were mostly blank.
- Additional training was provided in addition to mandatory training on topics such as falls, diabetes, and care pathway training.
- Staff said they felt supported if they wished to complete any further training. For example the bariatric nurse specialist attending a study day in London, and was also attending the British Obesity and Metabolic Surgery Society (BOMSS) training.
- The staff who worked in the HDU all had extensive experience and qualifications in critical care. The data provided showed that in the last 12 months all the patients on HDU had required level one care. There had been no patients requiring level two care.
- The critical care lead attended the West Yorkshire critical care network meetings.
- We saw a file with details of the qualifications, competencies and completed induction checklists for agency staff who worked in theatre.
- The estates manager who led for health and safety had attended risk management training then cascaded this to heads of departments.

Multidisciplinary working

- We saw good multidisciplinary working in all areas we visited. All staff reported good working relations with the consultants and RMO. The ward had tried multidisciplinary ward rounds involving the RMO and pharmacy, but there had been difficulties in aligning everyone's schedules. However, patients received a multidisciplinary review and a member of the pharmacy team visited the ward each day.
- Physiotherapy staff had a copy of the handover sheet and asked which patients required physiotherapy input. Once they had seen a patient, the board in the ward office was updated with details on how they mobilised.
- On Wednesday evenings, clinics were run by bariatric nurse with a specialist dietitian.
- There was a representative from each clinical speciality on the MAC.
- There were a number of SLA in place, for example provision of pathology services and the provision of blood products.

Seven-day services

- The RMO provided 24-hour medical cover and staff reported they did not have any difficulty in obtaining a medical review. The RMO told us they could contact a consultant when needed.

Good

Surgery

- Physiotherapy staff were available seven days a week and provided an on-call service. We were given an example of them coming to the ward at 8pm to facilitate a patient's discharge home.
- There was an on call rota for plain film imaging (x-ray). This service was provided where an x-ray was required urgently out of hours.
- CSSD was open Monday to Saturday and ran flexibly to meet the needs of the hospital.
- Pharmacy provided a six day service. The RMO had access to pharmacy out of hours, but a registered nurse was required to check out any medications.
- Band adjustment clinics, following bariatric surgery ran each month. However the clinical nurse specialist was available in-between for advice.

Access to information

- Integrated single patient records were maintained on site. Staff reported no concerns about accessing relevant patient information. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- We saw leaflets available to patients on a variety of clinical procedures. Leaflets were given detailing post discharge advice. Advice sheets were given to patients at the Lodge about administration of eye drops.
- The ward produced a discharge letter which was sent to the patients' GP.
- On the ward, there was a file containing consultant preference protocol data. This covered areas such as when to stop particular medications pre operatively, VTE prophylaxis and skin preparation.
- Policies and guidelines could be accessed on the hospitals intranet site.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed consent forms in the 14 records we reviewed. We found that appropriate risks had been discussed.
- Policies and procedures were in place for the consent process, including the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Patients told us staff explained their care and treatment to them and sought consent prior to delivering care.
- However, MCA and DoLS training was not provided in the hospitals mandatory training. Information explaining the principles of this was displayed in staff areas.
- We asked staff in pre assessment about capacity and were told if there were any concerns it would be discussed with consultant and anaesthetist and a different consent form would be used.
- We reviewed a patient's medical record in which a diagnosis of vascular dementia had been recorded. We could find no evidence of an assessment of capacity. We asked staff about this and were told they would expect to see this documented.
- We found staff to have a limited understanding in relation to the use of advocates and making decisions in patients' best interests. Although it was acknowledged this only related to a small number of patients using the service, it was noted as an area requiring improvement.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- We spoke with 17 patients on the wards during our inspection. They all gave positive feedback about the service and told us they were happy with the care. Comments such as 'fantastic' and 'first class' were used.
- One patient shared that they had needed to call the nurse every two hours the previous night and the buzzer had been attended to promptly each time. Another patient had just returned from theatre; they described it as a 'great experience' and that they were kept informed at all stages. The patient was having a day case procedure and liked the recliner chair as opposed to a bed, as it psychologically prepared them for going home.
- Another patient mentioned that they particularly liked being greeted at reception and being taken up to the ward.
- Patients told us they were treated with kindness, dignity and respect. They felt safe and 'looked after'. All patient rooms were single rooms, which meant their privacy and dignity was maintained. Throughout our inspection, we observed call bells being answered promptly.

Good

Surgery

- All the patients we spoke with told us they had been given good information prior to and after their surgery.
- We observed staff being compassionate and caring when speaking to patients.
- Two hourly comfort rounds were undertaken for all patients.
- All staff received training on customer service; compliance rates for the wards were 90% and 91% for theatre staff.
- During the announced inspection the HDU was closed. On the unannounced inspection there were patients on the high dependency unit, however two had been taken to theatre. We returned in the afternoon and observed the care. Privacy and dignity was maintained with curtains pulled round when staff were attending to them. We observed positive interactions between patients and staff.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The hospital had consistency scored 100% from January 2016 to June 2016; this was higher than the England average. With the exception of June the response rates for the same time period were also higher.
- Patients reported good relationships with the staff and that they were treated with dignity and respect. Dignity champions had been identified in clinical areas.

Understanding and involvement of patients and those close to them

- Any patients with additional needs were highlighted at pre assessment and plans put in place such as asking family to stay with them.
- All the patients we spoke with felt involved in their care and were aware of their pathway and discharge arrangements.
- We saw patients were informed and involved in planning for their post-operative care. Some patients had been sent information in the post before admission about their operation detailing what to expect. Those patients who had received this said it had answered all the questions they had. We observed a patients and relative on HDU being seen pre operatively by a physiotherapist. They were told their arm would be in a sling and what exercises they would be asked to do post operatively to aid their recovery.

Emotional support

- Visiting times were flexible and visitors said they could contact the ward at any time. On discharge patients were provided with contact numbers for the hospital and encouraged to call if they had any concerns.
- We observed staff offering support and reassurance for patients going to theatre.
- Psychological assessment was considered in patient pathways for particular types of surgery.
- There was comprehensive support for patients undergoing bariatric surgery which covered a two year period from initial referral.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital had trialled having HDU open all the time, but there was not the need for it. The unit currently was being opened one week each month for planned admissions.
- A new pathway had commenced in September 2016 for patients undergoing bariatric surgery. This involved the bariatric nurse consultant running clinics three times each month. This was in response to the previous service discontinuing, so there had been patients who had nowhere to go with any problems. We were told the first clinic was held in October and was very busy; patients could self-refer in to the clinic.
- The service had agreements in place with the local clinical commissioning group regarding referral and treatment of NHS patients. The hospital's service development plans included NHS work.

Access and flow

- Patients were referred to the hospital by their GP, self-referral or NHS referral. The majority of referrals were directly commissioned through the NHS choose and book patient pathway.
- Data from July 2015 to June 2016 showed the referral to treatment time for NHS patients using the service was consistently less than the 18 week national indicator.

- To help with patient flow, medical questionnaires were given at initial appointments. This meant planning for their admission could begin at an earlier stage.
- Consultants informed the booking office when they were available and the booking office staff filled the theatre lists with patients. At the clinical operations meeting, staff were proactive with managing theatre lists. For example, they identified one was likely to overrun, so additional staff were rostered on. On another list the order was changed to ensure those planned as day cases would be discharged the same day.
- Patients arrived for their operations on the day the surgery; admission times were staggered for theatre lists to reduce the amount of time patients were waiting on the ward before going to theatre.
- Rapid recovery care pathways were in place for those patients undergoing total knee replacement.
- The hospital reported they had cancelled 54 procedures for a non-clinical reason in the last 12 months; of these 100% (54 patients) were offered another appointment within 28 days of the cancelled appointment.
- The patients we spoke with did not have any concerns in relation to their waiting times, admission or discharge arrangements.

Meeting people's individual needs

- The wards were accessible for people who used a wheelchair or walking aids. Disabled toilets and showering facilities were available in the ward areas we visited.
- Assessments took place on admission or during pre-assessment to identify individual patient's needs.
- Translation services were available for people whose first language was not English. We were told interpreters were booked for consent forms to be signed and to accompany patients into theatre; family would also be encouraged to stay. We were given an example of lady who was Chinese and spoke no English. Flash cards were made to enable simple communication between them and staff.
- Dementia screening was competed for all patients over the age of 75. An initial question was asked about any episodes of forgetfulness over the last 12 months; if yes was replied then a six item cognitive impairment tool was completed.
- Training was provided on 'stand by me' which was about patient centred care, factual information on dementia and workplace diversity. Staff reported low numbers of patients admitted living with dementia, but stated they would be provided with 1:1 care and family would be asked to stay with them.
- Staff could not recall caring for any patients with a learning disability but spoke about reasonable adjustments if the situation were to arise.
- For patients undergoing bariatric surgery, there was a standard operating procedure (SOP) for psychological assessment. Both the consultant and the specialist nurse could refer to psychiatry services if concerns were identified.

Learning from complaints and concerns

- Information on how to make a complaint was available for NHS and private patients. Leaflets were available in clinical areas.
- The provider complaints policy promoted openness and candour when dealing with complaints, but did not specifically mention duty of candour requirements.
- 49 complaints had been received by the service in the reporting period of July 2015 to June 2016. Three of these complaints had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service). This was a lower number per 100 patients compared to other independent hospitals.
- There was a policy and process within the organisation for dealing with complaints and learning from them. We saw complaints were responded to in a timely manner, monitoring of performance was in place with regards to responding to complaints.
- The senior management team told us that learning from complaints and comments made on feedback forms was cascaded to staff in the customer focus group and departmental meetings. We saw evidence of this in the minutes we reviewed; however staff were not able to articulate any changes in practice in relation to complaints.
- We saw evidence in one of the complaints inspected that the duty of candour had been applied. We saw the complainant had received an explanation and apology when things had gone not as expected.

Good

Surgery

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The hospital was led by the general manager. The senior management team included human resources, operations and a finance manager and the matron. They were supported by heads of departments.
- The hospital manager visited a different department each week and the matron did a daily walk round. They had an open door policy and displayed strong leadership skills.
- Head of departments were visible and accessible and experienced in their clinical specialty and management role. Each head of department reported to a member of the senior management team.
- Managers were passionate about the service and the well-being of their staff. This was reflected in the conversations we had with staff. Staff reported a very supportive culture and that they could ask anyone anything. This meant staff morale was very high.
- Staff reported a good learning culture in relation to learning from incidents and the never events were specifically mentioned.
- Staff felt confident in escalating concerns and described a 'no blame culture'. We were provided with examples where staff had escalated concerns about behaviour and competency these were addressed.
- Staff received an annual update on workplace diversity and demonstrated awareness of how discrimination was avoided.

Vision and strategy for this this core service

- The hospital vision was to be 'the leading healthcare provider where clinical excellence, safety, care and quality are at the heart of everything we do, whilst growing our business and profitability.' The staff we spoke with were patient focused and generally aware of the hospitals vision.
- The clinical strategy was displayed in staff areas and objectives were based on the CQC domains.
- From speaking with senior staff it was clear that there was a focus on clinical excellence and quality. For example, the bariatric service felt there had been improvement and they wanted to apply to be accredited as a centre of excellence. The infection control annual plan had a clear focus on incidents, surveillance, cleaning and training.
- Staff spoke about 'The Ramsay Way'. This represented the values of the organisation, which were to provide caring, progressive work in which staff felt the value of integrity, credibility and to provide positive outcomes for all.

Governance, risk management and quality measurement

- The hospital had a defined governance structure in place to ensure performance, quality and risk was monitored. Regular meetings took place against a set agenda.
- The information governance forum and risk management group met quarterly with the senior management team meeting weekly. Each of these fed into the Medical Advisory Committee (MAC), head of departments meetings and the clinical governance committee.
- The corporate risk register was established in 2014 by Ramsay and each hospital site assessed their position against the corporate risks. The risks were a mix of clinical, financial and health and safety risks.
- We were told of a risk to the Yorkshire Clinic site which had been added to this risk register. This was around the doors to access the Lodge.
- Following a visit from a manager from another Ramsey hospital, discussions took place about how each department had conducted a local risk assessment then created a local risk register. The Yorkshire Clinic had implemented this in the summer. We viewed this 'live' during the inspection and saw each department's folder where the detailed risk assessments and action plans could be viewed. This included how each risk was being monitored, control measures, score and review date.
- The local risk register was monitored through the health and safety committee. The corporate governance risk register was monitored through clinical governance committee.
- Whilst there had been a focus on improving the reporting culture the number of incidents reported was still lower than other independent hospitals.

Good

Surgery

- We were provided with different figures with regards to staff appraisal rates. Data provided after the inspection showed compliance levels for theatre staff were 60% and staff from the Lodge were 70%.
- The matron confirmed that they had received the new National Safety Standards for Invasive Procedures (NatSSIPs) policy and were developing a local SOP. NatSSIPs are a set of high-level national standards of operating department practice that support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures.
- Each clinical area had designated notice boards, which contained information relating to policy updates, and safety information.
- There was a robust system in place to ensure that relevant documentation was held to demonstrate that the requirements for practising privileges were met for each consultant.

Public and staff engagement

- The hospital collected data as part of the NHS Friends and Family test initiative. Data provided showed 100% of patients recommending the service with good response rates.
- A patient focus group meeting was planned in November 2016. The hospital had implemented this to engage and involve the public to drive improvements and make changes to services.
- Monthly Customer Focus Group meeting were in place with representation from all departments. The aim of the group was to learn by acting on the feedback from customers.
- Staff from the service was able to attend a monthly staff engagement forum. This group looked at ways of engaging with staff to improve services.
- The hospital also had 'Monthly Magic' events where staff received recognition for their work. We were told that examples of this included an ice cream van visiting the hospital and a photo booth being on site.

Innovation, improvement and sustainability

- The hospital planned to apply for accreditation as a centre of excellence for bariatric surgery.
- It had been identified that having the HDU open all the time was not sustainable. Moving forward to make effective use of staff and resources, ad provide safe care for those patients who needed closer observation, admissions would be planned for one week out of each month.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

We rated safe as good.

Incidents

- The three registered sick children's nurses we spoke with knew of and had used the organisations incident reporting system.
- There were no incidents specific to children's services for the reporting period of June 2015 to July 2016. However we were provided with an example from the staff we spoke with. There had been a recent medication incident when a mother had given her child infant paracetamol from her own supplies. This resulted in the resident medical officer (RMO) and child's consultant being informed and the local poisons unit contacted to ensure no further action was required. Following this simple changes were made which would mitigate re-occurrence and this was shared across the hospital.
- The service reported no never events between July 2015 and the time of our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Cleanliness, infection control and hygiene

- There were no children in the hospital at the time of our inspection. However the cubicle we were shown as an example was visibly clean and tidy. There was access to sinks in bedrooms in clinical areas that adhered to regulations of the Department of Health Building Note 00-10 part C: sanitary assemblies (HBN 00-10).
- We did not see that there were any incidents of infections to children and young people. Children's nurses we spoke with (and other nurses) were seen to adhere to arms bare below the elbows guidelines and used hand gel which was available in bedrooms and public areas.
- We saw that staff had access to nationally recognised infection control and prevention policy, hand hygiene and uniform policy. These met with World Health Organisation (WHO) Guidelines on Hygiene in Health Care (2010).
- At the time of our inspection there was a hand hygiene awareness stall in the hospital main foyer. We were informed that this was a regular event.

Environment and equipment

- We saw that both outpatients and inpatient areas had appropriate resuscitation equipment and emergency medication for children and young people. We saw that these were checked daily and in date and that drugs were clearly pre packed paediatric doses in tamper proof boxes.
- Previously there had been no dedicated children's area on the inpatient wards due to low numbers of children treated. However the week prior to inspection a dedicated children's area on the ward had been established. This area had restricted access via a swipe system in line with national guidelines.
- The theatre area had an easy to access large push button outside the entrance. This could be a security risk as there was no confirmation who would be going in and out. This was a risk for all age groups but

particularly vulnerable groups. We fed this back to the senior management team and were told plans were already in place to address this. Swipe access was being installed in the next two weeks which would resolve this issue.

Medicines

- We saw that children's medications were available. We were informed by pharmacy staff that there had never been a difficulty to obtain paediatric medications. There was an on-site hospital pharmacy and there were procedures in place for staff to obtain patients medicines when it was closed.
- We saw evidence in ten paediatric records that assessment had been completed with weight, height and health status considered in prescribing decisions.
- There had been a recent medicines incident whereby a mother had given a child paediatric paracetamol from her own stores. This had been dealt with appropriately and processes put in place to prevent re-occurrence.

Records

- We saw evidence in ten paediatric records that there had been child specific assessments prior to surgery. These included weight and markers of health status (WET).
- We saw that pre-operative assessments were completed in the ten paediatric records reviewed.
- Paediatric records were paper based. We saw that these we were well organised with referral letters, results and medical/ nursing information visible.
- Both medical and nursing entries in the records were contemporaneous and line with professional body guidelines. They were signed, printed and dated correctly allowing for traceability.
- We observed that paediatrician information was integrated into the body of the paper records.
- Integration of medical notes was made by consultants working under practising privileges.

Safeguarding

- Safeguarding children's level one and two was completed by all staff. Compliance figures for the ward and theatre staff were between 93% and 100%. Safeguarding children's level three, was only required by particular staff. Compliance was 100% for five staff on the wards and the five staff identified as requiring this training in theatre.
- All three registered sick children's nurses had received level 3 safeguarding training as per the intercollegiate document 2014. In addition there had been provision for female genital mutilation and PREVENT training. All staff we spoke with were also aware of local issues, in particular child sexual exploitation.
- The registered medical officers had received level 3 safeguarding children training as part of the employment procedures.
- All staff we spoke with understood the implications of the Saville enquiry and there were clear guidelines into the use of celebrity figures accessing the hospital.
- All staff we spoke with knew where to take concerns about a child or young person. They understood that young people 16-18 may still be subject to child safeguarding considerations. They told us that they understood children who were looked after by the local authority (LAC) may be vulnerable and could present with unmet health needs.
- The new senior children's nurse was building links to the local authority safeguarding children's board and had attended a recent link meeting.
- The senior registered sick children's nurse had started weekly two hour information and advice safeguarding children 'drop ins'. These had proved popular and provided a link between local and national developments and staff.
- We saw easy access to hospital and links to local safeguarding children's board procedures including an easy to follow flow chart if staff were concerned about a child or young person, this included out of hours contact numbers.
- The registered sick children's nurses told us that adult nursing staff understood their own roles and responsibilities if adult behaviour or health needs affected a child's welfare or safety.

Mandatory training

- We could not find separated figures for the children's nurses, however training compliance figures were high, please refer to mandatory training section in the surgical report.
- All three children's nurses told us they were up to date with mandatory training and had allocated time to complete this. This was available on the Ramsay learning and development site.

Good

Services for children and young people

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- We spoke with medical secretaries and saw there was a robust system to ensure that there was a registered children's nurse was on duty when a child was booked in for their operation in accordance with NICE guidelines. This included overnight arrangements in case a child had to be admitted overnight.
- There had been the decision not to undertake surgery on babies in the unit. Children under three years of age were treated at the local NHS trust but may be seen in the outpatient department and diagnostics.
- We observed separate risk assessment tools for children and young people which formed part of the Ramsay paediatric pathway. This included weight, energy and endo tracheal tube (WET) and paediatric early warning score (PEWS). There were nutritional and fasting risks considered in the pre –assessment process.
- We saw evidence that information about a young person's functioning was recorded where appropriate to care for example a young person who had attended with attention deficit disorder (ADHD).
- A registered children's nurse undertook a pre-operative assessment. This could be over the phone for minor procedures. We saw that general practitioner (G.P) information was available. The child was assessed in order to ensure that there were no pre-existing medical conditions which would form an additional risk.
- The registered children's nurses and the RMO were training in advanced paediatric life support. Nursing staff in theatre who cared for children were trained to safeguarding level three and had undertaken paediatric basic life support training. In addition to this staff working in recovery who cared for children had undertaken paediatric immediate life support training.
- There was a formal arrangement for patients to be transferred to the local NHS hospital if there clinical condition could not be safely managed. There was a service level agreement (SLA) with EMBRACE in order to transfer children to the local NHS trust in an emergency. The registered medical officer (RMO) told us that there were good links with the paediatric department at the local NHS trust.

Nursing and support staffing

- As the number of registered sick children's nurses was only three then the use of a formal acuity tool was not used. We saw that there was flexibility in the system and all three were willing to change shifts according to staff on leave and if children were admitted at short notice.
- We saw duty rotas and were assured that registered children's nurses were on duty at times children were admitted. Two of these nurses were also general trained, and one had adult nursing competencies so delivered care to adults when there were no children admitted.
- There had been no requirement to use agency registered sick children's nurses in the previous year of July 2015 to June 2016. The hospital were very clear that they adhered to guidance about only registered sick children's nurses caring for children.
- There may be occasions when young people 16 to 18 years may be cared for by adult nurses with competencies. However we were told that registered sick children's nurses would be the lead nurse and on duty.

Medical staffing

- There was always a registered medical officer (RMO) on site who provided 24 hour cover on a week on, week off basis with a colleague with handover and daily handover of individual patients from consultant to RMO.
- The registered medical officer (RMO) provided medical cover for children and young people over 24 hours. We were told that there were good links to the child's consultant in the local NHS trust and a paediatric consultant was available for advice 24 hours.

Emergency awareness and training

- This information has been reported on under the surgery service within this report.

Are services for children and young people effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We saw that care pathways were in line with the Ramsay organisation paediatric pathways and that care for children and young people was delivered in line with NICE guidelines and those from the local NHS trust.

Pain relief

- We reviewed ten paediatric records of children and young people from ages three years to 17 years of age which included the medication charts. We saw that there was evidence of appropriate pain relief had been given. There were no children admitted at the time of our inspection; however when we contacted six parents with prior consent, all told us that their child had been offered and given pain relief when required. There had also been discharge advice and pain relief medication to take home.
- We saw in the ten paediatric records we reviewed that there had been assessment of weight and pre-operative assessment prior to the prescribing of pain relief. If children required morphine based pain relief post operatively, then they were kept in overnight for appropriate monitoring.
- There had been a recent pain relief audit which had been completed in September 2016. One of the actions following this was for a tool for the assessment of pain in younger children to be developed. The registered sick children's nurses had looked at several models to adapt. At the time of our inspection this had not been embedded.
- The registered sick children's nurses told us that they were planning to deliver a pain management workshop in the coming year although no dates had been set.

Nutrition and hydration

- The child/young person's nutritional status was assessed as part of the pre-assessment pathway and in their hospital stay.
- Fasting times were given to parents in advance and adhered to paediatric anaesthetic guidelines. We were told by parents in telephone contact that this had been explained clearly in the pre-operative assessment. We did not see any instances when we reviewed the paediatric records that the fasting times had been breached so as to cause undue distress to a child.
- We were told by the parents we contacted by telephone that they had been very happy with the food provided by the hospital when they were admitted. It was of good standard and there was a good choice for children. If their child was not happy with the choice then an alternative could be cooked to order.

Patient outcomes

- Specific data was not collected for children and young people. This information has been reported on under the surgery service within this report. Plans had been put in place to start monitoring this.

Competent staff

- Three registered sick children's nurses were available for the ward area. These nurses had specific clinical skills. They had undergone training in advanced paediatric life support. Staff competence formed part of the current paediatric gap analysis which was being completed at the time of our inspection.
- There had recently been a registered sick children's nurse employed in the out patients department. We were told that this new member of staff would take the children's' agenda forward and look to provide a more focussed approach.
- · Nine adult nursing staff had paediatric basic life and intermediate support training (not broken down).
- The registered medical officer had completed and updated European Paediatric Life Support competencies, There had been a paediatric resuscitation scenario the week previous to our inspection which staff told us had reported to have gone well.
- The registered children's nurses were appraised by the senior children's nurse who had been in post since July. All three staff had had a recent appraisal.
- Clinical supervision in the children's service took place but was not formalised. The registered sick children's senior nurse told us that this an area she was keen to progress

Multidisciplinary working

- There was evidence of good working relationships for children and young people pathways with the local NHS trust and general practitioners (G.P's).
- The senior registered sick children's nurse had recently been to the local NHS trust children's services to build relationships and ensure that the Yorkshire Clinic

standard operating procedures reflected those in the trust. There were plans to have this as an ongoing process and to visit other Ramsay hospitals which offered paediatric care.
- The registered sick children's nurses told us that they understood children had a health visitor or school nurse as part of universal child health arrangements and when it would be appropriate to contact them.
- The local designated doctor for safeguarding children employed by the NHS trust undertook a routine weekly evening clinic at the hospital which allowed for good working relationships and communication.
- There were was a service level agreement between the Yorkshire clinic and paediatric services at the local NHS trust.

Seven-day services

- Services were available for children over seven days if a child required admission. We saw that the rota for registered children's nurses allowed for this. Staff told us they were flexible and would change duties to accommodate longer than anticipated stays.

Access to information

- We were told that children's paper based records were readily available for children on admission.
- We reviewed ten sets of paediatric records and saw that parents had received information regarding fasting times and other pre-operative information which was in line with national guidance.
- We saw where Ramsay policies and procedures relevant to children's and young people's care were kept on the intranet. In addition the registered sick children's nurses and the matron knew where to access other important guidance for example the local safeguarding children's board procedures.
- The registered medical officer (RMO) knew where to access local NHS trusts services and Ramsay protocols and procedures.
- We saw information for staff clearly displayed in staff areas. This included safeguarding information, hand washing guidelines and professional information such as upcoming courses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Registered children's nurses and the registered medical officer (RMO) knew the difference of and between the Gillick competencies and Fraser guidelines. They also understood the procedures to follow if a child presented for surgery who was looked after by the local authority.
- From the records were reviewed we found consent forms to be appropriately completed.

Are services for children and young people caring?

Not sufficient evidence to rate

We Inspected but did not rate caring.

Compassionate care

- At the time of inspection we did not see care provided to children and young people due to no attendances or theatre bookings. However, six families agreed to speak to an inspector over the telephone and told us that were happy with the care they provided and all stated the nurses were very caring.

Understanding and involvement of patients and those close to them and emotional support

- There was a rota to ensure that a registered sick children's nurse was assigned to their care. Registered sick children's nurses have a child focus and have specific clinic skills. In addition, the training encompasses the understanding of child development and holistic family care.
- Parents told us that the registered sick children's nurses had understood that this had been an anxious time for parents and had explained procedures clearly and kindly.
- We saw that nurses were trained to provide care but we could not observe this during the inspection.
- The registered sick children's nurses told us that part of their role included supporting the parents as well as the child as they were often anxious. We were not able to observe any direct care or emotional support offered, although were told in telephone contact with parents that this had been good and appropriate to their child's age.

Good

Services for children and young people

Are services for children and young people responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- At the time of our inspection the Yorkshire Clinic treated low numbers of children and young people. We were told that it was envisaged that there were plans to increase activity.
- Between July 2015 and June 2016 there had been 14 children under two years of age seen in outpatients. 71 children between 3years and 15 years old had been treated as day patients and 15 of children between 3 and 15 years had been treated as in patients. There had been 293 children between 3 years and 15 years treated in the outpatient department.
- Children aged 0-3 years old were only seen for consultation in the outpatient department. Children and young people aged 3-18 years old were seen for diagnostic testing, elective procedures, physiotherapy and non-invasive radiology tests.
- There had been 276 young people between the ages of 16 and 18 seen in outpatients. 13 young people between the ages of 16 years and 18 years treated as in patients, and 26 young people in this age group treated as day cases.
- At the time of our inspection there were not sufficient numbers of staff to warrant a separate children's operating list although moving forward this was a future goal. However, children and young people were always put first on current operating lists. This was verified in the review of ten paediatric operation notes.

Access and flow

- Children and young people were assessed and admitted for elective surgery only. If the individual consultant considered any case to have additional risk then procedures were referred to the local NHS trust. The most common surgical procedures were ear, nose and throat (ENT) and knee procedures associated with sports injuries.
- Four out of the six parents we spoke with told us that they did not have to wait very long to be seen and treated which they were positive about.
- We saw clear evidence in ten paediatric records of discharge letters to the general practitioner. We also saw that health visitors or school nurses were included in the circulation of these letters for example ear surgery cases.

Meeting people's individual needs

- Although the number of paediatric patients seen was low in comparison to adults, two of the six parents contacted commented on the lack of child focus in terms of the room furnishings and toys. The outpatient and in-patient environments were not child focussed however staff were starting to address this following parent feedback. Items such as sticker books, toys and bed linen to suit a child had been introduced.
- National guidance encourages services to ensure that the environment reflects the psychological and development needs of young people in terms of play, recreational activities and educational provision (RCN 2003). However, there was a distraction box available and this had been used in a recent case where a young person had been admitted for surgery and had attention deficit disorder (ADHD).
- Six parents who we had contacted by phone told us that they had received post-operative advice in relation to their child's procedure. They also said they had been pleased with their child's care and the nurses communicated with the children on their individual level.
- The Yorkshire Clinic was based in an area with a diverse population. We saw that there was access to a telephone interpreting service and a face to face service which could be booked in advance. The registered sick children's nurses we spoke with knew of and where to find the Ramsay interpreting policy and the importance of using trained interpreters. All three staff said they would never use family except in an emergency.

Learning from complaints and concerns

- There were no complaints in the time period July 2015 to June 2016 regarding the care offered to children and young people.

Good

Services for children and young people

Are services for children and young people well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The three registered sick children's nurses we spoke with told us that they felt well supported by senior management and all felt involved in the development of the service. They considered that the culture of the hospital was open and honest and they said that if they raised a concern they would not fear recriminations.
- The registered sick children's nurses and other staff we spoke with told us that this was a learning environment.
- The two registered sick children's nurses told us that they considered that there had been a significant improvement in the children's service since the new senior registered sick children nurse had come into post. They felt now that the service could be developed further and would look forward to an increase of children being treated and dedicated operating lists.

Vision and strategy for this this core service

- The registered sick children's nurses and other staff we spoke with had a clear vision of the service and that of the wider Ramsay organisation. Staff we spoke with could tell us about the Ramsay 6 C's: care, compassion, courage, competence communication and commitment.

Governance, risk management and quality measurement

- We saw that the Yorkshire Clinic clinical strategy included a paediatric gap analysis which was being completed at the time of our inspection. This included, staff training, staff competence, resuscitation and transfer safeguarding, environment and the patient journey. The staff responsible to undertake this were the matron and paediatric lead nurse. We saw that the issues had started to be addressed.
- We saw that there had been a recent formation of a paediatric governance committee which reported to the hospital clinical governance committee, heads of department meetings and the medical advisory committee (MAC) The terms of reference (TOR) stated that a named paediatrician from the local NHS trust and a consultant paediatric anaesthetist were members of the committee. The committee was formed to have oversight of paediatric governance issues and form links to the medical advisory committee (MAC) and hospital and group governance arrangements, compliance to a range of standards including Ramsay children's care policies and align with those of the local NHS trust.
- Individual cases and pathways of care were also discussed at the paediatric governance committee as numbers were low and it was feasible to do so.

Public and staff engagement

- The hospital public and staff engagement processes have been reported on under the surgery service within this report.

Innovation, improvement and sustainability

- The senior registered sick children's nurse had made good links with the local NHS trust and local safeguarding board to avoid the hospital working in a silo.
- The senior registered sick children's nurse had instigated regular drop in sessions for all staff to disseminate safeguarding information gained from external agencies.
- The hospital planned to develop its children and young person's services once all the necessary safety and governance arrangements were embedded.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- The hospital reported 15 incidents within the outpatient service from July 2015 to June 2016. This was lower than the rate of other independent acute hospitals we hold this type of data for. The service had identified that two incidents in July 2015 related to the provision of bowel preparation prior to endoscopy. Changes had been made to the provision of bowel preparation and no further incidents were reported.
- Eighteen incidents had been reported within radiology. The service had identified that three incidents in December 2015 related to an equipment fault. This was rectified and no further incidents were reported. This also included one incident where exposure 'much greater than needed' had occurred. All incidents had been appropriately raised with the independent radiation protection lead in line with the IRMER regulations and an appropriate notification had been made.
- The physiotherapy service reported only one incident. This was reported as low risk in June 2016.
- The hospital had an incident reporting policy in place. This included guidance on how to report incidents and how to investigate concerns. We saw that incidents had been reported in line with this policy.
- Staff we spoke with understood how to report incidents on the hospital's electronic reporting system. They were confident about reporting issues and raising concerns with senior staff.
- The service reported no never events between July 2015 and the time of our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We saw evidence that staff discussed clinical and non-clinical incidents at staff meetings. Staff told us that incidents were shared that had occurred across the outpatient and ward based services.
- Staff we spoke with were broadly aware of the principles behind the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents'andprovide reasonable support to that person. This regulation was introduced to all NHS trusts in November 2014.
- All staff could describe the principles of being open and honest with patients. However, the majority of staff we spoke with had a limited understanding of the formal regulatory steps and requirements of the statutory duty.
- We saw posters on display setting out the duty of candour and what this meant for staff and patients that used the service.

Cleanliness, infection control and hygiene

- Staff within the service had achieved between 95% and 100% compliance with infection prevention and control training.

- Hospital wide hand hygiene audits (referred to in the Surgery report) included staff from within this service.
- Areas we visited during the inspection were visibly clean and we saw evidence that cleaning schedules had been appropriately completed.
- We looked at 15 pieces of equipment. All equipment had 'I am clean' labels in place to show the date of cleaning and that the equipment was ready for use.
- Hand gel was available for patients and staff to use on the entry and exit from the various departments. These were visible and we observed staff using appropriate hand hygiene technique before interacting with patients.
- Hand washing basins were available to staff in all clinic rooms and treatment areas. We observed staff using appropriate hand hygiene techniques before interacting with patients.
- Staff had access to appropriate personal protective equipment, including gloves and gowns. We observed staff using appropriate protective equipment when interacting with patients.

Environment and equipment

- Patient led assessment of the care environment (PLACE) is the new system used by NHS England for assessing the quality of the patient environment. Service level scores could not be calculated. However, the scores for the hospital were around the England average for all domains apart from disability (73% against an England average of 81%).
- The 15 pieces of equipment we checked had all been appropriately tested. Testing labels were displayed to identify the date of testing, and when testing was next due.
- Flammable cleaning materials and solutions were stored securely in a locked cabinet within the minor treatment room.
- Areas where ionising radiation was used were clearly marked with appropriate warning signs and lights to indicate when rooms were in use.
- We checked the resuscitation equipment available in the diagnostic imaging and outpatient department. Logs kept with the equipment showed that appropriate daily and weekly checks had been completed to assure staff that equipment and stock was available, in date, and ready to use in an emergency.

Medicines

- Medicines were stored in the minor treatment room within the outpatient department. These were in a locked fridge and we found that room and fridge temperature monitoring was taking place on a daily basis. This meant that medication was stored securely and at appropriate temperatures to maintain its usability.
- Nursing staff in outpatients told us that they did not administer medications to patients. Staff would be asked to collect medications for consultants and would be involved in medicines checking processes.
- Private prescription cards were available to consultants in the outpatient department. These were stored in a locked cupboard and were numbered. Staff told us that they were provided to consultants on request and could be used at the onsite pharmacy, or local pharmacies, to obtain medication.
- Pharmacy staff told us that batches of numbered cards were provided to the department. These were signed for by staff and a note of the numbers provided to the department and who signed for receipt was kept by pharmacy. When medicines were dispensed, pharmacy staff told us that a copy of the private prescription was kept on file.
- However, no central record was held to show what had been prescribed against each numbered prescription, or to show what numbered prescriptions may not have been used or may be missing. This meant that there was a risk that prescription cards could go missing and would not be accounted for. We raised this with management staff.
- When we returned on the unannounced inspection we saw that a new protocol had been issued to ensure that numbered prescription cards were signed for and that all issued cards were reconciled on return to pharmacy. This provided a clear log of how prescription cards had been used. This resolved the concerns we had identified.
- Records we checked included prompts for staff to enter patient allergies to medications. In the majority of records we reviewed, this section of the records had been left incomplete or was not consistently completed across different care documents. In one case, an allergy to contrast media and medication noted on the front of the medical records had not been recorded on care pathway documentation. The allergy status had instead been written as 'none'.

Good

Outpatients and diagnostic imaging

Records

- Records from the service were incorporated into a hospital wide audit of record keeping. Results from the latest audit in October 2016 showed a 96% compliance with the audit standards.
- We reviewed 15 sets of medical records from the outpatient and physiotherapy service. The records were legible and the majority included appropriate information on patient care and the care pathway. However, many of the records did not contain all the relevant information completed on the standard pre-printed care pathway documentation. For example, only one of five physiotherapy records had a fully complete 'pathway intervention' front sheet for each patient visit, as directed by the template. The hospital told us this information may be contained in the body of the records. However, this meant that there was a risk that information could be overlooked and pathway documentation was not always completed appropriately.
- Data provided by the service showed two percent of patients attending outpatient appointments were seen without the appropriate medical records being available. The service explained that to mitigate any impact to the patient previous correspondence, such as clinic letters, were available electronically. These could be obtained, printed and put within a temporary set of notes along with patient labels. The temporary notes would then be amalgamated with the patient notes once they became available.
- The service explained that as of 1 August 2016, no patient notes were taken off site. This process change had been implemented to support a single and complete case note for all patients. All case notes were now held within the medical records department and were tracked electronically by the hospitals patient administration system.

Safeguarding

- The service reported no safeguarding concerns to us in the reporting period from July 2015 to the time of our inspection.
- Data provided by the hospital showed 100% compliance with staff training in adult safeguarding levels one and two, and safeguarding children and young people at level one, two and three.
- The safeguarding policies we reviewed were in date and accessible to staff. They informed staff of the safeguarding considerations around children failing to be brought to planned appointments by parents or carers.

Mandatory training (report on mandatory and statutory training)

- At the time of our inspection, all mandatory training modules had been completed by between 95% and 100% of staff.
- Management staff told us that all staff were booked to attend relevant sessions where these had not yet been completed. We saw records to support this.
- Staff described training being delivered via e-learning and face to face modules. They did not report any problems in accessing training or using the e-learning system.

Assessing and responding to patient risk

- Care pathway documentation for minor outpatient procedures included reference to patient early warning scores being required to ensure that patients were well enough to return home following procedures and not in pain. However, the early warning tool was not included in the pathway documentation and the records we reviewed did not contain separate early warning score charts. This meant there was a risk that patient risk was not being assessed appropriately before they were discharged. However, at the time of our inspection, we saw no incidents of harm reported due to this omission.
- Following the inspection we were provided with an updated care pathway which addressed these issues.
- There had recently been a registered sick children's nurse employed in the out patients department. We were told that this new member of staff would take the children's' agenda forward and look to provide a more focussed approach.
- There were systems and processes for escalation of care or transfer out to local NHS hospitals should nursing staff and the resident medical officer (RMO) have concerns about a patient.
- Resuscitation equipment was available to staff within the departments and details of how to make a call for emergency assistance were displayed in clinical areas.
- A notice advising women of child bearing age to inform staff if they could be pregnant was displayed in a range

of languages. We saw that possibility of pregnancy was also prompted on radiology request forms. Staff told us that they would also routinely discuss pregnancy with patients prior to exposure taking place.

Nursing and other staffing

- The outpatient department had a dedicated team of registered nurses, healthcare assistants, and administration staff. Physiotherapy and radiology staff were managed separately, with radiology staff separated between radiography and cardiac specialties.
- There were no baseline staffing tools used in the outpatient department to monitor staffing levels. Instead, staff told us that staffing was determined based on planned activity levels. Our observations and interviews with staff confirmed there were adequate numbers to safely manage the outpatient's department clinics. During the inspection, actual staffing levels met the planned rota for staff needed per area.
- At the time of our inspection the outpatient department employed 7.28 full time equivalent (FTE) registered nurses and 6.6 FTE healthcare assistants. The physiotherapy service employed 13.7 FTE physiotherapists and a 1 FTE technical instructor. The radiology service employed 6 FTE radiographers and 2 FTE healthcare assistants.
- Between July 2015 and June 2016 the average rate of bank or agency nursing staff usage was 4.4%. In the same period, the service recorded a 0% usage of bank or agency healthcare assistants. Both of these levels were lower than the average of other independent acute hospitals we hold this type of data for.
- On average, the rates of sickness for nurses and healthcare assistants working in the outpatient department was below the average of other independent acute providers that we hold this type of data for.
- The service told us that there were no outstanding vacancies across the departments at the time of our inspection. The service had recently recruited an additional three staff to radiology to cover two substantive posts. Management staff told us they hoped that this would prevent against any future staffing issues.
- The rate of outpatient staff turnover was above the average of other independent acute hospitals we hold this type of data for in the reporting period.

Medical staffing

- For medical staffing, please refer to the Surgery report.
- Staff told us that they were able to contact medical staff via telephone when patients had contacted the outpatient service following a consultation or minor treatment. Staff reported no problems in being able to speak with medical staff when this was required.

Emergency awareness and training

- Operational staff had a limited understanding of the hospital's business continuity plan. Staff we spoke were unaware of the policy or how to react to major incidents that may affect the hospital. However, staff told us that they would contact their managers to seek support and guidance where necessary.
- Management staff were aware of the policy and understood the actions they would take in the event of a major incident.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected effective but did not rate.

Evidence-based care and treatment (this core service only)

- The physiotherapy service completed an audit of its patient literature in May 2016. This was carried out in accordance with Chartered Society of Physiotherapy audit tool and identified 100% compliance with the standard and quality of written information provided.
- The diagnostic imaging service carried out regular audits to monitor compliance with hospital policy and IRMER guidance. This included audits of referral forms, image quality and post examination records. Audits provided between July 2016 and the time of our inspection showed performance above 97% in each of the monthly audits.
- Diagnostic imaging services had also been subject to recent external reviews in 2016 by the designated radiation protection adviser. This had identified that the

radiography service was nearly fully compliant with IRMER regulations, with only minor improvements necessary. These improvements had been completed at the time of our inspection.
- The angiography service had been rated as partially compliant with a number of minor improvements necessary. This included improvements to the recording of operators and consultants with operating privileges and diagnostic reference levels. The service had developed an action plan to address the issues identified. This showed that actions had been completed in line with the audit recommendations.
- The outpatient service used care pathway documentation for patients attending for minor procedures. We saw that these were developed in line with appropriate professional guidance.

Pain relief

- Patients attending the outpatient department for minor procedures were provided with prescriptions for pain relief following their procedure. These could be collected from the hospital pharmacy.
- The outpatient service had designated clinics for patients with chronic pain. These were run by specialist consultants.
- Pathway documentation included prompts for staff to consider patient pain. This included a pain scoring tool which staff told us they could act on if they noted a patient was in pain.
- The physiotherapy service offered acupuncture to patients to help control pain.

Nutrition and hydration

- Beverages were available to patients within the waiting areas. This included hot drinks and water from designated drinks machines. These were free to use.
- Staff told us that they were able to request food from the kitchen if patients required anything to eat following minor procedures.
- A specialist dietitian was available for patients undergoing bariatric surgery that was available in weekly outpatient clinics.

Patient outcomes

- Wider audits of patient outcomes are considered within the Surgery report.
- The physiotherapy service undertook a baseline assessment of patient mobility and this was monitored and tracked through the discharge. This allowed the service to identify when patients had met the desired outcome and were ready for discharge.
- Management staff told us that no specific audits took place concerning clinic cancellations. Staff and patients did not report to us any concerns about clinics being cancelled at short notice.
- The hospital did not audit specific waiting times for patients to receive an appointment, or the length of wait when they attended for their appointment. The hospital told us it could routinely see patients within seven days of them requesting an appointment. None of the patients we spoke with raised any concerns about being able to access appointments in a timely manner or delays in clinic.

Competent staff

- Data provided by the service showed that 100% of physiotherapy and diagnostic imaging staff, and 98% of outpatient staff had received an appraisal at the time of our inspection.
- Staff told us that they found the appraisal process helpful and were able to engage with their managers to mutually agree on development needs.
- The hospital did not have a formalised process of clinical supervision for clinical and nursing staff within the service. However, the hospital told us any issues in regard to practice were discussed in one to one meetings with staff and at team meetings. This was supported by comments we received from staff.
- We spoke to new staff within the services we visited. They described a structured induction process and felt this had supported them in their role.
- Staff who may be involved in entering radiation-controlled areas received appropriate training, for example cleaners entering the diagnostic imaging area received training to ensure they were aware of radiation exposure risks.

Multidisciplinary working

- Staff in the service were able to access support from the RMO or consultant medical staff when required. At the time of our inspection, the ward and the outpatient department shared the same manager. Staff told us that this had supported closer working between the teams.

Good

Outpatients and diagnostic imaging

- Staff within the physiotherapy service provided support to the inpatient wards. This team liaised with ward based staff and attended handovers to ensure that the therapy needs of patients were adequately communicated to ward staff.
- Radiologists working within the service worked closely with consultant colleagues from the relevant specialties. For example, specialty musculoskeletal radiologists worked closely with orthopaedic surgical colleagues to discuss patient care and provide a consensus for treatment.
- Patients attending for total knee/hip replacement procedures within orthopaedics also attended an education session that was led by the physiotherapy service.

Access to information

- The service had a commissioning for quality and innovation (CQUIN) target to develop a robust process so that all initial outpatient clinic letters are sent via electronic transmission by 31 March 2017. This was to facilitate primary and secondary care providers become better integrated.
- At the time of our inspection, the service was expected to have implemented and embedded the process changes, to have communicated this with relevant staff and to have trialled the changes with a review at the end of September 2016.
- At the time of our inspection, staff told us that outpatient letters were now routinely sent electronically. This was subject to ongoing review.
- In the outpatient records we reviewed, we saw that timely discharge letters were provided to patient's GPs. This ensured that appropriate information was communicated to primary care providers.
- Staff reported no concerns in accessing medical records or patient information. Records were held in a paper format, with an onsite medical records department.
- Electronic copies of outpatient letters generated by the hospital were available on the hospital system. Staff could access these if required.
- Staff were able to access policies and guidance online via the hospital intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service explained that consultants completed stage one consent for surgical procedures in the out-patient consultation. This provided an opportunity for patients to discuss any concerns and provided time for them to evaluate the information prior to any procedure taking place.
- Staff we spoke with were aware of the Mental Capacity Act. They said that they would be confident in raising any concerns about capacity with senior nursing staff or consultant staff so that appropriate steps could be taken to ensure capacity and consent issues could be addressed.
- However, when we asked staff to demonstrate awareness of capacity issues they were unable to explain how these were comprehensively considered. An example of this was staff explaining that they relied on a pre-assessment question around 'any condition for which preparation may be needed' to identify if the patient had any capacity concerns. This did not constitute a capacity assessment. This meant that there was a risk that a robust assessment of capacity would not take place when patients attended the outpatient service for minor procedures.
- We saw that prompts to ensure patients consented were included on care pathway documentation in outpatient minor procedures and in physiotherapy. These were not consistently completed in the records we reviewed. This meant that there was a risk that the service could not evidence patient consent.
- We reviewed 12 consent forms completed for minor procedures within outpatients. Of these, eight forms had been fully completed. Examples of omissions included one form signed in the wrong place, no dates being present, and no consultant signature.
- One form three had been completed by the daughter of an elderly patient. We found no evidence to demonstrate that any assessment of the patient's capacity had taken place or that any best interest decision had been made to proceed with the patient's care. This meant that we could not be assured that consent had been appropriately taken in some cases.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring good.

Good

Outpatients and diagnostic imaging

Compassionate care

- We spoke with 18 patients and relatives during our inspection. All were positive about their experience and said that the service provided them with compassionate care.
- We observed staff interacting with patients in the waiting areas and clinic rooms. Staff were friendly and supportive when communicating with patients and their families.
- We observed physiotherapy treatment being provided. Patients were treated with dignity and respect by practitioners and told us that they felt they were treated with compassion.
- Some patients told us that they did not like waiting in the X-ray waiting area in a gown. Although this area was away from the main waiting room, a minority of patients told us that they felt uncomfortable having to wait with other patients whilst undressed and that this did not always feel dignified.
- Results from the September 2016 NHS Friends and Family test showed that 93% of people would recommend the outpatient service. However, the response rate to the survey was only 7%. The majority of specialties scored between 86% and 100% satisfaction. However, neurosurgery (63%) performed significantly worse than any other specialty.
- Results from the September 2016 NHS Friends and Family test showed that 100% of people (12 responses) would recommend the radiology service.
- The service had access to an in date corporate policy setting out the availability and role of chaperones in patient appointments. This made provision for chaperones to be provided and included details on the relevant qualities/training chaperones needed to undergo.
- We saw that posters were displayed within clinical areas informing patients that they could request a chaperone for their appointment.

Understanding and involvement of patients and those close to them

- Patients told us that staff discussed their care with them to ensure that they understood the nature of the care being provided. We saw observed staff discussing the care due to be provided to ensure that patients understood the care they were receiving.
- Relatives of patients we spoke with told us that they were involved in the discussions around their relative's care, when the patient had consented to this.
- The physiotherapy service recorded mixed performance in department patient satisfaction survey for questions in relation to the understanding and involvement of patients and family. This included scoring a quarter average of 100% for patients understanding the role of the physiotherapist. However, there were lower scores for the information provided being clear to understand (78.6%) by patients.

Emotional support

- Patients told us that staff were friendly and willing to listen to concerns. Patients felt that staff were able to provide them with support when required in stressful or challenging situations.
- Staff were confident and able to deliver challenging messages to patients and relatives. We saw that a private room was available within the outpatient and physiotherapy department to allow sensitive conversations to take place away from clinical areas.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The service provided care for a range of patients. The majority of patients seen within the service between July 2015 and June 2016 were between the ages of 18 and 74 years old (85% or 51,553). The next major patient group seen were aged over 74 years old (14% or 8308). The remaining one percent of patients were shared between children aged 0-2 years (14), children aged 3-15 years (293), and young people aged 16-17 years (276).
- Facilities for outpatients included 13 consulting rooms, one minor procedure room, one phlebotomy room, and one room used for ear, nose and throat specialty patients.
- The diagnostic imaging service included plain film X-ray, ultrasound, mammography, fluoroscopy, and angiography.

Good

Outpatients and diagnostic imaging

- The physiotherapy service incorporated six cubicles and a private bay within one clinical area. The gym also had the ability to be divided into further cubicles if necessary.
- Outpatient appointments were routinely available between 8.00am and 9.00pm Monday to Friday. Appointments were also available from 8.00am to 3.30pm on Saturday.
- Radiology services were available Monday to Thursday from 8.00am to 8.00pm, Friday from 8.00am to 6.00pm, and Saturday from 9.00am to 1.00pm. In addition, there was a radiographer on call out of hours twenty four hours a day, seven days a week out of hours'
- Outpatient physiotherapy appointments were available from 7.30am to 5.00pm Monday, Wednesday and Friday, with services available from 7.30am to 8.00pm on Tuesday and Thursday.
- The physiotherapy service had developed a range of group sessions for patients to allow cohorts of patients to be seen together where appropriate. This included groups for acupuncture, Pilates, falls, and knee problems.

Access and flow

- There were 60,444 outpatient total attendances between July 2015 and June 2016. Of these, 73% were NHS funded and 27% were privately funded. Of this figure, NHS patients were responsible for 16,752 initial appointments and 27,238 follow up appointments. Private patients accounted for 6,093 initial appointments and 10,361 follow up appointments.
- The service met the indicator of 92% of patients on incomplete pathways waiting 18 weeks or less for an appointment from time of referral between July 2015 and June 2016. In addition, over 95% of patients started non-admitted treatment within 18 weeks of referral in this period.
- The service told us that average waiting times for outpatient physiotherapy were around four weeks and that this would not exceed six weeks for any patient.
- Post-operative physiotherapy was booked at the time of patient discharge. The service told us that the number of sessions and date of appointments was discussed with the patient based on their clinical need.
- On average, the service had no patients waiting six weeks or longer from referral for diagnostic tests. We were told that patients identified as requiring plain film imaging in an outpatient appointment could be seen on the same day.
- Patients referred for ultrasound scanning were seen on average in four to five weeks. Urgent outpatient requests were performed within five days.
- Average reporting times for routine plain film imaging and ultrasound scanning were around 48 hours.
- The service had recently begun collecting data on patients that did not attend their appointments and clinic cancellations. At the time of the inspection, a cancellations group had recently been formed and non-attendances were being monitored. No data was yet available.
- A policy was in place to manage patients that did not attend for appointments. This stated that patients would be removed from the list if they failed to attend two appointments. Reminders of the policy were in place in clinic areas for patients. Staff told us that there was some flexibility toward the policy dependent upon the needs of the patient and instructions from consultant staff.
- We observed patients being called into clinic appointments on time and no concerns were reported to us about delays in clinic appointments.

Meeting people's individual needs

- A notice in the diagnostic imaging department included a 'language identification chart'. Patients who could not communicate in English were asked to point at their language so that a telephone interpreter could be contacted.
- A private room was available within the therapy service. Staff told us that this could be used for patients who may have additional health, cultural or social needs. In addition, staff were able to accommodate requests for a specific male or female therapist if the request was made in advance. If a request was made on the day of treatment, staff told us that they would try to accommodate this where possible. If not, then the patient would be offered the chance to rebook.
- Staff in the outpatient department told us that they were not always aware of when patients may be attending with additional healthcare needs. This meant that staff could not be proactive in planning for any additional requirements these patients may need.

Good

Outpatients and diagnostic imaging

- Staff told us that they would be able to spend time in 1:1 care of patients with additional needs. This would include being able to sit with the patient and follow them through their patient journey. Staff told us that they would also engage with any accompanying family or carers to help adapt to the specific needs of the patient.
- Leaflets were displayed advertising local services for patients and their carers who may be affected by issues around learning difficulties, dementia, mental health concerns, or physical disability.
- The physiotherapy service had scored 100% over the quarter in the department patient experience survey in response to the question whether any patient specific needs were accounted for in the treatment provided.
- Patients paying for treatment had access to a separate area of the waiting room adjacent to the main waiting area.

Learning from complaints and concerns

- Between July 2015 and June 2016 the outpatient service received ten complaints. No particular trend or themes were identified within the service. The physiotherapy department received three complaints, with no particular themes, and the diagnostic imaging service received no complaints.
- Staff told us that they tried to address complaints as soon as possible. Where informal concerns were raised, staff were encouraged to resolve these concerns with the patient as soon as possible.
- Where complaints were escalated to a formal complaint, staff told us that they received feedback on complaints via their team meetings. We saw this included in team meeting minutes we reviewed.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership/culture of service related to this core service

- The outpatient department was managed jointly with the wards by a senior nurse. The diagnostic imaging and physiotherapy service had separate managers.
- Staff we spoke with told us that they received good support and leadership from their immediate managers and senior staff.
- Staff described leaders as approachable and told us that they were happy to raise concerns and share ideas with managers.
- The physiotherapy service had identified that some staff leaving the service had raised concerns about a lack of senior support. In response to this, the service had started a mentoring system for junior staff to provide more support.
- Staff we spoke with were positive about the culture of the hospital and told us that they were happy in their working environment and committed to providing high quality patient care.

Vision and strategy for services

- There was no specific vision and strategy for outpatient, physiotherapy or radiology services. Instead, this was linked to the wider hospital strategy and strategy and the Ramsay regional strategy and group vision.
- Senior staff told us that they were limited in how the physiotherapy service could expand or develop due to the limited physical space available to them at the hospital.
- Staff we spoke with were aware of the wider Ramsay vision and elements of the regional strategy and hospital strategy that were relevant to their practice areas.

Governance, risk, management and quality measures for this core service

- A risk register was in place for the hospital. This included specific risks identified within the services. During the summer each department had had conducted a local risk assessment then created a master list of local risks. We viewed this 'live' during the inspection and saw each department's folder where the detailed risk assessments and action plans could be viewed. This included how each risk was being monitored, control measures, score and review date.
- Staff told us that regular team meetings took place within the service. We saw that meeting minutes were displayed for staff to read and that wider learning and feedback from incidents and hospital wide developments were shared.

Good

Outpatients and diagnostic imaging

- We observed a daily 'huddle' taking place in the physiotherapy service. This allowed a 10 minute breakout for staff in the early afternoon to discuss the day so far, planned activity for the afternoon, and to share any relevant information.

Public and staff engagement

- The hospital public and staff engagement processes have been reported on under the surgery service within this report.

Outstanding practice and areas for improvement

Outstanding practice

- The pharmacy department had undergone external benchmarking of their aseptic department.
- The new senior children's nurse was building links to the local authority safeguarding children's board and had attended a recent link meeting.
- The senior registered sick children's nurse had started weekly two hour information and advice safeguarding children 'drop ins'. These had proved popular and provided a link between local and national developments and staff.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider making designated areas more child focused.
- The provider should ensure that all staff receive an annual appraisal.
- The provider should ensure best practice guidance is followed in relation to mental capacity assessment and best interest's decisions.