Claremont Hospital

Quality Report

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Date of inspection visit: 20 February to 21 February and 3 March 2017
Date of publication: 08/08/2017

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Claremont Hospital is operated by Aspen Healthcare Limited. Claremont Hospital has 42 beds, three laminar flow theatres, 13 consulting rooms, a static MRI and CT scanner, and plain and digital X-ray. The hospital provides surgery and outpatients with diagnostic imaging services and we inspected both of these services.

We inspected this hospital using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 to 21 February 2017 with an unannounced visit to the hospital on 3 March 2017.

We rated the hospital as outstanding overall, with surgery rated as outstanding and outpatients and diagnostics rated as good.

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 services provided by this hospital were surgery, outpatients and diagnostics. Where our findings on surgery, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We rated this hospital as outstanding overall because:

- We saw excellent leadership from managers who were passionate about patient care and staff welfare. They were visible to all levels of staff and patients.
- There were robust governance structures and reporting mechanisms in place where performance and the quality of the service was reviewed and changes made. Actions were monitored through audit processes and reported to leadership and governance committees.
- We saw a service wide vision and strategy that was embedded across the organisation.
- Patient care was at the heart of the service and the priority for staff. We saw several areas of outstanding caring practice.
- Staff were trained in a nationally recognised accreditation programme in customer care. Following this staff completed a Values Partners programme which is a workshop to explore values and behaviours between staff and towards patients and aims to create a positive working culture.
- The hospital took part in a recognised comprehensive observational study process to consider the approach by staff to the general care of patients, the level of patient/visitor engagement, and the environmental factors within patient reception areas. We saw an example of one survey in July 2016 and there had been an overall high score of 97%.
- There were effective systems to keep people safe and to learn from critical incidents.
- The hospital environment was visibly clean and there were measures to prevent the spread of infection.
- There were adequate numbers of suitably qualified, skilled, and experienced staff (including doctors and nurses) to meet patients' need.
- There were arrangements to ensure staff had and maintained the skills required to do their jobs.

Summary of findings

- There were arrangements to ensure people received adequate food and drink that met their needs and preferences.
- Care was delivered in line with national guidance and the outcomes for patients were good when benchmarked.
- Robust arrangements for obtaining consent ensured legal requirements and national guidance were met.
- The individual needs of patients were met including those in vulnerable circumstances, such as those with a learning disability or dementia.
- Patients could access care when they needed it.

However:

- We observed some environmental concerns in theatre areas. There was a refurbishment plan in place.
- Surgical safety checklists were not completed consistently.
- Not all checks had been completed in theatre for controlled drugs, drug fridges and warming cabinets. Some cleaning checks in the theatre areas had not always been completed daily.
- Not all eligible staff had received an appropriate level of safeguarding training to allow them to recognise any issues of concern.
- Mandatory training figures did not reach Aspen Healthcare Ltd targets.

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

Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Outstanding** ☆	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 outstanding overall. We rated caring and well-led as outstanding. We rated safe, effective and responsive as good. The service had reported no never events and two serious injuries between October 2015 and September 2016. There had been one never event, involving wrong site surgery, that had been reported in January 2017 prior to our inspection. We saw that this was being investigated and an action plan developed. Learning was cascaded via the governance committees and received at staff team meetings. Internal patient satisfaction surveys indicated 98% satisfaction for cleanliness and the service had a low rate of hospital acquired infection. The hospital training performance for the surgical services showed mandatory training completion results were predominantly above the hospital target of 85%. Integrated care records covered the entire patient pathway from pre-operative assessment to discharge and included comprehensive care plans for identified care needs. We reviewed 11 sets of medical and nursing care records whilst on site and records were legible, complete, and contemporaneous. We saw excellent individualised care which was delivered by highly motivated staff. The surgery service at the hospital had a good overall safety performance and patients were protected from harm. We found good processes for reporting and escalating incidents and good sharing of learning from incidents. There was a good understanding of the duty of candour regulation and major incident policies amongst clinical staff.

Summary of findings

There were good patient outcomes across surgical specialties and care was delivered in line with relevant national guidelines.
The hospital performed well in national clinical audits.
Staffing needs were based on acuity of patients and reviewed daily to ensure safe staffing.
Patients had effective and timely pain relief.
Staff felt supported with training opportunities to fulfil their role
There was effective multidisciplinary team (MDT) working between doctors, nurses and allied health professionals and local NHS hospitals.
Staff across the surgery service were caring and professional and patients were treated with dignity.
Staff often went 'the extra mile' to ensure that patient needs were met and patients were comfortable and informed about their treatment and care.
Patients that we spoke to consistently highly praised staff of all levels, in particular their caring attitude.
Patient flow from admissions, through theatres and onto to surgery wards was smooth and bed availability was managed effectively.
We saw leadership from staff who were passionate about patient care and staff welfare. They were visible to all levels of staff and patients.
There were comprehensive and robust governance and risk management processes in place.
During the inspection, we observed warm, open, and positive interactions between staff and patients. All patients we spoke with were happy with the care they received and we received universally positive written feedback from patients during the inspection.

Outpatients and diagnostic imaging

Good

We rated this service as good. Safe, responsive and well-led were rated as good. Caring was rated as outstanding. We did not rate effective as we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients & diagnostic Imaging.
The service had reported no never events or serious incidents and one incident had been reported to the CQC in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). Staff were encouraged to raise concerns and report incidents. We saw evidence of lessons learnt from safety incidents and changes to clinical practice.

Summary of findings

Medications in radiology were stored securely in appropriately locked rooms and fridges. There was an effective process in place for monitoring the use of prescription charts.
Policies and procedures were accessible to staff and had been developed and referenced to the National Institute for Health and Care Excellence (NICE) and national guidance.
Staff knew how to report incidents and there was good evidence of sharing and learning from incidents.
All areas were clean, organised, and well equipped.
Staff complied with 'arms bare below the elbows' policy, correct handwashing technique, and use of hand gels.
Staff we spoke who were aware of their roles and responsibilities in relation to safeguarding. They were able to identify different types of abuse and were aware of how to escalate concerns.
Staffing levels were good with no vacancies in the outpatients and physiotherapy departments. One vacancy in the radiology department was in process of being filled.
The culture across the hospital was replicated in outpatients and diagnostic services. Patients told us they were treated with kindness, dignity, and respect. We observed staff interacting with patients and their families in a respectful and considerate manner.
Reception staff were welcoming and friendly and patients told us they were courteous.
All patients we spoke with said they felt informed about their care and treatment. They said staff had time to explain things fully and to answer any questions they had.
Nursing staff could provide emotional support to patients receiving bad news and psychiatric support was available for patients receiving cosmetic, bariatric or breast cancer treatment.
Referral to treatment time (RTT) for patients on incomplete pathways waiting 18 weeks or less at this hospital, was consistently 95% or higher.
Patients were seen promptly and able to access appointments at a date and time to suit them.
Outpatient clinic cancellations were low.
Staff in outpatient and diagnostic imaging services met the individual needs of patients. Waiting areas

Summary of findings

had been improved for patients with dementia and telephone and face to face interpretation services were available for patients whose first language was not English.
Patients were made aware of how to complain and staff dealt with patient concerns immediately to prevent them escalating. The outcome of formal complaints was shared with staff at team meetings, which included feedback and learning.
Staff spoke highly of both local and senior leaders. They said they were accessible and approachable. There was a positive culture with good staff morale. Staff felt able to raise concerns and said they felt listened to and valued.
Risks were managed well and there was a clear mechanism for escalating risks when necessary.
Outpatients and radiology departments were continually seeking to improve services for patients.

Summary of findings

Contents

Outstanding ☆

Claremont Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Claremont Hospital

Claremont Hospital is operated by Aspen Healthcare Ltd. The hospital opened in 2002 and became part of the Aspen Healthcare Group in 2012. It is a private hospital in Sheffield, Yorkshire. The hospital primarily serves the communities of Sheffield and surrounding areas. It also accepts patient referrals from outside this area.

The hospital has had a nominated individual in post since January 2013.

The hospital has had a registered manager in post since June 2012.

The hospital has had a Controlled Drugs and Accountable Officer (CD AO) since July 2012.

Surgical services at the Claremont Hospital provide day and overnight facilities for adults and young people between the ages of sixteen and eighteen.

The hospital provides elective treatments for different specialities such as orthopaedic and spinal surgery, general surgery, urology, ophthalmology, ENT, vascular, gynaecology, cosmetics and plastics, oral and maxilla facial and dermatology. Facilities at the Claremont Hospital include one inpatient ward with 30 registered beds with six day case beds and an additional day case area with six beds. Whilst most rooms are ensuite, some do not have ensuite facilities. The hospital had three laminar flow theatres that were open from 7.30am until 9.30pm, Monday to Friday and from 8.30am until 5.30pm on Saturday.

Our inspection team

The team that inspected the service comprised a CQC manager, Cathy Winn, four CQC inspectors, and specialist advisors with expertise in governance, radiology, outpatient services, surgical and operating theatre nursing and clinical surgery. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection as part of our planned, comprehensive inspection programme.

Information about Claremont Hospital

Claremont Hospital is a purpose built in-patient facility situated in Sheffield and opened in 1953. It was originally owned by the Institute of Our Lady of Mercy and has been owned by Aspen Healthcare Limited, or predecessor organisations, since 2012. Claremont Hospital has 42 beds, three laminar flow theatres, 13 consulting rooms, a static MRI and CT scanner, and plain and digital X-ray. The hospital provides surgery and outpatients with diagnostic imaging services and we inspected both of these services.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures (5 February 2015)
- Surgical procedures (5 February 2015)
- Treatment of disease, disorder or injury (5 February 2015).

Activity (October 2015 to September 2016)

Summary of this inspection

There were 10,205 inpatient and day case episodes of care recorded at the hospital in the reporting period (October 2015 to September 2016); of these 78% were NHS funded and 22% were other funded (insured and self-pay).

For children aged 16 and 17, there had been four inpatients, eight day cases and 244 outpatients during October 2015 to September 2016.

There were 7,405 visits to the theatre between September 2015 to October 2016. The five most common procedures performed which accounted for visits to theatre were optical lens surgery, injections of a therapeutic nature to the spinal nerve root, primary posterior decompression of lumbar spine, primary total knee replacement and inguinal hernia repair. The most common five surgical procedures for children and young people between the ages of sixteen years to eighteen years old were anterior cruciate ligament reconstruction, endoscopic excision of synovial pica, arthroscopic meniscectomy, multiple arthroscopic operation knee and stabilisation of shoulder.

There were 59,670 outpatient total attendances (including follow up appointments) in the reporting period (Oct 15 to Sep 16); of these 63% were NHS funded and 37% were other funded.

There were 240 consultants including surgeons, anaesthetists, physicians, and radiologists who worked at the hospital under practising privileges. Two resident medical officers (RMO) worked on an alternate weekly rota. The hospital employed 41.4 whole time equivalent (WTE) registered nurses, 30.9 WTE care assistants and operating department practitioners and 105.5 WTE other staff, as well as having its own bank staff.

Track record on safety (October 2015 to September 2016)

- No never events
- Two serious incidents.
- There were 283 non-clinical incidents of which 30% (85 incidents) occurred in surgery or inpatients and 64% (181 incidents) occurred in other services. The remaining 6% of all non-clinical incidents occurred in outpatient and diagnostic imaging services (17 incidents).
- Out of 97 clinical incidents, 79% (77 incidents) occurred in surgery or inpatients and 9% (nine incidents) occurred in other services. The remaining 11% of all clinical incidents occurred in outpatient and diagnostic imaging services (11 incidents).
- No incidents of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile (C.diff)
- No incidents of hospital acquired E-coli.
- There were seven unplanned returns to the operating theatre.
- Nine unplanned readmissions.
- Eleven unplanned transfers to an NHS hospital.

Services provided at the hospital under service level agreement:

- Catering
- Facilities management
- Medical device servicing
- Waste collection
- RMO provision

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 most recent inspection took place in January 2014. That inspection found that the hospital met the standards of quality and safety that were inspected.

At this inspection, we inspected two core services at the hospital; these were surgery and outpatient and diagnostics. We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records, and results of surveys and audits. We requested information from the local clinical commissioning group. We placed comment boxes at the hospital before our inspection, which enabled patients to provide us with their views. We received 44 completed comments cards from patients.

We held two focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and

Summary of this inspection

chair of the Medical Advisory Committee. We spoke with a wide range of staff, including nurses, the resident medical officer, radiographers and administrative and support staff. We also spoke with seven patients and three relatives who were using the hospital. We observed care in the outpatient and imaging departments, in operating theatres and on the wards, and we reviewed 22 patient records. We visited all the clinical areas at the hospital.

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:

- The hospital promoted a culture of reporting and learning from incidents. Incidents were fully investigated with actions for improvement identified and put into place.
- There were sufficient staffing levels in place to meet patient's needs.
- Nursing records had been completed appropriately and in line with each individual patient's needs.
- A modified early warning score system was in place to support staff to recognise a deteriorating patient.
- There was an out of hours on call system. There was a senior manager on call rota in place seven days per week. This rota was circulated and all staff were aware of the senior contact for the hospital each week.
- Each Resident Medical Officer (RMO) on duty was Advanced Life Support (ALS) and Paediatric Advance Life Support (APLS) trained and was available for assistance 24 hours per day, seven days per week.

However,

- Surgical safety checklists were not completed consistently.
- There were defects in the theatre environment and some equipment which were a potential infection risk. There were plans in place to address these.
- Not all checks had been completed in theatre for controlled drugs, drug fridges and warming cabinets.
- Not all eligible staff had received an appropriate level of safeguarding training to allow them to recognise any issues of concern.

Are services effective?

Good

We rated effective as good because:

- Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, and best practise legislation. Adherence to evidence-based practice was monitored as part of the annual audit plan to ensure a consistent approach to care and to monitor patient outcomes.
- Policies and procedures used within surgery and theatres followed evidence based practice. For example, the surgical site

Summary of this inspection

infection monitoring in orthopaedics was followed in accordance with guidance from the National Institute for Health and Care Excellence (NICE) for prevention and treatment of surgical site infection (SSI) clinical guideline number 74 (CG74).

- There were a range of clinical pathways and protocols for the management and care of a range of surgical interventions which were based on best practice and NICE guidelines. We observed a range of surgical management pathways in the patient medical records which were easy to follow and were fully completed.
- Staff used a pain-scoring tool to assess patient's pain levels; staff recorded the assessment on paper records.
- The hospital participated in those national audits relevant to the services they provided. This included the patient reported outcomes measures (PROMS) for NHS funded patients and the National Joint Registry. The hospital had scored highly in the assessment for health gain using the Oxford hip score and was in the top fifty providers.
- Anaesthetists had a 24-hour post anaesthetic responsibility for the care of their patients and were available 24 hours a day for any deviation or concern with patient's health progress.
- Staff skills and competence were examined and staff were trained to ensure they were competent to provide the care and treatment needed. Staff were supported to obtain new skills and share best practice. Staff appraisal was ongoing.
- Consent to care and treatment was discussed and obtained in line with legislation and guidance.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients.
- Children and young people's needs were assessed and care and treatment was delivered in line with legislation, standards, and evidence-based guidance.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patient care was at the heart of the service and the priority for staff. We saw several areas of outstanding practice.
- The hospital had been accredited with a recognised customer service programme. This meant that staff had training to offer patients respect and courtesy.
- Patients had their privacy and dignity maintained at all times.

Summary of this inspection

- Patients were listened to and actively involved in their care and treatment. Staff were committed to working in partnership with the patients and making this a reality for each person.
- People's social and emotional needs were highly valued by staff and we were given examples of how these needs were met.
- The emotional needs of young people were embedded in the care provided. Parents were able to accompany their child to theatre and be present in recovery to give extra emotional support.
- Patients felt staff went the extra mile and the care they received exceeded their expectations.
- Theatre recovery nurses visited the young people on the ward prior to surgery so they would see a face they recognised and be less anxious after their surgery.
- There was an emphasis on the family as a whole and ensuring that parents were put at ease as much as the young people.
- Nursing staff could provide emotional support to patients receiving bad news and psychiatric support was available for patients receiving cosmetic, bariatric or breast cancer treatment.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned to meet patients' needs. The flow of patients through the hospital was well organised.
- An average of 95% patients were treated within 18 weeks of referral between the time frame September 2015 to October 2016.
- There were facilities for those patients who had a disability including sensory impairments.
- In the inpatient and theatre areas, we saw that the Aspen Healthcare Limited dementia strategy had been rolled out and there were five dementia champions in place.
- Patients felt well informed about the procedure and what to expect during their recovery. Patients received "going home packs". These packs contained information relating to the type of anaesthetic the patient would receive the surgical procedure, VTE information, booklets for cardiac patients and National Joint Registry (NJR) consent forms for patients who agreed to contribute to the hip and knee NJR.
- Services were tailored to meet the needs of individual patients and were delivered in a flexible way.
- Complaints were responded to in a timely manner and any learning was taken forward to develop future practice.

Summary of this inspection

- Staff actively invited feedback from patients and their relatives and were very open to learning and improvement.
- There was access into the building and a passenger lift to all floors ensuring patients could move around the building.
- The service provided mostly inpatient care for NHS funded patients who would attend on contract through the local commissioning groups (CCG's). The hospital worked closely with the local NHS providers and CCG's to ensure that services were planned to meet the needs of the local population.
- We saw that clinics were flexible to meet the needs of patients. There were a small number of satellite clinics which meant, for some patients, this minimised travel.
- New self-funded and insured patients could be seen in some cases within 24 hours.
- There was a discharge co-ordinator in place to ensure there were minimal delays and that services were in place at home.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- There were robust governance structures and reporting mechanism in place where performance and the quality of the service was reviewed and changes made. Actions were monitored through audit processes and reported to leadership and governance committees.
- We saw a service wide vision and strategy that was embedded by staff in both inpatient wards and in the
- Staff were very proud of their service and felt as though their managers and senior managers were very approachable and caring.
- There was a learning culture within the hospital. Staff were encouraged and supported to further their skills and knowledge.
- There was strong local leadership of the service from the hospital director supported by the matron and heads of departments. Senior staff provided visible leadership and support to staff on a daily basis. Staff had confidence in leadership at each level and felt they would be listened to.
- Staff were very proud of the job they did and without exception, the staff we spoke with enjoyed working at the hospital. We found morale to be universally positive.
- Staff demonstrated a strong belief in delivering high quality service in their individual role and as a team, felt supported by management and were committed to striving for the best patient experience.

Summary of this inspection

- Leaders ensured that employees involved in the performance of invasive procedures were given adequate time and support to be educated in good safety practice, to train together as teams and to understand the human factors that underpin the delivery of safer patient care.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice were introduced, shared throughout the hospital, and monitored for compliance.
- The leadership, governance, and culture were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the patients in their care, their staff, and the unit.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was a high level of staff satisfaction with staff saying they were proud of the departments as a place to work. They showed commitment to the patients, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital.
- The development of the new endoscopy suite was in progress at the time of our inspection. This was on target for opening. There were associated plans to become JAG accredited.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Surgery

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Are surgery services safe?

Good ●

We rated this service as good.

Incidents

- The hospital reported and investigated incidents using a computerised incident management system. We reviewed incident data supplied to us by the hospital for the time period October 2015 to September 2016.
- Reported incidents showed no incidents graded as death, or severe harm, 12 as moderate harm, 43 graded as low harm and 97 graded as no harm/ near miss.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. During the period, October 2015 to September 2016 there had been no never events had been declared within the hospital.
- There had been one never event, involving wrong site surgery, that had been reported in January 2017 prior to our inspection. We saw that this was being investigated and an action plan developed.
- There were a total of 283 non clinical incidents reported between October 2015 to October 2016. Thirty percent of these (85) were in the surgical areas and 64% in other areas. This was higher than the rate of other independent hospitals we hold data for and senior staff told us that this reflected an open reporting culture.
- Serious incidents are incidents that require further investigation and reporting. Two serious incidents (SI) were reported in the hospital during the reporting period October 2015 and September 2016 and related to unexpected deaths. There were no associated themes between the serious incidents reported. We saw that there had been 97 clinical incidents in the hospital reported from September 2015 to October 2016, of these 77 occurred in surgery and inpatients.
- During the same reporting period, surgery and inpatients reported 107 non-clinical incidents. The rate of clinical and non-clinical incidents in surgery and inpatients was higher than the average of other independent acute hospitals we hold information for during the same reporting period. During the inspection, we reviewed minutes of clinical governance meetings and we saw that themes of incidents reported were unrelated.
- Managers told us, and we saw from the minutes of meetings that incidents were discussed at the local Quality and Governance Committee and the Aspen Healthcare quality and governance Committee. We saw minutes of local meetings, which showed that incidents were discussed in detail in these forums.
- Staff were able to tell us about incidents and the actions that been taken to prevent them reoccurring. We spoke with three members of theatre staff who were able to share that they knew how to raise incidents and gave us examples of when they would do so. One member of the team told us that that they had completed an incident form the previous week due to the theatre list not including a patient on the ward. This had been rectified in a timely manner

- We saw an Aspen Healthcare patient safety newsletter that shared information from serious incidents and never events with learning points across the whole organisation.
- Staff and managers we spoke with were aware of their responsibilities to report, learn from incidents and were able to articulate the principles of being open and honest and when the duty of candour would be implemented.
- Aspen Healthcare were implementing a STEP-up to safety campaign across the organisation to raise staff awareness of human factors in patient safety incidents and to encourage staff to report incidents and near misses and to share learning. We spoke with three theatre staff and four ward staff who had completed this and told us that it was a simple and effective method of getting safety messages across to staff.
- The hospital provided information which showed that there had been three serious incidents in the reporting period of October 2015 to September 2016. The rate was not high compared to other independent hospitals about which we hold data.
- Incidents of moderate or above were investigated via a root because analysis (RCA) investigation and action plans developed to prevent the incident from occurring again. We reviewed reports and noted timely investigation and action plans documented. For example, a recent grade two pressure ulcer incident had identified gaps in training which was being addressed including employing a consultant tissue viability nurse on a consultancy basis to plan a training programme.
- Reported incidents were reviewed daily by the director of clinical services and discussed monthly at the hospital board, quality, safety and clinical governance committee and the quarterly at other hospital committees, for example, integrated clinical governance and the medical advisory committee (MAC).
- All staff we spoke with had a working knowledge of the reporting incidents system. This included clerical staff in addition to clinical staff.
- Staff told us that learning from incidents was shared internally through team meetings. Staff we spoke with knew of local incidents and what actions had been taken to prevent reoccurrence.
- Mortality and morbidity was discussed through the medical advisory committee.
- In addition to the daily review of incidents, there was a senior management monthly meeting which had a board style format and allowed a more thorough review of incidents and associated actions
- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They were aware of their responsibilities with regards to duty of candour.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw this was applied in practice on reviewing a root cause analysis.

Safety thermometer

- The hospital monitored performance against harm for example incidents of falls, pressure ulcers, venous thromboembolism and hospital acquired infection.
- Information about harm was displayed in public areas. In the reporting period October 2015 to September 2016, there had been no pressure ulcers, no falls with harm and no catheter acquired urinary tract infections (CAUTI's). There had subsequently been a grade two pressure ulcer reported in December 2016 which had been escalated appropriately with a root cause analysis and action plan completed.
- A venous thromboembolism (VTE) is a blood clot, which forms in a vein, often in a leg, which can lead to harm to patients. Venous thrombolysis assessments were carried out in the hospital and data we reviewed showed 100% compliance in the reporting period July 2015 to September 2015 and 98% October 2015 to June 2016. The proportion of patients risk assessed for venous thromboembolism was much better than expected when compared to other hospitals we hold this data for. There were no incidents of hospital acquired VTE or pulmonary embolism (PE) in the reporting period.

Cleanliness, infection control and hygiene

Surgery

- Wards and departments were visibly clean and we saw ward cleanliness scores displayed in public areas.
- There were dedicated cleaning staff that had been appropriately trained and were aware of nationally agreed colour coded equipment and standards.
- Infection prevention and control information was visible in all areas. This information included hand washing guidelines. We saw that these were in line with Aspen Healthcare policies.
- All patients had MRSA screening as part of their pre-operative assessment prior to admission. This meant that infection was not brought into the hospital.
- The hospital had an infection prevention and control subcommittee which met monthly and reported to the hospital governance committee. The hospital reported no cases of hospital acquired Methicillin resistant Staphylococcus aureus (MRSA) and no cases of hospital acquired Clostridium difficile (C.diff) in the reporting period October 2015 to September 2016.
- We observed hand gel available in each room of the ward, enhanced recovery area and the six bedded day area. Sinks were compliant with the NHS standard (HB09).
- Hand hygiene audit data we reviewed showed 100%compliance in the reporting period May to September 2016. During the inspection, we observed hand hygiene compliance data displayed on the wards and department we visited
- We observed staff washing their hands, using hand gel between patients and staff complied with 'arms bare below the elbows' policies. Protective clothing was available and seen to be worn in appropriate areas.
- We saw that staff had access to nationally recognised infection control policy, hand washing policy and uniform policy. These met agreed standards of the World Health Organisation (WHO) Guidelines on Hand Hygiene in Health Care 2010.
- Surgical site infection surveillance was carried out and reported .There was one surgical site infection reported between October 2015 and September 2016.
- The rate of surgical site infections in primary hip arthroplasty procedures was below that of other hospitals we hold similar data for.
- No infections were reported for revision hip arthroplasty, other orthopaedic procedures, breast surgery, and gynaecology, and upper gastro intestinal tract, colorectal urological cranial or vascular procedures.
- Testing of water on site for legionella bacteria was carried out to avoid cross infection to patients and the risk of developing legionnaires disease, a potentially life threatening pneumonia.
- Equipment cleaning labels provided assurance that re-usable patient equipment was clean and ready for use. We reviewed six pieces of clinical equipment and noted these to be clean and labelled.
- Environmental cleaning schedules were available and displayed in public areas. However, we observed in the anaesthetic rooms that some cleaning schedules had not been completed on a daily basis. We raised this at the time with the theatre manager who included it as an action within a theatre action plan before we left the inspection.
- We reviewed the patient led assessment of the care environment (PLACE) results for the hospital and found it was above the national average for cleanliness.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and environmental cleanliness. We observed staff adhering to these in practice.
- Deep cleaning of theatre took place yearly. We noted that this had last taken place in August 2016.
- There was a service level agreement with a third party company for the decontamination of equipment.
- In the endoscopy department, there was a dedicated area for storage and decontamination of the scopes and a member of staff was allocated to that area for each list
- We saw records staff used to record checks for the endoscopy decontamination washer daily. We saw that there were between one and three missing entries every week for the previous six weeks. Therefore, we could not be assured whether these checks had been completed. A senior staff member was informed at the time of inspection and stated that they would remind staff to complete these.

- We reviewed records of weekly rinse water tests and found them to be complete. A senior nurse was able to describe an incident when bacteria was found in the water. Appropriate action had been taken; the decontamination machine was taken out of use, the contingency plan was implemented to obtain scopes from the local NHS trust and patients were prioritised.

Environment and equipment

- We saw that there was appropriate resuscitation equipment available. This was checked daily and was in date. We saw one medication which was out of date on a resuscitation trolley; staff replaced this immediately.
- We found that there were recording systems for implants. These had been completed appropriately and were stored within the theatre area for ten years for traceability purposes.
- Traceability of scopes was recorded for every patient. The slip from the scope was inserted into the patient notes that stated the serial number, who removed it and when and decontamination information. A slip was also placed in the scope tracing book.
- We reviewed six pieces of electrical patient equipment which had been routinely checked for safety testing with stickers visible demonstrating when the equipment was next due for service. This included an electrocardiogram monitor and blood pressure and oxygen levels monitoring machine.
- We saw that weighing scales in the pre assessment area had been recently calibrated and a sticker placed to show when this was due for repeating.
- Staff we spoke with was aware of the process for reporting faulty equipment.
- Staff we spoke with said there adequate stocks of equipment and we saw evidence of stock rotation both in the ward and theatre areas
- We reviewed safety checks of anaesthetic machines; records we reviewed provided assurance that daily safety checks had been undertaken when the theatre was in use, however, this was not always recorded when the theatre was not in use.
- We spoke with a consultant anaesthetist who told us that he was always confident that the equipment provided was safe and up to date with maintenance
- A third party company provided sterile services and supplies. Surgical instruments were available for use.
- We saw that the theatre ventilation system had received annual checks to show safety compliance.
- We found that hoists to move patients were available and staff were aware how to use these safely. One member of staff told us that the hospital had recently acquired a new model and that the manufacturers had been invited to train staff how to use this appropriately.
- We found issues of concern in the theatre environment with issues of maintenance of the environment.
- In theatre one, there was rust on the wheels of three trolleys and on the legs of a stool. This was raised at the time of our inspection and was part of an action plan developed before we left the inspection.
- In anaesthetic room three we saw that there were cracks in the wall which exposed bare plaster around the doors. Floor covering was coming away and the work surface was coming away from the worktop which exposed the wood underneath.
- We saw that the environment in theatre three showed defects in the maintenance. This included cracks in the walls and on the floor under the scrub area.
- We saw that there was a refurbishment plan in place which had clear timescales. There had been partial refurbishment of the theatre corridor.
- Before we left the announced inspection we were given an overall improvement plan which included the issues raised about the environment.

Medicines

- Medicines were appropriately stored, with access restricted to authorised staff. Controlled drugs (CD) are medicines, which are stored in a designated cupboard, and their use recorded in a special register. We checked CD registers and found entries signed by two staff and stock levels counted and checked in the theatres and on the ward.
- We saw that an analgesic medication which was a recorded drug was also accounted for in a separate book in the ward area.

- We saw that robust management controls were in place to access the drug rooms. The keys to the CD drug cupboards were held by the nurse in charge and these were stored in a locked cupboard within a locked cabinet
- The hospital had a pharmacy on site and a pharmacist was available 9am to 5pm Monday to Friday and 9am to 12pm on Saturday. A pharmacist was available out of hours on an on call basis
- During out of hours when a pharmacist was not on site and access to the pharmacy was an emergency, the RMO and senior nurse had access via a dual key alarm system where both staff needed to be present to gain access. Access to the pharmacy CD cupboard could only be accessed by a pharmacist.
- The organisation had a provider that was used to deliver medication stock to the hospital. We spoke with the lead pharmacist who told us it was rare to have a problem in obtaining medicines and there were alternatives suppliers who they sometimes used.
- To improve the pharmacy service, there had been a campaign for consultants to inform pharmacy of their top five prescribed medicines to help with appropriate stock requests.
- We looked at the prescription and medicine administration records for patients on the ward. We saw appropriate arrangements were in place for recording the administration of medicines. We saw six records were clear and fully completed. The records showed patients getting their medicines when they needed them and as prescribed.
- Medicines on the inpatient area, requiring cool storage, were stored in line with hospital policy. We saw records of daily checks of the fridge temperatures. Fridges we reviewed had been kept at the appropriate temperature for optimum preservation. These were in a locked area.
- We saw that fridge checks in theatre may not have been completed every day as some dates were missed from the record book. There had been eight days in February 2017 up to our inspection when these had not been recorded. This was brought to the attention of senior staff who confirmed that the minimum and maximum temperature should be recorded daily.
- Emergency medicines were readily available and they were found to be safely stored and in date.
- We observed controlled drugs were checked in theatres by two practitioners. All drugs were correct. Staff told us that drugs were not always checked at the start of the list. We spoke with the theatre manager who confirmed that the policy was that they were checked on a daily basis although these should be checked prior to the morning list, whenever there is change of an anaesthetic practitioner and at the end of the day. We saw that this was included in a theatre action plan generated during our inspection.
- Daily records were kept of the temperature of the fluid warming cabinet in theatre. The guidelines set out for fluid warming by the National Institute for Health and Care Excellence (NICE) advised that fluid administered to all patients, whether during short or prolonged anaesthesia, should be warmed to 37°C. Records showed that on the 20/02/2017, the temperature ranged between 37°C and 43°C. The cabinet did not show guidelines as to acceptable temperatures and we highlighted this to the theatre manager at the time of our inspection.
- We saw there was system of antibiotic stewardship. The hospital followed the same policy as the local NHS trust. The lead consultant microbiologist at the NHS trust was also the lead microbiology advisor for the hospital.

Records

- We looked at ten medical and nursing paper records and observed a good standard of record keeping. Records were legible and contemporaneous. The surgical care pathways included pre-operative assessment such as previous medical history, social history, and anaesthetic assessment, input from physiotherapy, discharge planning, and allergies.
- The care records included multidisciplinary input where required, for example, entries made by physiotherapy. This meant there was evidence of sharing of information and treatment plans.
- Patient records were stored in a cupboard at the nurse's station that could be locked, or were stored in secure areas. The hospital told us that over the previous three months, no inpatients had been seen without medical records being available.

- Information governance was part of the mandatory training at the hospital. We saw that there was 100% compliance rate in staff completing the refresher course which meant that staff knew how to keep information was kept safe.
- The Aspen Healthcare Clinical Director was the Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information sharing with other agencies.
- There was an Aspen Healthcare policy for the destruction and archiving records. We saw that, at the Claremont Hospital, there was a service level agreement in place for this with a third party company.

Safeguarding

- The wards and departments had systems in place for the identification and management of adults and young people. There was access to current information about vulnerable people which was easily identifiable in the nurse's office in the inpatient ward.
- There was a corporate safeguarding and protecting vulnerable people policy and procedure, which included guidance on safeguarding adults.
- Four senior staff were trained to level three safeguarding children. This meant there was always a member of staff on duty who could be contacted if there was a concern about a young person. However, we spoke with two staff members who were not aware that more than one person was trained at that level.
- We saw that both resident medical officers and consultants with practising privileges had all completed the appropriate safeguarding training.
- Staff also had access to the national ASPEN Healthcare safeguarding lead for advice.
- All eligible staff who worked in surgery and theatre areas had received level one training and this was backed up by flow charts in staff areas.
- Information provided by the hospital prior to the inspection, showed a number of eligible staff who were not trained to level two in children's safeguarding. Information obtained before our inspection showed that 63% of registered nurses and 73% of health care assistants had received training in patient areas, and 72% of registered nurses and 56% of health care assistants and operating practitioners in theatre areas. Although staff we spoke with during the inspection informed us that they had received training, we were not fully assured us that all eligible staff had the knowledge to recognise issues of concern.
- The safeguarding lead received safeguarding supervision from the local safeguarding board and contributed to local Section 11 audits.
- Four registered nurses we spoke with, told us that they understood the PREVENT agenda and the reporting mechanism for female genital mutilation. These were included in the Aspen safeguarding training e-learning package.
- Four registered nurses we spoke with had an understanding of recent abuse issues highlighted in the sports world and were alert to the young people in their care who were admitted for sports injuries.
- All staff we spoke with could describe their roles in relation to the need to report and take action as required when safeguarding issues were identified.
- Staff were able to give a recent example when they had used the safeguarding pathway for a vulnerable adult and this had been resolved in conjunction with emergency services.

Mandatory training

- Mandatory training was delivered as both face to face training sessions or via the Aspen Healthcare e-learning programme.
- The corporate target for mandatory training completion was 90% compliance. The overall training compliance was 82%. However, training data we reviewed showed variable training compliance rates for the hospital with some subjects, for example, fire training showing 100% and moving and handling training for registered nurses and ODP and HCAs in theatres being 61%. However, not all newly appointed staff had received mandatory training, but they were booked on sessions.
- All new staff had received a corporate induction, which included some aspects of their mandatory training such as fire, health and safety issues.
- Resident medical officers (RMO) were not directly employed by the hospital. It was a requirement of the

hospital that all RMO's completed mandatory training on employment and attended yearly refresher training. We saw that the current RMO's had received up to date mandatory training.

- Consultants with practising privileges received mandatory training via their local NHS trusts. We reviewed six staff files which showed that these were up to date or had been provided by the hospital for those consultants who were not employed by the NHS.

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

- All patients attended or were contacted by telephone to undertake a nurse-led pre-operative assessment. This included observations, review of medication and discussion of admission and discharge arrangements.
- We were told that there was joint school delivered by the physiotherapy service. Joint school is a rehabilitation and education course delivered pre-operatively to prepare patients for hip and knee joint replacement surgery and is part of the replacement surgery pathway.
- We saw in the records we reviewed, that risks to patients, for example falls, malnutrition and pressure damage were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.
- Patients attending for day surgery, which included those who had undergone a general anaesthetic (GA), were given a hotline telephone number to ring if they had concerns after discharge.
- From July 2016, there had been a new process which included a consultant anaesthetist seeing those patients referred by the pre- operative nurses or general practitioner (GP) where further assessment was required to assess their suitability to be treated at the hospital. We were told that this process had worked well and reduced risk of post-operative complications.
- Patients who had a high body mass index (BMI) were considered for surgery if they did not have any additional complex needs. This was in line with current evidence based guidance.
- We saw that there was a four bedded area in the inpatient ward to nurse patients requiring a higher nurse- patient ratio. This was the enhanced recovery area and the minimum ratio was two patients to one nurse. Patients could be pre–booked for this level of care, for example bariatric patients, or those with a history of sleep apnoea.
- The hospital used a national early warning (NEWS) track and trigger system. It was based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support.
- In all the ten records we reviewed, we saw that risk assessments were completed and included: VTE, moving and handling, and pressure ulcer risk assessments. The records had evidence of the National Early Warning Score which is used to identify any clinical deterioration in a patient's condition completed.
- A root cause analysis (RCA) resulting from a mortality highlighted that staff required further training on its use. We saw that this had taken place and staff were using the tool appropriately with 94% compliance on audit. This meant that a high percentage of staff had completed training to recognise a deteriorating patient.
- We reviewed the notes of two patients who had required transfer out of the hospital and found that escalation and the completion of NEWS charts had been completed appropriately.
- The hospital had been ALERT accredited. This is a multi-professional approach to pre-empt critical illness and provide a structure to recognise the deteriorating patient.
- We spoke with five registered nurses who were able to articulate the clinical condition of a deteriorating patient.
- The hospital undertook the World health Organisation (WHO) safety checklist Safer Steps to Surgery. This checklist consisted of five steps; these were team briefing sign in before anaesthetic, time out before surgery starts, and sign out before any member of the staff leave theatre and debrief.

- We reviewed six post-operative patient records on the inpatient and enhanced recovery area and saw that, in all cases, the surgical checklist based on the WHO checklist were completed in the notes.
- However, we observed during the inspection that aspects of the checking were not always completed appropriately. We observed with consent two patient journeys in theatre. The 'team brief 'phase was held in the coffee room which was not a suitable venue. In the 'sign in' phase in both cases not all elements of the checklist were verbalised. In both cases staff did not focus fully on the 'Time Out' phase. We observed in both cases not all elements of the sign out phase were verbalised and some staff were cleaning up. This was raised at the time and included in a theatre action plan submitted before we left the inspection.
- We saw that there was an audit plan of the safe surgery checklist process. Two audits we reviewed showed above the 95% safe completion criteria as required to offer assurance of safety.
- The endoscopy team used a surgical safety checklist for endoscopy procedures which included a sign in and sign out phase. Staff told us it was a team approach and checks were signed by a registered nurse and consultant.
- Staff we spoke with was knowledgeable about sepsis pathways. These were found on the corporate website and we observed information in staff areas.
- We saw that there was an escalation policy for patients with sepsis who needed an immediate review. There was a formal protocol for immediate management and transfer to the local NHS trust if necessary.
- We saw posters in staff areas which informed them of early recognition, the 'Sepsis Six Pathway' poster.
- There was a clear hospital policy in place for the emergency management of cardiopulmonary resuscitation and there were regular scenarios to update staff's skills.
- We saw a risk assessment process in place for those patients having sedation for endoscopies. This included alerting the carer to the potential side effects of the drugs used in the procedure.
- A resident medical officer (RMO) was on duty 24 hours a day, on a one week rota, alternating with another RMO. The RMO responded to any concerns staff had regarding a patient's clinical condition. These roles were supplied via a service level agreement with a third party supplier.
- There was a formal arrangement in place for patients to be transferred to the local NHS trust hospital if the patient required level two or level three critical care. This was for critically ill patients who required either organ support or closer monitoring in the immediate post- operative period.

Nursing and support staffing

- The hospital used the Aspen Healthcare staff manager plus acuity tool which incorporated NICE staffing guidelines. This tool supported the provision of the correct numbers of staff and skill mix to meet patient acuity and needs. An annual review of inpatient nurse staffing levels was also completed using the Shelford staffing tool which looked at the wider aspects of staff turnover and sickness levels. This process had resulted in an increase in establishment.
- We saw that the electronic reporting system also had been adapted to have a flagging system for staff to report concerns about staffing levels.
- At the time of the inspection, the inpatient department had 18.4 WTE registered nursing posts and 10.9 WTE unregistered nursing posts. We reviewed vacancy rates for registered nurses and this equated to one WTE posts. No vacancies were noted for healthcare assistants.
- At the time of the inspection, the theatre department had 14.9 WTE registered nursing posts and 16.5 WTE unregistered nursing posts and operating department practitioners. We reviewed vacancy rates for theatre nurses and this showed a 2.3 WTE vacancy rate with active recruitment. No vacancies were noted in operating department practitioners (ODP) and HCA roles.
- Theatre staffing was reviewed by the theatre manager and was in line with safe staffing as per the Association for Perioperative Practice (AfPP) guidelines 2014.
- We saw that nurse staffing duty rotas were reviewed daily by the senior nurse to ensure that there was safe

staffing in line with the acuity of the ward. The inpatient and theatre services operated a staff shift pattern. However, during busy times staff worked together as a team and this could involve working beyond their shift.

- At the time of our inspection, there were two WTE, two 0.8 WTE registered nurses and four health care assistants who worked in the endoscopy department and had relevant training and experience. Saturday lists were staffed by the same group off staff who took time back or claimed overtime, as required.
- There was one WTE senior physiotherapist allocated to work in the inpatient area and one WTE junior physiotherapist who worked across the inpatient areas and outpatients
- We observed staff using electronically generated handover sheets for nursing handovers. These included information and advice to staff about completing fluid balance charts.
- The hospital had an aspirational registered nurse staffing ratio of one nurse to seven or eight patients with a flexible approach, depending upon the needs of the patients.
- Skill mix assessments were completed monthly by the matron and if a member of staff left employment. The skill mix in the inpatient department for nurses to health care assistants was 1.7 to one.
- We reviewed three weeks of duty rotas which confirmed a safe level of staffing as per Aspen Healthcare and national guidance.
- Between October 2015 and September 2016, there was minimal bank or agency staff used, in the inpatient area for both qualified and unregistered nursing staff. Overall use of bank and agency staff was lower than the average of other independent acute hospitals we hold this data for.
- We saw that the hospital utilised bank staff where possible. In the preceding three months, this equated to a ratio of 9.1 to one for qualified nursing staff and 9.8 to one for health care assistants.

Medical staffing

- Patient care was consultant led. There was the expectation that the patients' consultant reviewed their patients on a daily basis. This might be more frequently at the request of the resident medical officer (RMO) or senior nursing staff. The doctors and dentists practiced under rules and privileges for the provider. All consultants had to meet the criteria set out in Aspen Healthcare's practising privileges policy to be granted authorisation by the executive director at the hospital to undertake the care and treatment of patients in the unit. Consultants could also just have private practice as long as they meet the Aspen Healthcare practising privileges policy criteria.
- To be eligible for practising privileges with the hospital, the policy stated that consultants must hold a substantive or honorary contract with the local NHS trust. Any practitioner applying for practising privileges had to attend a meeting with the Executive Director and Medical Advisory Committee Chair to discuss their credentials. They must be licensed with and on the specialist register of the General Medical Council (GMC) and were required to demonstrate relevant clinical experience appropriate to practice in an independent clinic.
- We saw that 98% consultants with practising privileges were up to date with indemnity insurance. The remaining 2% were being contacted to ensure compliance.
- A resident medical officer (RMO) provided 24-hour medical cover for patients. The RMOs worked on a week rotation. They did not assist in theatre.
- It was a requirement that consultants were able to be contacted 24 hours a day if they had patients in the hospital and were able to return to the hospital within 30 minutes. The hospital carried out formal risk assessment if a consultant did live outside this travel time. If the consultant was unable to attend because of theatre duties in the local NHS trust, then they arranged alternative cover.
- We saw staff in the ward area and theatres had access to up to date contact numbers for those consultants with practising privileges
- There was a 24 hours a day, seven days per week, anaesthetic on call cover and an emergency service level agreement (SLA) transfer arrangement with the local NHS trust.

- The hospital followed the recommendations of the 'Association for Perioperative Practice' with regard to numbers of staff on duty during a standard operating list. This comprised of two nurses, an operating department practitioner (ODP), a healthcare assistant, a consultant and an anaesthetist.
- We spoke with one RMO who told us they had stayed for two years, as the hospital maintained high standards and that consultants were accessible if concerns arose.

Emergency awareness and training

- The hospital had a business continuity plan. This was available to staff on the Aspen intranet. Comprehensive business continuity plans were in place to make sure that the service was able to continue to provide services in the case of a major incident. These covered staffing shortages, electronic system failures and equipment breakdowns and major financial situations.
- We saw a major incident plan which had been recently updated; this outlined the process for managing unexpected major events and incorporated fire drills, which allowed staff to rehearse their response in the event of a fire. We saw clear fire instructions in areas and senior staff demonstrated the alarm on our inspection. Three ward staff we spoke with told us that there were regular fire drills within the hospital and could articulate the evacuation process.
- There were regular clinical emergency scenarios which took place at the local NHS trust. This included haemorrhage and CPR management.
- Monthly tests took place on the backup generator to prevent power failure of essential equipment.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Policies and procedures used within surgery and theatres followed evidence based practice. For example, the surgical site infection monitoring in orthopaedics was followed in accordance with guidance from the National Institute for Health and Care Excellence (NICE) for prevention and treatment of surgical site infection (SSI) clinical guideline number 74 (CG74).
- Interventions which included the pre-operative assessment and enhanced recovery complied with NICE guidance.
- Venous thromboembolism in orthopaedic surgery guidelines were in accordance with NICE clinical guideline number 92 (CG92).
- We saw from four medical advisory committee meeting minutes we reviewed, that NICE and other guidelines were discussed and plans made to incorporate them into practice.
- Staff had access to national Aspen Healthcare Limited and local guidelines via the intranet. We observed information folders on the ward that were readily available to staff and included safeguarding and end of life care.
- There were a range of clinical pathways and protocols for the management and care of a range of surgical interventions which were based on best practice and NICE guidelines. We observed a range of surgical management pathways in the patient medical records which were easy to follow and were fully completed.
- The endoscopy provision at the hospital was not Joint Advisory Group (JAG) accredited at the time of our inspection. However, improvement actions in order to achieve the standards for accreditation had been implemented and work on a new unit was due to be completed in May 2017. The JAG Accreditation Scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and Independent Sector.
- Care to patients undergoing cosmetic surgery adhered to the Royal College of Surgeons Professional Standards for Cosmetic Surgery. We saw evidence in patient records that patients had been given a 'cooling off' period from attending consultation to having surgery,

although this was not explicit in five records we reviewed, although the time scales between consultation and surgery reflected this. The risks of surgery were documented.

- At the pre assessment clinic, patients were offered counselling for the opportunity to discuss any anxiety or psychological issues.
- We observed registers that were kept which recorded details of any implants used should they be required by regulatory authorities.
- The hospital had a policy in place for escalating concerns about the deteriorating patient and staff could access the policy on the intranet. The hospital used a national early warning (NEWS) documentation of which use was audited.
- The hospital had processes in place to reduce the risk of surgical site infections in adherence to NICE Quality Standard 49 guidelines. We observed in patient records that patients had their temperature monitored before during and after surgery. We observed that skin preparation was performed prior to incision using an antiseptic preparation and appropriate laminar systems were in place in the theatres used for orthopaedic surgery.
- Patients receiving bariatric surgery had access to a dietitian in adherence to best practice. They also received care post operatively in the enhanced recovery area which provided two to one patient to registered nurse care.

Pain relief

- We saw the pre-admission health questionnaire detailed adverse reactions to analgesia. This reduced the risks of post-operative complications and allowed for alternative medication to be prescribed.
- Information about pain management was given to patients prior to surgery and following their operation. This enabled the patient to communicate effectively with staff and obtain the correct pain relieving medication following their surgery.
- Staff used a pain-scoring tool to assess patient's pain levels; staff recorded the assessment on paper records. We observed staff reviewing pain in the recovery area post-surgery. If a patient had pain, then staff administered pain relief and checked that this became effective prior to transfer to the ward.
- At the time of our inspection, we asked three patients if they thought their pain had been well managed and all three told us this had been well managed. All three patients told us they were regularly asked about pain and nurses responded quickly if they identified they were in pain.
- We saw that a pain management audit had been completed. This showed that patients were receiving pain relief according to their level of need.

Nutrition and hydration

- There were systems in place to ensure that patients were appropriately fasted prior to receiving a general anaesthetic. Information about pre-operative fasting was given at the pre-operative clinic contact.
- We saw evidence in the patient record that patients were asked when they last had something to eat and drink. The hospital kept the time for patients to be nil by mouth to a minimum with patients allowed to drink water up to two hours prior to surgery in accordance with national guidance.
- We spoke with two patients post operatively about the advice they had been given on fasting prior to their surgery. Both told us that this had been discussed at their pre assessment appointment and the information had been clear. We saw that this was recorded in patient's records in bold script for visibility.
- We saw that there had been fasting audits in the previous twelve months. In August 2016, there had been a score of 57% compliance against a range of standards which included if the time of the last intakes of food and fluid had been recorded. We saw that in a follow up audit in November 2016, this score had improved to 98% which was a significant improvement following further training and awareness.
- The hospital used the Malnutrition Universal Screening Tool (MUST) as part of the assessment process to assess patients that may be at risk of under nourishment.
- All hydration and nutrition needs had been assessed in all the patient records we reviewed.

- There were menus available for patient to select their meals from. Any nutritional needs or special diets were identified at the preoperative assessment and the kitchen staff was made aware when patients were admitted. We saw that care had been taken to prepare alternative diets for patients who were gluten free or had allergies.
- We saw that the provision of food rated highly on the patient led assessment of the care environment.
- The hospital had developed an action plan in March 2016 following concerns that fluid balance charts were not completed fully. We reviewed this plan and saw that health care assistants now undertook a ward based competency pack to ensure patient fluid intake and output was recorded correctly. We saw that an audit was planned to take place in May 2017 to assess how the competencies had changed practice.

Patient outcomes

- The hospital participated in those national audits relevant to the services they provided. This included the patient reported outcomes measures (PROMS) for NHS funded patients and the National Joint Registry .The hospital had scored highly in the assessment for health gain using the Oxford hip score and was in the top fifty providers.
- At the time of our inspection the primary knee replacement data could not be calculated for the period of April 2015 to March 2016, as there were fewer than 30 modelled records.
- We saw that Aspen Healthcare was a founder member of the private healthcare information network (PHIN). This is aimed to improve data within the independent sector and this was submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). The hospital had won a national award in 2016 for the quality of the data collected.
- The hospital reported surgical site infections to Public Health England. There was one infection reported between September 2015 to October 2016. This was an infection in a primary hip replacement. This figure was below surgical site infection data we hold for other independent hospitals. There had been one surgical site infection.
- In the reporting period September 2016 to October 2016, there were seven unplanned returns to theatre. These figures were lower than compared to a group of independent acute hospitals that we hold data for.
- In the reporting period September 2016 to October 2016, there were eleven cases of unplanned transfer of inpatients to another hospital in the reporting period. This equated to 0.4 patients per 100 inpatient attendances. This figure was not high compared to other independent hospitals that we hold data for.
- In the reporting period September 2015 to October 2016, there were nine unplanned readmissions to the hospital within a twenty eight day period. This equated to 0.2 per 100 day cases and inpatient attendances. This is not high when compared to other independent acute hospitals that we hold data for.
- One of the aims of the new pre-assessment process was to reduce risk and unplanned patient transfers and treatments. This was being audited at the time of our inspection.

Competent staff

- Records we reviewed confirmed that there was a corporate and local induction processes in place for new staff. Staff were assessed against competencies that were required for their roles. We reviewed three competency files and found competencies signed off and reviewed annually.
- There was an identified theatre training lead that supported staff with learning and development.
- Consultants had their pre-employment checks completed in order to be granted practising privileges. The Medical Advisory Committee (MAC) reviewed and authorised all practising privileges applications
- Consultants were required to provide evidence of satisfactory annual appraisal from their NHS practice as well as undergo Aspen practicing privileges processes.
- More than 75% of nurses and health care assistants and other staff working in inpatient departments had received an appraisal in the current appraisal year of January 2016 to December 2016. More than 75% of staff,

including nurses, operation department practitioners (ODPs) and health care assistants working in theatre departments had received an appraisal. The target was to reach 100% compliance by December 2017.

- Staff we spoke with told us they could discuss training needs during their appraisal and felt supported to learn and develop. There was no central programme available for clinical supervision at June 2016, however, staff supported each other and discussed and reflected on incidents during handovers, and team meeting.
- The nurses working in the pre-assessment clinic told us that they were supported to learn new skills for their role. This included an electro- cardiogram (ECG) course and they had worked with an advanced nurse practitioner in the local NHS trust.
- There was not always advanced life support staff on duty in the recovery area. However, this was mitigated by a consultant anaesthetist being available at all times when the patients was in recovery which complied with the Royal College of Anaesthetists (RCOA) guidance. All qualified members of staff across the theatre areas were trained in immediate life support and two trained in advanced life support. We saw that there were plans and timescales to train all recovery area staff to advanced life support.
- The hospital was recognised as being a suitable learning environment for student nurses from a local university. There were none on duty at the time of our inspection. Staff we spoke with told us they were a positive addition to the team.
- There were three externally qualified Surgical First Assistants (SFA) in post at the time of our inspection. There was one in training and plans to develop another ten over the coming year. The training package was developed in house and complied to the AFPP SFA competencies. These had been checked appropriately.
- We observed that there were Aspen Healthcare competency frameworks for registered nurses and health care assistants working in the endoscopy department. These had been locally adapted for use at the Claremont Hospital. These were completed annually and staff were up to date with these.
- The manager in the endoscopy department had set up rolling programme of training on all different types of equipment.
- Staff had been supported to develop, following allocation of specific role leads in their department. For example, there were training leads in theatre and the ward that were responsible for coordinating training to maintain a highly skilled team.
- Staff took part in regular scenarios regarding haemorrhage and cardio pulmonary resuscitation to keep up their skills in rare clinical events. These took place in a local NHS trust scenario facility.
- All staff we spoke with consistently told us that they were encouraged to undertake further training and post qualification study. Key managers had studied to master's level and had appreciated the broad perspectives this had given them.

Multidisciplinary working

- Care planning took place at pre-assessment with input from the multidisciplinary team, including doctors, nurses, and allied health professionals. The patient's general practitioner was sent information about their patients care and any ongoing arrangements.
- Housekeeping and catering staff were involved if any special needs in relation to diet were identified.
- We attended a multi-disciplinary team meeting which was held on the ward each morning and attended by the director of clinical services. The meeting included nurses, consultants, anaesthetists, ODPs and healthcare assistants. We observed staff treated as equals with a cohesive team approach.
- The hospital had good relationships with local NHS hospitals and the local authority and could make referral for additional services if required. There were service level agreements in place with NHS providers should patients require transfer to an acute hospital.

Seven day services

- Care was consultant led in the hospital and surgeons visited each inpatient on a daily basis for the duration of their admission and were available 24 hours a day for any deviation or concern with patient's health progress. Any annual leave was supported by cross cover arrangements

- Anaesthetists had a 24 hour post anaesthetic responsibility for the care of their patients and were available 24 hours a day for any deviation or concern with patient's health progress.
- Radiologists did not have an on call rota, but 24 hours a day radiographer cover was in place in the hospital.
- Physiotherapy was available seven days a week, with bank staff in place to provide the service at the weekend.
- The hospital had a pharmacy on site and a pharmacist was available 9am to 5pm Monday to Friday and 9am to 12pm on Saturday. During out of hours there was a pharmacist on call that could be contacted and there were systems and protocols in place to allow the RMO to dispense discharge medication should a patient require discharge at a weekend.
- There was availability of an emergency theatre team 24 hours a day should an emergency arise and a patient required a return to theatre.

Access to information

- Staff had access to paper and electronic patient records. Staff had access to the organisations intranet to obtain information. They could access local and corporate Aspen Healthcare policies and procedures, and e-learning. They could also access external reference sources such as NICE guidelines and professional guidance.
- All general practitioners were sent a discharge letter with relevant information about treatment given and plan of care.
- Information such as incident reporting and safeguarding pathways along with other key messages were displayed on notice boards in staff areas.
- Paper based patient records were available on the ward and were taken to the theatre with the patient. All of the eight records we reviewed at the time of our inspection included assessments, risk assessments, diagnostic test results and a record of surgical procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their responsibilities in relation to the mental capacity act (MCA) 2005 and deprivation of liberty safeguards (DoLS) and could describe the process should it be required. At the time of our inspection there were no patients on the ward that lacked capacity or required a DoLS.
- We reviewed eight sets of records for patients that had undergone surgery and found all had a completed signed and dated consent form in line with national and Aspen health care guidance
- If cosmetic surgery was carried out there were arrangements for two week cooling off period. We reviewed five records of patients who had undergone cosmetic surgery and all had completed surgery after the two week cooling off period. However this was not initially explicit in the records.
- The consent policy provided clear guidance on consent for children including information about Gillick competency.
- Staff were aware of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) guidance, but this was rarely used due to the admission criteria of the hospital.
- The pre-operative nurses confirmed that those patients who wished to undertake cosmetic surgery had the option at the time of their assessment to be referred for counselling, if required. We were told that this is not frequently requested, but can be offered at any stage.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- All NHS funded patients were invited to take part in the Friends and Family test. For the period April 2016 to September 2016, we saw consistently high scores where between 90% and 100% of patients would recommend the service to friends and family. We saw that the hospital response rate was variable with the highest rate being 45%; the hospital aimed to improve this.
- We observed staff in the inpatient and theatre areas speaking to patients in an attentive and caring way. Nursing staff made frequent checks on patients'

comfort, and were available to respond to patients when they made requests. We observed that staff were valued and cared about for by local and senior management. We were told by staff that they believed that this in turn enhanced patient care and promoted a highly caring environment.

- We saw that in the theatre environment, staff were kind and attentive to patients who had their surgery under local anaesthetic. We observed a health care assistant sitting with a patient throughout the procedure and offered continuous reassurance.
- We spoke with ten patients who all described their care as overwhelmingly positive. One post-operative patient described their care as 'excellent' and would recommend care at the hospital to anyone. They all stated that staff took time to get to know them 'like family', despite the busy turnover of the hospital.
- We spoke with a pre-operative patient who felt the care so far had been 'fantastic' and staff had explained everything so he felt less anxious. He said staff were so friendly and kind.
- We reviewed 44 comment cards which were all highly complementary of staff attitude and attention. One patient had stated that although they had come in for a knee operation, it wasn't like being in a hospital, but like being 'on holiday' as staff were 'so lovely'.
- We were told by staff that they all went that 'extra mile' and that they were proud of each other's practice. We were told that recently a patient had to be appropriately transferred to a local NHS trust due to unexpected deterioration. The staff nurse had accompanied the patient and stayed with her following the transfer, as the lady was anxious and had no one else with her. The staff nurse should have been off duty at that time.
- Patients we spoke with told us that staff always knocked on the door before entering the room and were very respectful in their approach. We heard patients being spoken to in a kindly and friendly manner with a genuine aim to please.
- We saw that there had been a privacy and dignity audit completed in May/June 2016 which demonstrated that out of the ten patients who were asked, all reported individualised care and had been asked about the preferred use of name, clothing and other individual requirements
- Staff were trained in a nationally recognised accreditation programme in customer care. Following this staff completed a Values Partners programme which is a workshop to explore values and behaviours between staff and towards patients and aims to create a positive working culture.
- We saw that the hospital took part in a recognised comprehensive observational study process to consider the approach by staff to the general care of patients, the level of patient/visitor engagement, and the environmental factors within patient reception areas. We saw an example of one survey in July 2016 and there had been an overall high score of 97%.
- The hospital was included in an indepth patient survey which benchmarked a variety of patient experience against other Aspen Healthcare sites. This included aspects of caring such as whether staff could have found someone on the hospital staff to talk to about worries and fears. The Claremont scored highly in all factors ranging from 93% to 98%.
- We saw that there had been the '15 steps challenge'. This was an opportunity for staff to 'put themselves in patient's shoes' and observe four aspects of care. This included speaking to patients on the ward about their experience of being cared for. This had been very positive. A registered nurse we spoke with told us it made her realise the importance of getting to know and understand a patient in a short space of time such as finding out hobbies and being able to discuss these. For example, she was able to talk to a gentleman about growing vegetables prior to theatre to distract him.

Understanding and involvement of patients and those close to them

- Patients reported that they had all been provided with clear information about their treatment and care by the consultant and nursing staff, with opportunity available to ask further questions for clarification.
- The hospital scored highly in an Aspen Healthcare patient satisfaction survey. Ninety seven percent of

patients reported that they had received answers to their questions in a way they could understand. Ninety six percent of patients reported that their care journey was based on their individual needs.

- Patients felt that they had been fully supported in making decisions regarding their treatment and that they had all that they needed to know for this. They also reported that they had felt involved with the planning of their own care.
- Discharge arrangement took place at the pre-operative assessment stage and included individual patient circumstances and needs. We saw that relatives were involved in the process and their coping mechanism was taking into account. We saw that a patient's wife had been offered support on discharge of her husband who had a hip replacement.
- There were chaperone arrangements for both in patient and day surgery patients. Staff that we spoke to were aware of the chaperone service and where to find the policy.
- Staff told us that they could be flexible about visiting times, particularly if a patient was vulnerable. We observed that a working relative could visit outside of visiting hours to fit around shift patterns.
- Self-funded patients we spoke with understood the cost of their care. The patient information pack contained details of care and accommodation costs. We saw that patients who were NHS funded received the same level of care and compassion as self-funded patients.

Emotional support

- All staff we spoke with had an understanding of the emotional impact care and treatment could have on patients. They were able to describe how they would provide emotional support. We heard that a patient with diabetes who had come in for surgery recently had needed particular support to manage their diabetes during the surgical period and this had made him anxious. Therefore he was nursed in the enhanced care unit where there was a higher nurse ratio and the nurse was visible throughout.
- People's emotional and social needs are highly valued by staff and were embedded in their care and treatment. We saw that staff spent time with anxious patients and ensured that their care was fully explained to them
- We saw care being delivered in an emotionally supportive manner. For example we saw that physiotherapy assistant took patients off the ward for coffee for psychological support.
- Clinical nurse specialist input was provided through a service level agreement with the local NHS trust.
- We were informed that there was an option to referral to counselling services should the need be identified. We were told by the pre assessment nurses that this was offered routinely for those patients undergoing cosmetic surgery.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The service provided mostly inpatient care for NHS funded patients who would attend on contract through the local commissioning groups (CCG's). The hospital worked closely with the local NHS providers and CCG's to ensure that services were planned to meet the needs of the local population.
- Staff we spoke with knew the local communities and factors which may affect attending the hospital, for example during significant religious festivals.
- The hospital provided elective surgery. This meant that admission was generally planned in advance.
- Patients we spoke with told us that the overall admission procedure, including promptness and efficiency was a positive experience.

Access and flow

- Patients could access surgery services in a timely manner. An average of 90% of NHS funded patients between September 2015 and October 2016 were treated within 18 weeks of referral, with a range of between 89% and 99%.
- New self-funded and insured patients could be seen in some cases within 24 hours.
- Admissions to the hospital were staggered according to each patient's position on the morning or afternoon theatre list. This meant that patients were not admitted to the ward for excessive periods of time before their surgeries.
- Endoscopy lists were managed by the bookings team and were dependent upon demand. All lists were single sex to maintain privacy and dignity for patients. Most of the patients were 'walk in, walk out' rather than day cases.
- We saw that all disciplines discussed and assessed patient flow in the daily morning multi-disciplinary meeting attended by the director of nursing. This included admissions and discharges.
- There were arrangements for unplanned re-admissions within twenty eight days of discharge. There were nine cases at the hospital in the reporting period between September 2015 and October 2016. This equated to 0.2 per 100 day cases and inpatient attendances. This was not high compared to other independent hospitals we hold data for.
- We saw there had been eleven unplanned transfers to the local NHS trust in the time period between September 2015 to October 2016. This was not high compared to other independent hospitals we hold data for. Nine of these had been prior to the development of the anaesthetic led pre admission clinic. This was being audited to assess changes in numbers of patient transfers.
- We observed that there was telephone follow up calls carried out within 48 hours of surgery. This was undertaken by the discharge co-ordinator with prior consent from the patient. This was monitored by the clinical director who sent reviews back to the co-ordinator on a quarterly basis. We saw that these were consistently positive. This was a hospital target for the commission for quality and innovation payments framework and aimed to share and improve patient experience.
- When patient's surgery was cancelled on the day it was planned, patients were rebooked within 28 days. There had been 116 cancellations for the period September 2015 to October 2016. These were cancellations due to clinical reasons which were predominately due to the patient being unfit or unwell on the day. All of 116 patients were offered another appointment within 28 days.
- Discharge arrangements included communication with the patients' general practitioner (GP) and other community based staff involved in their care.

Meeting people's individual needs

- We saw staff explaining to patients and their relatives the care and treatment that was being provided. Patients told us they were given sufficient information before their procedure to prepare them for their surgery.
- An Aspen Healthcare patient survey showed that the hospital scored highly for responsive aspects of care reaching over 90% for explanations given about their treatment and individual needs addressed.
- The hospital had been accredited with recognised business status. This meant that staff had training to offer patients respect and courtesy
- We observed catering staff delivering individualised meals. We saw that a post-operative patient who felt nauseous had requested a certain brand of soup and staff went outside of the hospital to obtain this.
- If patients were in for extended periods, then they could have any meal they wanted to request.
- Staff consistently told us that all patients were treated the same and care did not depend on the patient's fee paying status. Two patients we spoke with told us they were treated the same as those patients who were self-funded.
- We saw that there was an interpreting policy and that translators could be arranged, if required. However, there was not always the relevant information on the

referral documentation to alert staff at the pre assessment clinic as to whether an interpreter would be needed. Staff knew that family members should not be used for interpreting.

- Staff knew how to access information leaflets in other languages.
- There was now a discharge co-ordinator in place to ensure there were minimal delays and that services were in place at home.
- We saw that the quality improvement team in September 2016 had discussed the development of a procedure for identifying vulnerable patients before they come to hospital. The clinical administration team was looking at NHS guidance with a view to add this to training.
- We were told that the pre-assessment process would identify those patients who had a learning difficulty. This was included in the pre-admission documentation.
- Patients were informed of the Aspen Healthcare chaperone process if needed. There were information leaflets to support this.
- Staff we spoke with were aware of the need to provide services for those patients who had sensory impairment. There were hearing loops within the hospitals.
- We saw that there were desk areas at the reception which were low and could be accessed easily by wheelchair users.
- We saw toilets in the reception area which were easy to access for patients and their relatives who had a disability.
- Patients had call bells in their rooms. We saw call bells being answered promptly by staff. Two patients we spoke with confirmed that they never had to wait when they rang their bell.
- Staff we spoke with in the ward and theatre areas were aware of the Aspen Healthcare dementia strategy and were taking this forward. At the time of our inspection there had been a dementia champion appointed and 67 staff members had been appointed as dementia friends across the hospital. This had previously been noted by the patient led assessment (PLACE) as an area for action.
- There was suitable equipment and care available for bariatric patients such as trolleys and beds.
- Staff were able to offer advice about individual concerns. A registered nurse informed us that she had recently given patient information and contacts about domestic abuse.

Learning from complaints and concerns

- There were 27 self-reported complaints in the reporting period between October 2015 and September 2016. There were no complaints referred to the Ombudsman or Independent Healthcare Sector Adjudication Service (ISCAS) in that period. The rate of self-reported complaints is similar to the rate of other independent acute hospitals we hold data for.
- The responsibility for overseeing the management of complaints lay with the Hospital Director, the Registered Manager for the location. Other staff that supported the complaints process included the Director of Nursing and the Clinical Administrator.
- The hospital followed the Aspen Healthcare policy on dealing with complaints which was a three step process of escalation within Aspen Healthcare. None of the complaints in the reporting period reached stage two of escalation which meant that these were dealt successfully at hospital level
- The complainant was involved in reviewing the action plan following a complaint. This meant that the complainant felt involved in the process.
- Complaints were discussed at weekly senior team management meetings and, if of a complex nature, they were escalated up to Aspen Healthcare Clinical Director for discussion and oversight.
- Complaints were discussed in other forums as a standing agenda item to ensure learning. These included Quality Governance meetings and Medical Advisory Committee (MAC) meetings. An annual report of complaints was compiled to consider any overarching themes and any resulting changes to practice.
- The hospital had systems in place to learn and share information in relation to complaints and actively tried to identify complaints at service level with daily contact to patients from the hospitality manager.

- We saw leaflets and information in the reception area and ward about how to complain.

Are surgery services well-led?

Outstanding ☆

We rated well-led as outstanding.

Leadership / culture of service related to this core service

- The hospital was well led by a hospital director and director of nursing. There was a theatre manager and ward manager in place who reported to the director of nursing.
- We observed very strong, supportive and cohesive local and senior leadership. Staff we asked at the time of our inspection told us that managers, director of nursing and the hospital director were visible and approachable.
- Senior management were reported to have "an open door policy" for all staff and were proactive in visiting wards and departments at least daily. This was part of the Aspen Healthcare Leadership Walkabout Policy. We were told by staff that they found this helpful and saw it as an opportunity for dialogue.
- Aspen Healthcare had a whistleblowing policy in place, which staff were aware of when asked. This was supported by leaflets which we were shown on the intranet.
- Three theatre staff and four ward staff we spoke with knew of the 'Speaking out Campaign' and were clear that they would feel comfortable to raise concerns. Staff were confident that they would be considered and action taken if required. We heard of an example of staff being communicated with in a negative way and this had been dealt with immediately.
- Staff consistently told us that they felt valued and cared for as members of staff. This was reflected in the low turnover and sickness rates of staff.
- We spoke with one of the two resident medical officers. Both had been at the hospital long term and told us that this was because the culture of the hospital was positive and they felt valued. They gave an example where they had challenged a senior colleague's perspective about a case, and had been supported in their decision making.
- Managers and staff told us there were good working partnerships with consultants which fostered a seamless service for patients.
- Four consultants we spoke with confirmed that they felt senior managers very approachable and reported excellent working relationships with all staff they were in contact with.
- We observed in both the ward and theatre areas, despite the turnover of patients, there was a calm and well organised environment with staff speaking respectfully to each other.
- We spoke with two patients who commented on leadership of the ward area. One patient told us that the senior staff were to be congratulated on the smooth running of the ward.
- Issues we raised at inspection were addressed promptly and respectfully. This included the issues raised in the theatre area being developed into an action plan before we left the inspection.

Vision and strategy for this core service

- Leaders demonstrated that they had a clear vision for the service to drive improvements in patient care through robust and effective processes, and were committed to taking this forward. The Aspen Healthcare vision and strategy was integral to the Claremont Hospital processes and working practice for their service which was focussed on providing the highest level of patient care. The vision was 'Our aim is to provide first-class independent healthcare for the local community in a safe, comfortable and welcoming environment; one in which we would be happy to treat our own families.'
- We saw that the Aspen Healthcare mission statement was visible in patient and staff areas.
- Staff we spoke with had a clear knowledge of the vision of the service. They could tell us how this had been put

into practice on a daily basis. We were told by one registered nurse that she was comfortable with the inspection as she aimed to go 'beyond compliance' every day.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The hospital held a range of meetings. These included resuscitation, infection control and prevention, information governance, health and safety, medical devices, blood transfusion and medicine management. These informed the hospital quarterly governance committee where governance issues were addressed and the Medical Advisory Committee (MAC). The Aspen Healthcare governance committee had oversight of the hospital governance committee and the MAC. The Chair of the MAC was proactive and engaged with the service and had a good working relationship with the senior management team.
- We saw a plan of all relevant governance meetings with identified dates for the coming year. The MAC was well established and reviewed its own process on an annual basis and this included constitution and terms of reference.
- We saw annual work plans for all the governance and senior management teams. These were clear and had a focus on patient safety. The Aspen Healthcare Governance vision was that of a 'framework which goes beyond compliance'
- We reviewed the last four sets of minutes from the MAC meetings and found practice privileges compliance and quality assurance as standard agenda items. The MAC included key personnel from the local NHS trust, for example, the lead consultant microbiologist.
- Practising privileges were routinely discussed as part of the MAC. We reviewed ten consultant files which were all completed and up to date. Examples of where consultants had not adhered to requirements or fallen below the expected standards of behaviour were provided and we found that practicing privileges were removed.
- The local and corporate risk register were standard agenda items on the senior team meeting agenda, and risks were discussed at the clinical governance meeting and head of department meetings. We saw that the risks identified at the inspection matched those on the risk register and were subject to mitigation and action by departmental leads, for example the theatre environment.
- We also reviewed risk registers completed in theatre areas. We could see clear progression and monitoring of risks, with detailed updates and actions taken to mitigate risks where possible.This included clear reasons to downgrade and close risks on the register.
- There were clear service level agreements in place with local NHS acute hospitals which included the transfer of patients should they require acute care. We were given examples where this had been necessary.

Public and staff engagement (local and service level if this is the main core service)

- We saw that the senior and local leadership engaged all staff in the development of services and that staff morale was excellent.
- We saw that the hospital had developed a staff forum. A survey had been undertaken in January 2017 to monitor the effectiveness of this forum. This showed there was excellent engagement with all respondents indicating they felt listened to, felt the staff forum was effective and had created a greater understanding of the business and how they could all work together. Staff we spoke with confirmed this. We were told by staff that they were asked beforehand if there were any issues that the link staff could bring up on their behalf. Three staff from theatres and four from the ward areas told us that this worked well and that they felt there were people on the staff forum that could make a change. The hospital director attended each meeting.
- We saw that on a noticeboard in the management corridor, staff had the opportunity to place a suggestion which they thought would make an improvement to the service. We saw that between the time of our announced and unannounced inspection those suggestions recently placed had been moved to the completed area. This included the provision of clear signage on theatre doors.
- Staff had been consulted on the construction of the new endoscopy suite and told us that they felt their opinions had been valued.

Surgery

- There was a planned series of educational lunchtime sessions with local general practitioners. This included such topics as ophthalmology and orthopaedic developments.
- The management team were fully aware of the requirements relating to workforce race and equality standard. There was a corporate WRES strategy and action plan in place. The management team had identified further work was required and plans were in place to address this.
- We saw that the hospital adopted a local charity to support each year and actively fundraised.
- We observed staff were acknowledged and valued for their work in the hospital. There were several initiatives to note this which included having an ice cream van on hot days, lunch and coffee vouchers.
- There had been initiatives following feedback from staff. This included a newsletter 'Drs Orders', staff briefings and the establishment of the quality improvement team (QIT)
- A 'park and ride' system was established to assist staff and to mitigate limited parking spaces at the hospital.
- Staff had access to the local NHS trust occupational health department, if required.
- The hospital took note and made improvements from public feedback including social network sites.
- The Friends and Family Test was to be made available online within the near future with the aim of broadening the response rate.
- We were told that if patients experienced a minor problem with a service they were sent flowers.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- We saw refurbishment plans for the theatre area with clear timescales.
- The senior management team had introduced monthly departmental performance reviews (DPRs) with managers
- The development of the new endoscopy suite was in progress at the time of our inspection. This was on target for opening. There were associated plans to become JAG accredited.
- The hospital was a learning environment, supported by local senior leadership and the Aspen Healthcare organisation. For example, we saw that the Aspen Healthcare resuscitation lead was supporting the theatre manager in the development of staff being trained in the advanced life support programme.
- There had been a successful pilot of the anaesthetic led pre- assessment process with the aim to minimise risks, cancellations and improve patient experience. This was being monitored by auditing the number of cancellations and unplanned transfers.
- Following feedback from patients, there had been the appointment of a discharge co-ordinator to minimise delays in the discharge of patients, and to ensure that all services which may be required in the home environment were in place. A discharge lounge for patients had also been developed.
- The hospital was working with the local NHS trust on a recognised model for an outcome based pathway for all orthopaedic patients. They were collaborating with the trust on launching a new patient app to track outcomes.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good

Incidents

- The hospital had an incident reporting policy in place. This included guidance on how to report incidents and how to investigate concerns. Staff we spoke with understood how to report incidents.
- Staff were confident about reporting issues and raising concerns with senior staff.Staff described a clear process for reporting incidents. Staff completed an incident form and reported to the senior nurse on duty.The hospital director's personal assistant or a delegated administrator transferred the information from the form to the hospital incident management database.
- The service reported no never events between September 2016 and the time of our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between October 2015 and September 2016, there were 11 clinical incidents and 16 non clinical incidents in outpatients. All had been thoroughly investigated and lessons learned and shared across all teams in the hospital.No specific themes were identified.
- Managers within outpatients told us they provided staff with verbal feedback from incidents at team meetings. Staff confirmed the manager fed back the learning from incidents and discussed how they could do things differently to improve.
- Staff told us that they were encouraged to report incidents and that the senior team managed them well. Staff told us that any lessons from incidents were shared with staff at Claremont. Managers reviewed incidents and we saw some evidence of this in practice, team meetings and clinical governance minutes and action plans from serious incidents.
- There had been one radiological incident reported by the hospital under Ionising Radiation Medical Exposure Regulations (IR(ME)R) 2000 in the previous year.This incident had been thoroughly investigated. Providers must report to the Care Quality Commission (CQC) any unnecessary exposure of radiation to patients.
- Incidents were discussed as part of the clinical meetings. Staff took the opportunity to learn, work as a wider team and liaised with the specialty medical teams.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood the principles of duty of candour and the importance of being open and honest with patients when mistakes were made.

Cleanliness, infection control and hygiene

Good

Outpatients and diagnostic imaging

- There was good infection control information displayed in patient areas and we observed visitors using alcohol hand gels.
- Staff adhered to uniform policy and followed arms bare below the elbow guidelines.
- The outpatients department consisted of thirteen consulting rooms, a clean utility, dirty utility and a nursing work area. These areas were visibly clean and clutter-free.
- Policies and procedures for the prevention and control of infection were in place. Staff understood them and could describe their role in managing and preventing the spread of infection.
- Personal protective equipment (PPE) such as gloves and aprons was used correctly and available for use in the departments.Once used it was disposed of safely and correctly.We saw PPE being worn when staff were treating patients and during cleaning or decontamination of equipment or areas. All areas had stocks of hand gel and paper towels.
- We saw all consulting rooms had handwashing facilities.
- The provider participated in the Patient Led Assessments for the Care Environment (PLACE) scores for cleanliness showed 99% between the periods of February 2016 to June 2016. Overall, the hospital scored the better than the England average for cleanliness (98%).
- Staff mandatory training compliance regarding infection control showed 100% compliance for all clinical staff on the mandatory training matrix dated October 2016.

Environment and equipment

- The environment in outpatient areas was uncluttered, and well maintained.
- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments.
- Staff stated they had sufficient equipment to meet the needs of patients.
- We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained.
- We found that electrical safety testing and calibration stickers were in place on fridges and scales and labels were clearly evident and in date. We saw completed records to confirm that appropriate checks had taken place, with no gaps in the records.
- There was a good provision of equipment across outpatient, physiotherapy and radiology departments. Staff did not report any issues with the environment and told us that equipment and stock items were available to provide safe patient care.
- There was a single emergency trolley within outpatients that was centrally located and easy to access by all departments on the ground floor. We checked the contents of the trollies and found the contents were correct and all drugs and sterile equipment were within their expiry date.
- We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained.
- Results from PLACE audit in June 2016 and local environmental audits were good. In the PLACE audit the condition appearance and maintenance scored 94% against the England average of 93%.
- There was an appropriate secure storage area for waste and clinical specimens and we saw that this was well organised and free of clutter.
- Imaging equipment was found to satisfactory. Staff told us the equipment was old but was capable of carrying out safe and efficient diagnostic imaging. Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment.X-ray equipment maintenance contracts were checked and records showed all schedules were up to date.Staff told us requests for service and repairs were met effectively by all contractors.
- Restricted access areas were locked appropriately and signage clearly indicated if a room or scanner was in use. The department had radiological protection/hazard signage displayed.
- The hospital had policies and procedures in place in relation to principle radiation and protection

regulations. These included principle radiation legislation, radiation protection advisor report, local rules and description of the duties to be undertaken by staff in accordance with legislation.

- Staff felt they were provided with appropriate protective equipment to undertake their role safely.
- The last RPA report was completed in November 2016 and concluded that "There is a good level of compliance with radiation protection legislation at Claremont Hospital. The highest risk is the lack of local rules training and records in the theatre area."These risks had been addressed and resolved by the time of our inspection.

Medicines

- Medicines including local anaesthetic and contrast media were supplied and audited by the pharmacist. We looked at audits from the last twelve months which showed evidence of high levels of compliance.
- Medicines in the departments were stored and monitored appropriately. Medicines were kept in locked cabinets and we saw evidence that daily temperature checks of medication fridges and the ambient room temperature were recorded. These were all in appropriate temperature ranges.
- A prescription pad was located within the ward area and was kept in a locked drawer. Nurses were able to sign to collect the pad and return it for those consultants wishing to prescribe medication.
- No controlled drugs were stored within the outpatient departments.

Records

- We reviewed six sets of medical records across the outpatient department. We found these were of a good standard. They contained sufficient up to date information about patients including referral letters, medical and nursing notes including patient care pathways, operation and anaesthetic records and discharge documentation.
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely.We saw that records were appropriately stored within the departments we visited. The outpatient and physiotherapy departments used paper records. These were stored in the management office in lockable cabinets. For outpatients, consultants attended the office to collect records for their clinic and returned them when clinic was completed.
- Staff told us all patients attending an outpatient appointment would have either an accompanying GP referral letter, or their current records from a previous appointment or admission to the hospital available. There were no patients seen without full medical records being available.
- Staff we spoke with in outpatients, radiology and physiotherapy could not recall an instance were medical records had not been available for a clinic, or where a patient could not be seen because their records were not available.
- Staff told us that if any patient information or paperwork were missing, then depending on the nature of the missing details, this would be obtained from either the patient or consultant in advance of an appointment.
- The hospital had a policy that consultants should not take patient medical records out of the hospital.Staff told us that all consultants adhered to the policy.
- Diagnostic imaging referrals and requests were made on paper forms or via fax from GPs.Information was transferred onto an electronic patient administration system and reports were produced electronically.

Safeguarding

- Staff were aware of how to raise safeguarding concerns for both adults and children; however no-one had needed to raise any.We saw safeguarding flowcharts on the wall to identify the process to follow and staff knew who the safeguarding leads were in the hospital.
- Staff on the unit completed safeguarding training for adults and children. The safeguarding children and young people level two compliance was 55%. The figure reflects the small number of staff within the outpatient's team. Training was due to be completed at 100% by March 2017.
- There were no safeguarding concerns related to the outpatients department from October 2015 to the time of our inspection.

Good

Outpatients and diagnostic imaging

- All staff we spoke with were fully aware of safeguarding policies and procedures and felt confident when raising concerns. Staff told us they were able to seek advice from their manager when needed.
- Patients who did not attend appointments were contacted via telephone and referrers were informed.
- Staff we spoke with had an awareness of the hospital corporate whistleblowing policy. Staff said that they would feel comfortable in raising issues under the policy.
- The Aspen Healthcare Limited training target was 90% compliance for level one vulnerable adults training and 90% for level one safeguarding children. We saw the hospital had met this target.

Mandatory training

- Mandatory training was available via on-line courses as well as face-to-face training.
- The management office in the outpatient department had notices displayed for staff about training. This included reminders to check the status of mandatory training every month and a monthly learning log sheet which staff were to complete.
- Staff told us they were provided with adequate time to complete all aspects of their training.
- At the time of our inspection of staff had completed all the required mandatory training. This included health and safety, infection control, manual handling, prevent, customer service, information security and equality and diversity.
- Medical staff completed mandatory training at their main employing NHS trust. There were assurance systems in place to make sure that medical staff were up to date with mandatory training.

Nursing staffing

- We looked at the staffing levels within the outpatient department. Staffing levels were planned in accordance with the number of clinics operating on each day and the nature of the clinics. For example, we saw during our inspection that an additional nurse was present to assist with patient pre-assessments.
- The outpatient department had a team of eight whole time equivalent (WTE) registered nurse, 3.6 WTE healthcare assistants, receptionists and administration staff. The staff provided clinic cover Monday to Friday, generally between 8.30am to 6.00pm. This varied to accommodate specific patient requests and consultant working arrangements.
- The physiotherapy team had a team of one manager, 2 WTE outpatients senior physiotherapists, 1 WTE senior physiotherapist, 1 WTE junior physiotherapist.
- Staff in the outpatients department told us that workload varied depending upon the number of clinics and the number of patients attending.
- A lead nurse managed outpatients. Staff told us that the lead nurse was very supportive and always available for advice.
- The service used no agency nurses and had bank staff to cover specialist clinics if required.
- There were no vacancies within the nursing and health care assistant staff in the outpatient department at the time of inspection.
- There was no sickness for outpatient staff between the period of October 2015 to September 2016.
- Vacancy rates were extremely low. Retention of staff was also good.

Medical staffing

- All patients were referred under the care of a named consultant. There were 105 consultants with practising privileges at the hospital.All were employed by surrounding NHS trusts and had practicing privileges to run clinics, carry out treatment and procedures and operate at this hospital. The hospital director held information for every consultant.The Medical Advisory Committee had oversight of arrangements for consultants.
- There was a resident medical officer (RMO) onsite 24 hours a day, 7 days a week on weekly rotation with a Monday handover. The hospital employed two RMOs through
- The RMOs had experience of working with patients across all specialties and their induction at Claremont was good and covered mandatory training and orientation.

Emergency awareness and training

Good

Outpatients and diagnostic imaging

- The hospital had an overarching business continuity policy put in place by the wider Aspen Healthcare Limited group.
- Staff we spoke with were aware of the major incident policy and could describe how they would access this in an emergency.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Inspected but not rated

Evidence-based care and treatment

- Care and treatment within the outpatient department was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- We saw examples of policies referring to professional guidance. For example, the chaperone policy referred to professional guidance from the Royal College of Nursing.
- Local and National Aspen Healthcare Limited policies were adhered to in accordance with Radiology Protection Association (RPA) IR(ME)R guidance and requirements.
- We noted a structured audit calendar for planned audits.We saw evidence of regular audit activity and action plans where improvements were required.

Pain relief

- There was a process in place to enable patients attending the outpatient department to access pain medication.
- We reviewed medication stored within the outpatient department and saw that patients were provided with analgesia should they require it.
- Patients we spoke with during the inspection had not needed pain relief during their attendance at the outpatient department.

Nutrition and hydration

- There were water fountains in each department and the outpatient department had a hot drinks machine for patients to use, as required.

Patient outcomes

- Between October 2015 to September 2016 the hospital outpatient department saw 59,690 patients. Of these, 18,628 were new appointments and 41,062 were follow-up appointments.
- The hospital compared survey results and activity with other locations within the region and other regions across locations in the Aspen Healthcare Group.
- The Hospital reported participation in positive patient feedback and monitoring of variances in care pathways as part of overall monitoring of patient outcomes.
- A senior manager told us that the numbers of cancelled appointments were low. We reviewed data submitted by the provider, which showed that no appointments were cancelled on the day of consultation during the period of October 2015 to September 2016.

Competent staff

- Managers told us formal arrangements were in place for induction of new staff and all staff, including bank and agency staff, completed full local induction and training before commencing their role. Staff we spoke with confirmed this.
- Staff told us they were encouraged to undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role.
- Staff received a formal annual appraisal and mid-term appraisal every six months. We reviewed an appraisal compliance audit that confirmed 100% of staff had undergone an annual appraisal.
- We spoke with two nursing and three allied health professional staff and they told us that they were supported to develop professionally and had opportunity to attend courses and training.
- We saw a robust induction programme for all staff which included on-going support from an experienced mentor.

- Staff at all levels felt well supported in relation to participating in training opportunities, both internal and external. They stated that there was always opportunity for professional growth and that they were encouraged to further their careers.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and told us they all worked well together as a team.
- Staff were observed working in partnership with a range of staff from other teams and disciplines including radiographers, physiotherapists, nurses, booking staff, and consultant surgeons.Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.Staff members were observed to be respectful towards the time pressures and skill mix of others.
- There were clear agreed protocols for staff to follow and where patient care deviated outside of these, nursing, radiology, laboratory and physiotherapy staff told us they were able to easily access consultants and specialist staff. For example, the hospital leads for safeguarding to discuss required interventions.
- We observed effective team working and good communication between consultants, outpatients and x-ray staff including staff from the externally managed MRI service.
- Staff worked together towards common goals, asked questions, and supported each other to provide the best care and experience for the patient. For example, outpatient's staff met regularly with the physiotherapy team.
- Staff had links with other departments and organisations involved in patient journeys such as GPs, and therapies.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.Paper copies of local policies were also kept in folders in the nurses' office.
- Patient records were in paper format. Staff told us that records were brought to clinic in advance of the patient appointments. Missing records were not common, but we saw procedures if patient records were not available at the time of appointment. Staff had access to previous clinic letters electronically.
- The hospital shared relevant information with the patients GP and accessed specialist advice from local trust professionals regarding conditions such as dementia and learning disabilities.
- Staff were able to access patient information such as x-rays electronically and paper medical records and separate physiotherapy records appropriately.
- All diagnostic imaging staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as x-rays and medical records appropriately, through electronic and paper records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient records in outpatients contained care pathways specific to each medical specialty and all had a section to complete by staff regarding consent for surgical procedures.All records we looked at had been completed appropriately and showed patients had been provided with information to make an informed choice.
- All staff we spoke with had a good understanding of issues in relation to capacity and the impact on patient consent. We saw staff received mandatory training and were able to explain how they gained consent for care and treatment.
- The consent policy provided clear guidance on consent for children including information about Gillick competency.
- Senior staff in the department demonstrated understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Aspen Health Care had corporate policies to guide practice in the MCA 2005 and DoLS
- All staff had received training on MCA and DoLS as part of online level one safeguarding mandatory training.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- There was a strong visible person-centred culture across the hospital which was replicated within the outpatient and diagnostic departments. Staff were highly motivated to offer care that was kind and compassionate. This was valued by staff and senior management.
- All patients we spoke with told us staff had treated them well and respected their privacy and dignity when delivering care.We observed staff communicating with patients and their families in a respectful and considerate manner and there were no negative comments from patients or their relatives about the compassionate and caring aspects of the service.
- Physiotherapy teams had introduced a phone call to patients following shoulder surgery; patients do not have a follow up appointment until a couple of weeks after their surgery so a physiotherapistcalled a patienttwo days after discharge from the ward to reassure patients and answer any questions they may have.
- All NHS funded patients were invited to take part in the Friends and Family test. We saw that the hospital response rate was variable and the hospital aimed to improve this. We saw high scores of between 90% and 100% between April 2016 and September 2016.
- Staff were trained in a nationally recognised customer care programme. Following this staff completed a Values Partners programme which is a workshop to explore values and behaviours between staff and towards patients and aims to create a positive working culture.
- The hospital was included an in depth patient survey which benchmarked a variety of patient experience against other Aspen Healthcare sites. This included aspects of caring such as whether staff could have found someone on the hospital staff to talk to about worries and fears. The Claremont scored highly in all factors ranging from 93% to 98%.
- We observed staff interacting with patients and their colleagues across all departments in a professional and compassionate manner in clinic, physiotherapy department, x-ray and in the waiting areas. This included staff visiting the patient waiting area to check on the status of patients waiting for appointments.
- Staff spoke with pride about working at Claremont Hospital. Staff told us they placed care and compassion at the centre of everything that they did.
- Consulting rooms displayed 'free/engaged' signs on the door. We saw that staff used these to show when rooms were engaged to protect patient privacy and dignity. Staff were observed to knock on doors before entering when patients were in treatment areas and consulting rooms.
- Staff told us that they would be confident in raising any issues about disrespectful or discriminatory behaviour towards patients or visitors. Staff we spoke with could not recall an occasion when this had been necessary.
- We saw patients and staff had a good rapport with staff putting patients at ease. Some patients were regular attenders and knew the staff well.New patients also confirmed they were put at ease and felt staff were caring towards them. A patient told us "The staff are very professional and I never have to wait for anything".
- Staff offered tactful help and support to complete forms when patients had difficulty understanding the questions being asked.

Understanding and involvement of patients and those close to them

- We observed staff spending time to explain procedures to patients before gaining written consent.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.
- The physiotherapy team had introduced a pre-operative service that had been submitted for a national award.

This service was for patients who would be non-weight bearing post-operatively. The physiotherapist instructed the patient on how to use crutches, and they also provided information.

- All of the patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about the care and treatment they could have. They all confirmed they felt informed and involved in their care, were given time to make decisions, and staff made sure they understood the treatment options available to them.

Emotional support

- We saw staff spend time talking to patients and showing empathy and encouragement to complete aspects of therapy.
- The hospital had a policy in place for the use of chaperones. Information leaflets and signs were displayed in waiting areas to inform patients of this service. We saw chaperones were available in the departments we visited.
- Staff were aware of the emotional impact of pain on patient well-being and this was an integral part of quality of life measures used in physiotherapy to assess and evaluate clinical improvements and effectiveness of treatment.
- We observed staff of all grades and specialties talking to patients.They reassured them during procedures and engaged with their patients. They informed them of what would happen and was happening to them.
- We saw staff recognised and respected people's needs. We saw staff did not hurry patients and had time to chat with patients in a supportive manner.
- Staff told us they always take people's personal, cultural, social and religious needs into account.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- There was a range of outpatient clinics offered, including services such as a variety of surgical specialties, dermatology and oncology. Minor procedures such as colposcopies and VTE (venous thrombo-embolism) laser treatment were available.
- Clinics tended to run in predictable patterns and we saw that the busier time periods were staffed accordingly.
- We saw that clinics could be flexible to meet the needs of patients. There were a small number of satellite clinics which meant for some patients this minimised travel.
- The hospital engaged with the local Clinical Commissioning Group (CCG) to plan and deliver contracted services based on local commissioning requirements.
- Seating was available in outpatient and diagnostic areas and this was appropriate for the number of patients present in clinic. Chairs were all the same height and style.
- Magazines and newspapers were available for patients in all patient waiting areas.In the main outpatient waiting areas, televisions were turned on and showing programmes.
- Most patients who used the department, whether as a private patient or an NHS patient were referred by their GP.
- The physiotherapy team had introduced a pre-operative service that had been submitted for a national award. This service was for patients who were non-weight bearing post-operatively. The physiotherapist instructed the patient to use crutches, get up and down the stairs, they also provided information.

Access and flow

- Referral to treatment times (RTT) were all better than national targets. RTT waiting times for outpatients ranged from 99% and 100% for non- admitted pathways between October 2015 to April 2016.

Good

Outpatients and diagnostic imaging

- From October 2015 to September 2016, the hospital outpatient department saw 59,690 patients.Of these, 18,628 were new appointments and 41,602 were follow-up appointments. The hospital saw 37,816 NHS appointments and 21,874 private patient appointments.
- During the inspection, we clarified that the hospital did not provide outpatient services to children aged under three.They did see 264 young people between the age of 16 and 17.
- The hospital told us that no audit of did not attend (DNA) appointments took place, but that they routinely logged details of NHS patients who did not attend for appointments. We saw that the hospital discussed DNA rates per speciality with the CCG at quarterly review meetings.
- There was capacity within the departments to see patients or carry out diagnostic imaging urgently if necessary.
- Average turnaround times for outpatient diagnostic imaging appointments was two days. Staff told us that reports were routinely completed within 24 hours of imaging taking place.
- Staff in outpatient clinics told us that there was no cap on appointment numbers within the department and no minimum number of patients required for a clinic to run. This allowed patients to access clinic in a timely manner and avoided cancellations. Staff did reflect that this meant that some clinics could be very busy and delays could occur on these occasions.
- The hospital did not formally advertise waiting times in waiting areas, however; reception and nursing staff monitored these remotely. During inspection we saw that clinic times were met and there were no delays.
- Staff in outpatient clinics told us that there was no restriction on the number of appointment numbers within the department. The department would flex to manage the numbers on a weekly basis. We saw that appointment times were booked around the needs of the patient. Requests to re-arrange appointments due to personal circumstances were accommodated.

Meeting people's individual needs

- All patients were asked to complete a medical health questionnaire prior to undergoing any treatment or procedure. Health questionnaires were checked by administration staff and referred to the nurse should the patient have identified any issues. Conditions such as high blood pressure, epilepsy and stroke required the patient to visit the clinic for a pre-admission assessment.
- Patients told us they were provided with full information regarding their appointment at the time of the initial telephone enquiry and the same was followed up an appointment letter detailing location, directions, consultant information, specific requirements for the appointment and providing contact details.
- An examination couch for bariatric patients was available in the outpatients department.
- Staff told us they were able to access interpreting and translation services if they needed to. However, staff we spoke with identified this was rarely required. Staff confirmed they were aware not to use relatives as interpreters.
- A range of information leaflets were available, which provided patients with details about their clinical condition and treatment or surgical intervention. We saw staff used these leaflets as supportive literature to reinforce their physiotherapy treatment and exercise regimes.
- The hospital dementia rating in the PLACE audit February 2016 to June 2016 was lower than England average (64% compared to the national average 80%).
- Staff had recently received training since these scores, in relation to caring for patients living with dementia. Staff told us the training was extremely helpful and educational and felt they were well equipped to support individuals with this condition.
- Staff told us they could access specific advice regarding patients with a learning disability when providing care for patients with learning disabilities. Online guidance was available to staff and staff told us it was easily accessible.
- Some patient information leaflets were available in large print for patients with visual impairment. Patient information was not available in alternative languages but staff explained they would ensure the patient fully understood what they needed to, before they left the department.

Good

Outpatients and diagnostic imaging

- Staff told us when patients living with learning disabilities or dementia attended the departments; they allowed carers to remain with the patient if this was what the patient wanted. They also ensured that patients were seen quickly to minimise the possibility of distress to them.
- There were toilet facilities available for patients including toilets with disabled access within the hospital.
- The hospital team responded to meet patient need. For example, one patient had struggled to get out their car as the disabled parking bay was on a slight incline. Within three weeks, the hospital team had moved all disabled parking bays to a flat part of the car park and reconfigured the main car park.

Learning from complaints and concerns

- The hospital had a complaint policy in place and the overall management of complaints sat with the General Manager.
- The hospital or service had not received any complaints between the period of October 2015 and September 2016.
- Staff were aware of the complaints procedure and felt confident raising concerns as they arose.
- We saw that lessons were learnt as a result of complaints investigations. We reviewed one complaint regarding a patient with dementia needs, which saw the introduction of training for all staff within the hospital.
- Staff described how they would resolve patients' concerns informally in the first instance, but would escalate to senior staff if necessary.
- Leaflets were available for patients in the waiting area, which provided details of how to make a complaint.
- Systems were in place to capture concerns and complaints raised within departments, review these at monthly staff meetings and take action to improve the experience of patients.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good

Leadership and culture of service

- There was strong local leadership of the service from the hospital director, the director of nursing and heads of departments. Managers also worked clinically and worked with staff on a daily basis. There had been a temporary gap in leadership in radiology. An interim manager was in post, who had day to day responsibility of the service, whilst the post was recruited to. The hospital managers confirmed that, between the previous manager leaving and an offer being made to a new manager was 10 weeks.
- There were clear lines of management responsibility and accountability throughout departments.
- Staff said all managers were available, visible within the departments and approachable and leadership of the service was good.There was good staff morale and they felt supported at department level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience as a priority and the responsibility of every member of staff.
- Staff described managers as approachable and effective. There was strong leadership of the service and managers had an open door policy.
- The leadership structure was clear and all staff we spoke with were supported clinically by the department heads.
- We saw that staff had positive working relationships and staff told us they received support from all grades of management.
- Clinical governance meetings were held monthly and were attended by the heads of department. These meetings fed into the medical advisory committee (MAC) and hospital management team.
- Staff felt there was a positive working culture with their and were passionate about their patients and the standards of services that they provide.

- Staff told us they were actively encouraged to identify training needs specific to their needs, in addition to the mandatory training programme. Several staff gave us examples of courses they had identified and were supported to attend.

Vision and strategy for this this core service

- An Aspen Healthcare Limited group-wide corporate vision was in place. 'Our aim is to provide first-class independent healthcare for the local community in a safe, comfortable and welcoming environment; one in which we would be happy to treat our own families.'
- Most staff we spoke with within the departments could articulate the Aspen Healthcare Limited vision to us. Staff were clear on what the vision was for the services we visited throughout the hospital and how this would be implemented.
- During our inspection it was clear that quality of patients' care and treatment took priority over any drive for business or costs.
- We saw that the values were embedded into the appraisal process for staff and they displayed the behaviours expected of them.
- Staff were very proud of the job they did and without exception the staff we spoke with enjoyed working at the hospital. We observed that staff were empowered to deliver a caring service and make improvements or drive policy changes. Without exception staff told us that they were being supported by heads of department, director of nursing (interim and substantive) and hospital director.

Governance, risk management and quality measurement

- Clinical governance meetings were held each month. Heads of each department attended the meeting, the Medical Advisory Committee (MAC) chair and hospital executive director.
- Minutes of the clinical governance meeting showed rolling agenda items including audit activity and evidence based practice and departmental teams provided reports on, infection prevention and control, pharmacy updates and medicines management, radiation safety, physiotherapy update, recruitment, staff and patient feedback and complaints and incidents.
- The clinical governance quarterly report was provided to all staff.
- Staff told us that risks were discussed and actions from governance meetings were shared at team meetings and we saw evidence of this from staff team meeting minutes.
- We reviewed local team meetings minutes and saw that action plans and areas for improvement were clear following incidents.
- We noted a structured audit calendar for planned audits. We saw evidence of regular audit activity and action plans where improvements were required.
- Staff told us that minutes were circulated as a mechanism to share learning amongst all staff including consultants.
- The last RPA report was completed in November 2016 and concluded that "There is a good level of compliance with radiation protection legislation at Claremont Hospital. The highest risk is the lack of local rules training and records in the theatre area." These risks had been addressed and resolved by the time of our inspection.

Public and staff engagement

- Patients were encouraged to complete a patient satisfaction survey during or after their outpatient, physiotherapy or diagnostic imaging visits.
- A physiotherapy team event had been held which engaged staff to develop four team objectives.
- Mangers engaged regularly with staff informally and formally through monthly team meetings. A monthly team brief was circulated to staff and discussed in team meetings.
- Posters were displayed on walls asking patients to complete 'how are we doing' cards.
- There were collection boxes for patient satisfaction surveys throughout the hospital or they could be

returned by post.The results from surveys were analysed by an independent third party and communicated back to the hospital on a monthly basis for learning and action.

- Patients are also encouraged to complete the friends and family test and results were shared with all staff within the centre. The hospitals Friends and family scores were 100% across the period of April 2016 and September 2016.
- We spoke with a consultant during our inspection, who told us that the hospital was able to accommodate consulting times and that nursing support was appropriate.

Innovation, improvement and sustainability

- Staff were encouraged to suggest ways to make departments run more effectively and efficiently.
- Physiotherapy teams had introduced a phone call to patients following shoulder surgery; patients did not have a follow up appointment until a couple of weeks after their surgery so a physiotherapistcalled a patienttwo days after discharge from the ward to reassure patients and answer any questions they may have.
- A member of the physiotherapy team identified problems with the way shoulder surgery patients were having their slings fitted in in theatre following an operation. The physiotherapist team had arranged training in theatre for staff.
- The physiotherapy team had introduced a pre-operative service that had been submitted for a national award. This service was for patients who were non-weight bearing post-operatively. The physiotherapist instructed the patient to use crutches, get up and down the stairs, they also provided information.
- The physiotherapy team had introduced a satellite physiotherapy clinics based in a GP practice, the team found spinal patients were being advised not to sit for more than 15 minutes post operatively but had to attend Claremont Hospital for follow up. The team reviewed referrals and had set up two satellite clinics in areas where the highest number of patients lived. The senior physiotherapist managed the clinic.

Outstanding practice and areas for improvement

Outstanding practice

- Staff were trained in a nationally recognised accreditation programme in customer care. Following this, staff completed a Values Partners programme, which is a workshop to explore values and behaviours between staff and towards patients and aims to create a positive working culture.
- The hospital took part in a comprehensive observational study to consider the approach by staff to the general care of patients, the level of patient/visitor engagement, and the environmental factors within patient reception areas. We saw an example of one survey in July 2016 and there had been an overall high score of 97%.
- We observed that staff were empowered to deliver a caring service and make improvements or drive policy changes.
- Staff we spoke with had clear knowledge of the vision of the service. They could tell us how this had been put into practice on a daily basis. We were told by one registered nurse that she was comfortable with the inspection as she aimed to go 'beyond compliance' every day.
- The hospital undertook an in-depth patient survey which benchmarked a variety of patient experience against other Aspen Healthcare sites. This included aspects of caring. The Claremont Hospital scored highly in all factors ranging from 93% to 98%.
- There had been a successful pilot of the anaesthetic led pre-assessment process with the aim to minimise risks, cancellations and improve patient experience. This was being monitored by auditing the number of cancellations and unplanned transfers.

Areas for improvement

Action the provider SHOULD take to improve

Ensure the safer steps to surgery including the World Health Organisation checklist is consistently used.

Ensure all eligible staff receive an appropriate level of safeguarding training to allow them to recognise any issues of concern.

Address the maintenance of the theatre environment and equipment.

Ensure staff in theatre check and record controlled drugs, fridge and fluid warming cabinet temperatures in line with hospital policy.

Ensure mandatory training levels meet the Aspen Healthcare compliance target.