Chartwell Private Hospital

Quality Report

1629 London Road
Leigh-on-Sea
Essex
SS9 2SQ
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection of Chartwell Private Hospital on 18 July 2016 and an unannounced inspection on 27 July 2016.

We found the following:

We rated the service as requires improvement overall. Safe and well led was rated as requires improvement with caring and responsive rated as good. Effectiveness was inspected but not rated.

Are services safe at this hospital?

- There was a lack of incident reporting and systems and processes to support incident reporting were not robust.
- Medicines management training was not provided by the service. Fridge temperatures in radiology were not regularly recorded. No regular medicines audits were undertaken.
- The service did not use a formal early warning score system to monitor and observe patients following procedures for signs of deteriorating clinical condition.
- Resuscitation equipment was not checked regularly. However, during our unannounced inspection we found that the equipment had been regularly checked since our first visit.
- During our announced inspection, people's healthcare records were not stored securely and were kept in a public waiting area. However, during our unannounced inspection we found that these records had been moved and were now secure.
- Documentation within patients' healthcare records was clear, accurate and legible.
- Compliance with mandatory training was exceptionally good.
- There was a sufficient number of suitably qualified staff on duty at all times.
- Medicines were stored, prescribed and administered safely.
- Infection control was practised in line with the hospital policy, which reflected best practice.

Are services effective at this hospital?

- Local policies, procedures and care pathways had not been reviewed regularly and were not up-to-date.
- There was an audit programme which had been developed recently and consisted of 36 audits. However, the majority of audits had not been undertaken and the programme was in its infancy.
- Pain was assessed and managed appropriately.
- People's nutrition and hydration needs were monitored and there were appropriate food and drink facilities available.
- Multi-disciplinary team working within the hospital and externally was very good.
- Appraisal rates were excellent and staff had appropriate skills necessary to carry out their roles effectively.
- Hospital opening hours offered good access and flexible appointment times including evening and weekends.
- Staff told us that they could access patient healthcare records in a timely way prior to appointments.
- Training for mental capacity and Deprivation of Liberty Safeguards was provided to staff during mandatory training. Compliance with training was good.

Are services caring at this hospital?

- People who used the service were treated with kindness, dignity, respect and compassion. Patient feedback was consistently positive.
- Staff ensured that people received relevant information to ensure that informed decisions were made and that people were involved as partners in their care.
- The hospital provided relevant support to people who used the service to cope emotionally with their care, treatment or condition.

Summary of findings

Are services responsive at this hospital?

- Services were planned and delivered to meet the needs of people who used the service. This included flexible hospital opening times dependent on service demand which demonstrated outstanding practice.
- Each area of the hospital had an environment that was appropriate and patient centred.
- People could access care and treatment in a timely way. Referral to treatment times (RTT) were outstanding with all patients receiving initial consultation or treatment within seven to 10 days.
- The flow of services within the hospital was seamless and people could access next day appointments if their referral was urgent.
- Care and treatment was tailored to meet the needs of different people. Interpreters were available as required, and there was extensive patient literature available in a variety of formats including video clips on the hospital website which were impressive.
- There was an effective complaints system in place with which staff were familiar. People's concerns and complaints were listened and responded to and used to improve service quality.

Are services well-led at this hospital?

- The hospital's governance framework did not ensure that quality performance and risks were understood and managed effectively. This was in in relation to a weak incident reporting system and a lack of quality measures in place.
- There was a lack of comprehensive assurance system and service performance measures, which were reported and monitored. For example, hospital managers confirmed that an indicator dashboard to measure service quality was not in use.
- There was a clear service vision and strategy, which staff knew and adhered to.
- The hospital held regular hospital-wide meetings, which were well attended and minuted. Information from these meetings was disseminated to all staff.
- The culture of the service was immensely positive and staff felt valued, respected and well supported by their seniors.
- Patients and staff were encouraged to engage with the service through meetings and feedback forms.
- Where we raised concerns, hospital managers took appropriate action promptly and resolved the issue. This included ensuring that patient records were stored securely.

We saw some areas of outstanding practice including:

- Referral to treatment times (RTT) were outstanding.
- Multidisciplinary team working both within the hospital and externally was effective in helping maximise patient outcomes and experience and demonstrated outstanding practice.
- Flexible hospital opening times dependent on service demand demonstrated outstanding practice.

However, there were also areas of where the provider needs to make improvements.

Importantly, the provider must:

- Must ensure that there are effective systems and processes in place to report, analyse and learn from incidents.
- Must have robust arrangements for assessing and monitoring a patient's clinical condition for signs of deterioration.
- Must ensure that policies and procedures are reviewed regularly.

In addition the provider should:

- Should consider arranging regular audits and improve safe management of medicines.
- Should consider providing training to staff on learning disability and dementia.
- Should consider introducing a system so that service quality and safety can be measured.
- Should monitor and record fridge temperatures to ensure that integrity of medicines.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients and diagnostic imaging	Requires improvement 	We rated the service as requires improvement overall. Safe and well led was rated as requires improvement with caring, responsive and well-led being rated as good. Effective was inspected but not rated. There was a lack of incident reporting and systems and processes to support incident reporting were not robust. Medicines management training was not provided by the service. Fridge temperatures in radiology were not regularly recorded. No regular medicines audits were undertaken. The service did not use a formal early warning score system to monitor and observe patients following procedures for signs of deteriorating clinical condition. The hospital's governance framework did not ensure that quality performance and risks were understood and managed effectively. This was in in relation to a weak incident reporting system, a lack of quality measures in place and minimal local audits being carried out. Local policies, procedures and care pathways had not been reviewed regularly and were not up-to-date. Staff had not received training in learning disability or dementia, despite patients with these conditions receiving treatment at the service. However, we also found that there was a sufficient number of suitably qualified staff on duty at all times, and compliance with mandatory training was excellent. Medicines were stored, prescribed and administered safely. Infection control procedures reflected national best practice. Pain was assessed and managed appropriately. Multidisciplinary team working within the hospital and externally demonstrated outstanding practice. Appraisal rates were excellent and staff had appropriate skills necessary to carry out their role effectively. People who used the service were treated with kindness, dignity, respect and compassion. Patient feedback was consistently positive and people were involved as partners in their care. Flexible hospital opening times dependent on service demand demonstrated

Summary of findings

outstanding practice. Referral to treatment times (RTT) were outstanding with all patients receiving initial consultation or treatment within seven to 10 days. Complaints were minimal and handled effectively and used to improve service quality where necessary. There was a clear service vision and strategy, which staff knew. The culture of the service was immensely positive and staff felt valued, engaged with the service and well supported. Where we raised concerns, hospital managers took appropriate action promptly to resolve the issues. This included ensuring that patient records were stored securely.

Summary of findings

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Services we looked at
Outpatients and diagnostic imaging;

Summary of this inspection

Background to Chartwell Private Hospital

Chartwell Private Hospital opened in 2007 and was previously known as Leigh Medical Centre before changing hands in 2010 to the provider Chartwell Private Hospital and Diagnostics Limited. The provider is a privately owned business which works as a local NHS community health provider. The provider offers services in endoscopy, gastroscopy, colonoscopy, flexible sigmoidoscopy, electrocardiogram (ECG), phlebotomy and wound care. Chartwell Private Hospital also provides a diagnostic imaging service, outsourced from local NHS trusts and privately. The hospital also subcontracts other NHS services including outpatients, orthopaedics, gynaecology and ear, nose and throat (ENT) services. They also run a private cardiology outpatient service.

The diagnostic imaging service conducts on average 100 MRI scans per week. Information provided by the service showed that on average 85% of these were for NHS patients and 15% for privately funded patients.

The registered manager is Terence Copping who had been in post since 16 February 2014. There are 15 doctors working at the service under practising privileges. There are 3.7 full time equivalent (FTE) registered nurses, 1.3 FTE health care assistants and 7.5 FTE other hospital staff.

Our inspection team

Our inspection team was led by:

Inspection Lead: Leanne Wilson, Inspection Manager, Care Quality Commission

The inspection team consisted of a CQC inspection manager, CQC inspector and specialist nurse advisor with a background is surgery services.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the hospital and the services it provides.

We carried out an announced inspection visit on 18 July 2016 and an unannounced inspection on 26 July 2016.

During the inspection we visited all areas of the hospital and spoke with 15 members of staff including the managing director, clinical and medical lead, registered nurses (RGN), a doctor, and technical and support staff.

We also reviewed 16 healthcare records for people who used the service and analysed data provided during and after the inspection. We observed how staff interacted with people, but did not speak with any patients or relatives because they did not wish to speak with inspectors for privacy reasons, however we offered people the chance to speak with us regarding their experience. However, we did review the written feedback they provided to the hospital.

Information about Chartwell Private Hospital

Chartwell Private Hospital is registered for the following regulated activities:

Diagnostic and screening procedures (registered since 16 February 2014)

Surgical procedures (registered since16 February 2014)

Treatment of disease, disorder or injury (registered since 10 February 2014).

General activity:

Summary of this inspection

Outpatient department specialities are split between:

- cardiology (on average 10%);
- ear, nose and throat (60%);
- gynaecology (20%);
- orthopaedics (10%)

The following services are outsourced by Chartwell Private Hospital:

• CSSD (sterilisation)

• Pathology

• Radiology

Controlled Drugs Accountable Officer (CD AO)

The registered manager, Terence Copping is the CD AO (registered April 2012)

Services accredited by a national body

None at the time of our inspection but the hospital had an application underway for Joint Advisory Group (JAG) accreditation.

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?

Requires improvement

- There was a lack of incident reporting and systems and processes to support incident reporting were not robust.
- Medicines management training was not provided by the service. Fridge temperatures in radiology were not regularly recorded. No regular medicines audits were undertaken.
- The service did not use a formal early warning score system to monitor and observe patients following procedures for signs of deteriorating clinical condition.
- Resuscitation equipment was not checked regularly. However, during our unannounced inspection we found that the equipment had been regularly checked since our first visit.
- During our announced inspection, people's healthcare records were not stored securely and were kept in a public waiting area. However, during our unannounced inspection we found that these records had been moved and were now secure.
- Documentation within patients' healthcare records was clear, accurate and legible.
- Compliance with mandatory training was exceptionally good.
- There was a sufficient number of suitably qualified staff on duty at all times.
- Medicines were stored, prescribed and administered safely.
- Infection control was practised in line with the hospital policy, which reflected best practice.

Are services effective?

Not sufficient evidence to rate

- Local policies, procedures and care pathways had not been reviewed regularly and were not up-to-date.
- There was an audit programme which had been developed recently and consisted of 36 audits. However, the majority of audits had not been undertaken and the programme was in its infancy.
- Pain was assessed and managed appropriately.
- People's nutrition and hydration needs were monitored and there were appropriate food and drink facilities available.
- Multi-disciplinary team working within the hospital and externally was very good.
- Appraisal rates were excellent and staff had appropriate skills necessary to carry out their roles effectively.
- Hospital opening hours offered good access and flexible appointment times including evening and weekends.

Summary of this inspection

- Staff told us that they could access patient healthcare records in a timely way prior to appointments.
- Training for mental capacity and Deprivation of Liberty Safeguards was provided to staff during mandatory training. Compliance with training was good.

Are services caring?

Good

- People who used the service were treated with kindness, dignity, respect and compassion. Patient feedback was consistently positive.
- Staff ensured that people received relevant information to ensure that informed decisions were made and that people were involved as partners in their care.
- The hospital provided relevant support to people who used the service to cope emotionally with their care, treatment or condition.

Are services responsive?

Good

- Services were planned and delivered to meet the needs of people who used the service. This included flexible hospital opening times dependent on service demand which demonstrated outstanding practice.
- Each area of the hospital had an environment that was appropriate and patient centred.
- People could access care and treatment in a timely way. Referral to treatment times (RTT) were outstanding with all patients receiving initial consultation or treatment within seven to 10 days.
- The flow of services within the hospital was seamless and people could access next day appointments if their referral was urgent.
- Care and treatment was tailored to meet the needs of different people. Interpreters were available as required, and there was extensive patient literature available in a variety of formats including video clips on the hospital website which were impressive.
- There was an effective complaints system in place with which staff were familiar. People's concerns and complaints were listened and responded to and used to improve service quality.

Summary of this inspection

Are services well-led?

Requires improvement 

- The hospital's governance framework did not ensure that quality performance and risks were understood and managed effectively. This was in in relation to a weak incident reporting system and a lack of quality measures in place.
- There was a lack of comprehensive assurance system and service performance measures, which were reported and monitored. For example, hospital managers confirmed that an indicator dashboard to measure service quality was not in use.
- There was a clear service vision and strategy, which staff knew and adhered to.
- The hospital held regular hospital-wide meetings, which were well attended and minuted. Information from these meetings was disseminated to all staff.
- The culture of the service was immensely positive and staff felt valued, respected and well supported by their seniors.
- Patients and staff were encouraged to engage with the service through meetings and feedback forms.
- Where we raised concerns, hospital managers took appropriate action promptly and resolved the issue. This included ensuring that patient records were stored securely.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

Chartwell Private Hospital provided outpatient and diagnostic imaging services to adults aged from 18 years. Outpatient and diagnostic imaging services were provided from three main departments in the hospital and were spread over three floors: the diagnostic imaging, outpatient clinic and endoscopy department. Services available included X-ray and MRI imaging, outpatient clinics for cardiology, ear, nose and throat (ENT), gynaecology and orthopaedics, and endoscopy procedures including gastroscopy, colonoscopy and flexible sigmoidoscopy. There were no general anaesthetic services available at the hospital.

Data from April 2015 to March 2016 showed that 3943 people received care at the hospital during this period, of which 2248 were admissions for endoscopy procedures and 1695 were outpatient attendances. People who used the service were either private patients, who self-funded or had private medical insurance cover, or NHS funded, and could access services at the hospital via GP referral. Of the total number of people (3943) who accessed the service, 99.5% of inpatients and 72% of outpatients were NHS funded.

During our inspection we visited all areas of the hospital and spoke with 15 members of staff including the managing director, clinical and medical lead, registered nurses (RGN), a doctor, and technical and support staff. We also reviewed 16 healthcare records for people who used the service and analysed data that we requested. We observed how staff interacted with people, but did not speak with any people who used the service because they did not wish to speak with inspectors. However, we did review the written feedback they provided to the hospital.

Summary of findings

We rated the service as requires improvement overall. Safe and well led was rated as requires improvement with caring, responsive were rated as good. Effective was inspected but not rated.

We found that:

- There was a lack of incident reporting and systems and processes to support incident reporting were not robust.
- Medicines management training was not provided by the service. Fridge temperatures in radiology were not regularly recorded. No regular medicines audits were undertaken.
- The service did not use a formal early warning score system to monitor and observe patients following procedures for signs of deteriorating clinical condition.
- The hospital's governance framework did not ensure that quality performance and risks were understood and managed effectively. This was in relation to a weak incident reporting system, a lack of quality measures in place and minimal local audits being carried out.
- Local policies, procedures and care pathways had not been reviewed regularly and were not up-to-date.
- Staff had not received training in learning disability or dementia, despite patients with these conditions receiving treatment at the service.

Requires improvement

Outpatients and diagnostic imaging

However, we also found:

- There was a sufficient number of suitably qualified staff on duty at all times, and compliance with mandatory training was excellent.
- Medicines were stored, prescribed and administered safely.
- Infection control procedures reflected national best practice.
- Pain was assessed and managed appropriately. People's nutrition and hydration needs were monitored and there were appropriate food and drink facilities available.
- Multidisciplinary team working within the hospital and externally demonstrated outstanding practice.
- Appraisal rates were excellent and staff had appropriate skills necessary to carry out their role effectively.
- People who used the service were treated with kindness, dignity, respect and compassion. Patient feedback was consistently positive and people were involved as partners in their care.
- Services were planned and delivered to meet the needs of people who used the service. This included flexible hospital opening times dependent on service demand which demonstrated outstanding practice.
- Referral to treatment times (RTT) were outstanding with all patients receiving initial consultation or treatment within seven to 10 days. Service flow was seamless.
- Complaints were minimal and handled effectively and used to improve service quality where necessary.
- There was a clear service vision and strategy which staff knew. The culture of the service was immensely positive and staff felt valued, engaged with the service and well supported.
- Where we raised concerns, hospital managers took appropriate action promptly to resolve the issues. This included ensuring that patient records were stored securely.

- Resuscitation equipment was not checked regularly. However, during our unannounced inspection we found that the equipment had been regularly checked since our first visit.
- During our announced inspection people's healthcare records were not stored securely and were kept in a public waiting area. However, during our unannounced inspection we found that these records had been moved and were now secure.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the safety of outpatient and diagnostic imaging services as requires improvement. This was because we found:

- There was a lack of incident reporting and systems and processes to support incident reporting were not robust.
- Medicines management training was not provided by the service. Fridge temperatures in radiology were not regularly recorded. No regular medicines audits were undertaken.
- The service did not use an early warning score system to monitor and observe patients following procedures for signs of deteriorating clinical condition.

However, we also found:

- Resuscitation equipment was not checked regularly. However, during our unannounced inspection we found that the equipment had been regularly checked since our first visit.
- During our announced inspection, people's healthcare records were not stored securely and were kept in a public waiting area. However, during our unannounced inspection we found that these records had been moved and were now secure.
- Documentation within patients' healthcare records was clear, accurate and legible.
- Compliance with mandatory training was exceptionally good.
- There was a sufficient number of suitably qualified staff on duty at all times.
- Medicines were stored, prescribed and administered safely.
- Infection control was practised in line with the hospital policy, which reflected best practice.

Incidents

- There had been no never events reported for outpatient and diagnostic services from April 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers..
- The service had not reported any clinical or non-clinical incidents during April 2015 to June 2016, including no incidents relating to radiation exposure under The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) Regulation 4(5).
- There was an incident reporting policy in placed titled, Reporting an accident and adverse incident; version two dated June 2007. There were numerous dates on this policy and it was not clear as to when the policy was last reviewed. For example, on the front cover it stated that it was "approved [in] 2011". This lack of review date meant that the policy was not up-to-date. Furthermore the policy was brief and we were concerned about the lack of information in the policy regarding how to report an incident and when.
- Our concerns about incident reporting where heightened given the lack of incidents reported and because six members of staff we spoke with were not able to tell us what constituted an incident and they told us contradicting information when we asked how they would report an incident. One member of staff told us that there was an accident reporting book for all incidents, whilst another told us that there was an electronic form on the hospital intranet. A senior manager told us that they recognised that reporting of incidents and near misses required improvement.
- Due to a lack of incident reporting we were not assured that learning from incidents was taking place as there was no evidence to analyse.
- Managers were aware of the principles of duty of candour and could explain to us when this would be applied and why it was necessary. The Duty of Candour is a legal duty on hospital, community and. mental health trusts to inform and apologise to patients if there. have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful. information from health providers. However, no examples of how duty of candour had been used could be provided because no incidents had been reported.

Requires improvement

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- No cases of hospital acquired infections for MRSA, Clostridium difficile (C.difficile) or E-Coli were reported by the hospital from April 2015 to June 2016.
- All areas we visited were visibly clean and tidy. There were robust cleaning schedules in place and records confirmed that these cleaning schedules were practised.
- We saw that staff practised good hand hygiene, and all staff used personal protective equipment appropriately and wore their uniforms bare below the elbows.
- Hand sanitiser and hand washing facilities were available throughout the hospital and there were notices reminding people to clean their hands. There were sufficient supplies of personal protective equipment, such as gloves and aprons, available for staff throughout the hospital.
- We observed that clinical waste was disposed of appropriately and in line with the hospital's clinical waste policy and procedures. Yellow clinical waste bags were used, there were foot-operated waste bins, and sharps bins which were signed and dated and not over-filled throughout departments.
- Infection control training was part of mandatory training. Records showed that 100% of staff had either completed mandatory training in the past year or were scheduled to complete this in August 2016.
- All endoscopy equipment was maintained and validated through service contracts with other providers. There was also an allocated onsite scope technician who was a decontamination specialist for endoscopy and the decontamination unit, and a further three members of staff who had been trained in decontamination of this equipment when this lead was not working. We were assured that the provider was managing and decontaminating reusable medical devices in line with national guidance such as the Department of Health Technical Memorandum on Decontamination.

Environment and equipment

- People who attended the hospital reported to main reception at the front of the hospital and were escorted to the relevant department. There were three main departments spread over three floors: the diagnostic imaging suite was on floor zero, the outpatient clinic was on the ground level and endoscopy department was on floor one. All areas were accessible by stairs or lift. There were fire evacuation chairs on every floor in the event of the lifts not working and a person not being able to use the stairs.
- Resuscitation equipment was readily available in every department. However, we found that this equipment was not checked regularly. In the imaging department we found a significant amount of gaps in the resuscitation trolley checking history. For example in June 2016 the equipment had only been checked four times on 6, 27, 28 and 30 June despite normal services running during that month. A staff member confirmed our findings. The trolley was kept out of staff view in a small waiting area; the trolley was also not sealed with a breakable tab. This meant that emergency medicine was not stored safely.
- During our unannounced inspection we found that the trolley had been moved so that medicines were secure, and a new trolley which could be sealed had been ordered. This meant that the provider had taken appropriate action since our first inspection.
- In the endoscopy suite we found, during our unannounced inspection, that the resuscitation trolley had three separate records for checking the equipment. This meant that different days were recorded on different records and on some days the trolley had been checked several times unnecessarily. The provider assured us that they would address this.
- Each area we visited was bright, clear of clutter and well organised. The endoscopy suite was undergoing building work at the time of our visit. We found that this room was cramped due to a lack of space. However, we were assured that there was sufficient space to provide safe care during this period. Work was due to be completed in September 2016, which would see the expansion of the suite including two new decontamination units for endoscopes (washers).
- There were adequate storage facilities and suitable levels of equipment for safe monitoring and effective treatment.
- Records confirmed that equipment throughout the hospital had been serviced recently and electrical equipment had been portable appliance tested (PAT). There were contractual arrangements in place with suitable persons from outsourced services for servicing and PAT testing.
- Sterile equipment was supplied by a local NHS trust under a service level agreement (SLA).

Requires improvement

Outpatients and diagnostic imaging

- We checked single use equipment throughout the hospital and found that this equipment was properly stored, in date and packaging was intact.
- There was a service level agreement (SLA) in place with an NHS trust which was an authorised radiation protection centre, and provided the hospital with ongoing radiation protection support services. This meant that the imaging service at the hospital had easily access to expert radiation advice.
- At the time of our visit there was a temporary lead for imaging services who was the interim radiation protection supervisor. This lead position was vacant and being advertised. The service had a radiation protection advisor appointed.
- Throughout the imaging department there were signs and information displayed warning people about where radiation exposure takes place and not to enter certain areas. There were also lights that warned people not to enter due to procedures taking place. Staff also confirmed there was always a receptionist at the front desk of the department when imaging services were open.

Medicines

- There was a medicines management policy in place titled, Medicines policy; version 3 which was last reviewed in October 2014. Within the policy it stated that the policy should be, "reviewed on an annual basis or following any legislative changes". However, the front page says for review in 2017. Therefore this policy was potentially out of date.
- The provider used the services of a local pharmacy that provided stock medication. Staff told us that medicines were signed in by a registered nurse, and if it was a controlled drug in endoscopy, then by two nurses. However, there was no medicines reconciliation process I place from the service from either a trained member of staff or pharmacist. A manager confirmed that there was no SLA in place for pharmacy support and that a pharmacist did not regularly visit the hospital.
- Records showed that medicines management training was not provided by the service.
- We checked 10 medicine records of people who used the service and found that medicine had been prescribed and administered safely.
- We saw that medicines were stored securely and records showed that controlled drugs were regularly checked. However, a senior manager confirmed that no regular medicine audits had been carried out.
- Staff we spoke with were able to tell us how they would safely dispose of medicines including toxic waste, in line with the provider's medicines management policy.
- When a patient required prescribed medicine to take home the relevant consultant would write to the patient's general practitioner (GP) to complete the prescription. Staff confirmed that no prescriptions were written by the hospital.
- There was an appointed Controlled Drugs Accountable Officer (CDAO) who supervised management and use of controlled drugs within the hospital. This person had up-to-date registration for this role and attended Local Intelligence Network (LIN) meetings four times per year which provided updates about controlled drugs both at local and national level.
- In the imaging department we found that one fridge which was used to store contrast medicine did not have regular temperature checks recorded. A manager confirmed our findings as they could not provide us with a copy of the record. However, we saw that this medicine was stored at the correct temperature on the day of our visit and was securely kept. During our unannounced inspection we found that there was a record in place to monitor the temperature of the fridges. All dates checked showed that the fridge temperatures had been maintained to within safe limits.

Records

- In the hospital reception area we saw that there was a cabinet used to store healthcare records of people who used the service. This was unlocked and there were numerous healthcare records accessible to anyone in the waiting room area. We saw that the front door to reception was open and that anyone could walk in and therefore access these records. This meant that records were not stored securely. We asked the provider to take immediate action to address this which they did and records were found to be stored securely during our unannounced inspection.
- We looked at 16 healthcare records for people who used the service and found that documentation was clear, accurate and legible. Where a concern had been identified we saw that appropriate action was taken as a

result and then recorded. For example if a person had an allergy and was undergoing an endoscopy then this allergy was written in their healthcare records and they would be given a red patient wrist band to alert staff.
- Healthcare records were in paper format and kept onsite. In addition the hospital also used an electronic healthcare records system which contained duplicate information and was password controlled, which ensured only authorised staff could access this. Staff told us that access to people's existing healthcare records was never an issue.

Safeguarding

- There had been no safeguarding incidents raised by the provider during April 2015 to June 2016. However, staff told us that they had access to the provider's safeguarding policies and procedures via the staff intranet, and they were knowledgeable as to what constituted a safeguarding concern and how to raise matters appropriately.
- There was an allocated safeguarding lead for the hospital, and a safeguarding vulnerable adults policy in place which was up-to-date.
- Training in safeguarding vulnerable adults level two training was delivered to 100% of staff.

Mandatory training

- Ten members of staff told us that they had recently received mandatory training. Records confirmed that 100% of staff had either received mandatory training in the past year or were scheduled to complete this by August 2016.
- Mandatory training was provided on an annual basis to all staff and consisted of health and safety, risk management, fire, manual handling, infection control and basic life support (BLS). For all registered professionals such as nurses and radiographers, intermediate life support (ILS) training was also mandatory.

Assessing and responding to patient risk

- The service did not use an early warning tool such as the National Early Warning Score (NEWS) system. When completed, early warning tools generate a score through the combination of a selection of routine patient observations, such as heart rate. These tools were developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation. The concern was that the way in which patients were monitored following a procedure was not structured, and this meant that a patient's clinical deterioration could be missed.
- All admissions and appointments were agreed by a consultant who assessed each referral prior to accepting based on set exclusion criteria. This ensured that only low-risk service users accessed the hospital services and that the hospital was suitable for the person's needs. For example if the service user was an insulin dependent diabetic or required an overnight stay, then the referral was not accepted and the assessing consultant would recommend an alternative and more suited provider to the referrer.
- In the event of a patient not meeting the discharge criteria, or their condition deteriorating, there was a patient transfer policy in place, with which staff were familiar. A manager gave us a recent example where this policy had been followed correctly. It involved a person who developed an unexpected active bleed prior to an endoscopic procedure taking place.
- There were clear pathways and processes in place for service users who required referral to or admission to an NHS facility. This included a robust pathway for people who were found to require referral to the two week cancer pathway at a local NHS trust following investigation at The Chartwell Private Hospital.
- We looked at 16 healthcare records of people who had been admitted to the hospital for endoscopy procedure. We found that all records had completed, necessary risk assessments in place, including pre-operative checks such as whether the person wore dentures and concise medical history.
- Records confirmed that the World Health Organisation (WHO) 'Surgical Checklist, Five Steps to Safer Surgery' was used for admitted patients. It was embedded in to the provider's patient admission paperwork for those undergoing endoscopy procedures. There were also specific WHO checklists in place for diagnostic injections where required. We observed the process of safer surgery and found that this met all required standards of a safer surgery check.
- There were checklists in place to ensure that the right person got the right radiological scan at the right time. The checklist also included pregnancy assessment for

female service users. We looked at eight healthcare records of people who had undergone radiological scanning and found that all relevant checks had taken place.

Nursing staffing and support staff

- The hospital did not use a standardised tool to determine nursing staffing numbers required for the outpatient departments. However, in the endoscopy department the provider based its staffing numbers on staffing standards issued by the Joint Advisory Group (JAG) for gastrointestinal endoscopy. We found that there was a sufficient number of suitably trained staff on duty at all times in all departments.
- In total 3.7 whole time equivalent (WTE) registered nurses were employed by the provider.
- Regular bank staff, who had been approved by managers, were used frequently. Managers told us that this assisted them to offer a flexible service in relation to varying levels of service demand.
- Managers told us that agency nursing staff were rarely used.
- Records confirmed that new staff and bank and agency staff underwent a comprehensive programme of induction, which included orientation to the hospital. We spoke with five members of staff and all told us that they had completed this induction programme. One agency member of staff showed us their completed induction programme.
- Staff told us that there was always a senior member of staff on duty in each department, and that staffing skill mix was good.

The provider employed 1.3 WTE support staff and 7.5 WTE additional staff including administrative staff.

Medical staffing

- The hospital employed a medical lead, who was a consultant gastroenterologist. This member of staff also led the hospital's medical advisory committee (MAC).
- Medical staff were predominantly employed by other organisations (NHS organisations) in substantive posts and had practising privileges to work at the Chartwell Private Hospital. A practising privilege is defined as 'permission to practise as a medical practitioner in that hospital' (Health and Social Care Act, 2008).
- There were 15 consultants practising at the hospital under practising privilege contracts. Robust systems were in place to ensure that all consultants practising at the hospital were monitored in terms of General Medical Council (GMC) registration, revalidation of registration, training and appraisal.

Major incident awareness and training

- The hospital was not a major incident receiving centre and therefore there was no major incident training or policy.
- There were up-to-date policies and procedures for emergencies in place; for example in case of a radiation or radioactive incident, or fire incident requiring evacuation occurring.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but currently do not rate outpatient and diagnostic imaging services for effectiveness. We found:

- Local policies, procedures and care pathways had not been reviewed regularly and were not up-to-date.
- There was an audit programme which had been developed recently and consisted of 36 audits. However, the majority of audits had not been undertaken and the programme was in its infancy.
- Pain was assessed and managed appropriately.
- People's nutrition and hydration needs were monitored and there were appropriate food and drink facilities available.
- Multidisciplinary team working within the hospital and externally was very good.
- Appraisal rates were excellent and staff had appropriate skills necessary to carry out their roles effectively.
- Hospital opening hours offered good access and flexible appointment times including evening and weekends.
- Staff told us that they could access patient healthcare records in a timely way prior to appointments.
- Training for mental capacity and Deprivation of Liberty Safeguards was provided to staff during mandatory training. Compliance with training was good.

However:

- We requested to review the audits as part of our information request. However, no audits were provided.

Requires improvement

Outpatients and diagnostic imaging

Evidence-based care and treatment

- We looked at 16 healthcare records of people who used the service and 10 hospital policies and procedures. These records showed that people's needs were assessed and care was planned and delivered in line with recognised guidance, legislation and best practice standards. This included endoscopy procedures which reflected set standards from organisations such as the Joint Advisory Group (JAG) on gastrointestinal endoscopy, and relevant National Institute for Health and Care Excellence (NICE) guidelines including 'Healthcare-associated infections: prevention and control in primary and community care' (NICE CG139).
- The hospital also followed World Health Organisation (WHO) and Royal College of Radiologists guidelines for interventional radiology.
- New evidence-based care and treatment was identified by individual members of staff and discussed at the regular medical advisory committee (MAC) meetings that took place. From here changes in practice required would be taken to the board of directors and policy and procedures developed and ratified by appropriate persons as necessary.
- There were numerous local policies, procedures and clinical care pathways which all staff had access to and followed. For example, we observed a clinical pathway for endoscopy admission which was followed for all three of the patients' care we tracked who were undergoing endoscopic procedures during our visit.
- We however also found that five out of the 10 policies we checked were not up-to-date; for example, the provider's medicines policy; version three which was last reviewed in October 2014. Within the policy it stated that the policy should be, "reviewed on an annual basis or following any legislative changes". Therefore this policy was out-of-date. It was unclear from the front of the provider's policies when review dates were due and when they were completed and by whom.
- We also found that whilst some clinical pathways had clear review dates and specified authors not all did. For example, the care pathway for carpel tunnel decompression had no date of production or review, and there was no record of who developed this care pathway.
- A local audit programme had recently been developed which was comprehensive and included 36 audits ranging from infection control audits to tap flushing audits. Records confirmed that this audit programme had been developed in July 2016. A manager confirmed that all but five of these audits had been completed. We requested to review the audits as part of our information request. However, no audits were provided.

Nutrition and hydration

- In reception there was access to water jugs and a hot beverage machine where visitors could help themselves.
- People who used the service and visitors had access to drinks throughout departments, and staff told us that light meals were available if required for inpatients.

Pain relief

- We observed that people's pain levels were assessed and managed appropriately. For example in the hospital's endoscopy pathway there was a "patient comfort score" system used under the "endoscopy procedure" section of the care pathway. We checked seven healthcare records of people who had undergone an endoscopic procedure, and found that patient comfort scores were checked regularly and pain relief given as required.
- Pain management was not part of the hospital's satisfaction survey. However, there was an empty box on the survey if the person had any further comments. There had been one complaint reported in the past 18 months which related to pain management. We have reported this under the "Responsive" section of this report. We found that the hospital took appropriate action to resolve the complaint and improve practice subsequently.
- Endoscopy staff told us that a registered nurse routinely called all patients three days post colonoscopy and asked them about pain during this consultation, and gave advice as necessary.

Patient outcomes

- An endoscopy reporting tool was in place which was used to gather information for GRS (Global Rating Scale for Endoscopy) auditing. The GRS audit which is used to assess quality and safety of endoscopy practice, was submitted twice a year to JAG.
- The hospital did not participate in any other national audits and told us that this was because they were "a diagnostics centre and as such had no further access to patient outcomes in the short or long term".

- Staff confirmed that regular information was collated from people who had undergone a colonoscopy by way of a three day follow up telephone consultation to determine whether the service user had a positive outcome.
- People's experience of using the service was also reviewed regularly throughout the hospital. This was by way of patient surveys which were audited regularly in terms of overall scores relating to patient experience. These scores were based on a one to four scoring system, one being poor and four being excellent. Individual questions were asked from initial contact with the service to discharge. These figures were regularly reviewed by the senior management team at the hospital, and relevant information was cascaded to all staff as required.

Competent staff

- Records confirmed that 100% of staff had received an appraisal in the last 12 months.
- Staff we spoke with confirmed that they had either been revalidated in terms of their professional registration, or were working through this process.
- There was an induction programme for all staff which included education regarding the hospital's philosophy, key members of staff, relevant hospital policies and orientation. Staff we spoke with told us they had completed the hospital induction programme. Each member of staff was allocated an assessor who signed the induction as complete.
- One-hundred per cent of staff had completed their mandatory training.
- All staff had a personal development file which was specific to their role and this included relevant competencies.
- All doctors who had practising privileges were at consultant level and were registered with the General Medical Council (GMC) and had completed revalidation.

Multidisciplinary working

- We observed effective multidisciplinary team (MDT) working between staff. There was a good rapport, mutual respect and effective communication between staff from all disciplines and across the hospital.
- There were also examples of effective external MDT working which demonstrated outstanding practice. This included cancer pathways which had been developed which we have discussed fully under the "Caring" section of this report.
- The provider had worked in partnership with local NHS trusts to ensure that pathways were in place for patients who were found to require referral to an NHS trust, in relation to requiring a two week cancer pathway following investigation at Chartwell Private Hospital.

Seven-day services

- The hospital was open Monday to Friday between 8am and 8pm, and on Saturdays from 8am to 2pm as required. Service availability during this time was flexible and dependent on service demand.
- The hospital had extended its opening hours to the evenings during weekdays, and operated during the morning on a Saturday according to service demand. A hospital manager told us that this was due to an increased service demand during these times. This meant that hospital services were flexible and offered people choice of appointment.

Access to information

- Staff we spoke with confirmed that they had access to the hospital's policies and procedures via the intranet system.
- We observed that staff had access to people's healthcare records in both electronic and paper format as necessary, and access to relevant computer systems including imaging as needed.
- Referrals were received from general practitioners (GPs) in either electronic format, or via fax which general practitioners (GPs) usually preferred. We saw that general practitioner (GP) letters were written promptly following the patient using the hospital service, and were thorough and contained sufficient information about the hospital care received.
- Radiology scans were reported electronically and staff told us that the provider was able to share these digital images promptly with other organisations via an electronic system as required, and with the patient's permission.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Requires improvement

Outpatients and diagnostic imaging

- There were hospital policies which covered the legal aspects of consent, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007). These were accessible to staff via the intranet and staff confirmed they could access these.
- Patient records we checked showed that appropriate consent forms were in place, and these were fully completed for patients undergoing invasive procedures.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatient and diagnostic imaging services as good because:

- People who used the service were treated with kindness, dignity, respect and compassion. Patient feedback was consistently positive.
- Staff ensured that people received relevant information to ensure that informed decisions were made and that people were involved as partners in their care.
- The hospital provided relevant support to people who used the service to cope emotionally with their care, treatment or condition.

Compassionate care

- We observed that staff consistently acted in a friendly and caring manner with people who used the service and those close to them. The reception area was the first area of the hospital people saw. Staff welcomed them with a smile and were attentive to their needs.
- We also saw that staff responded to patient needs promptly and in a dignified manner.
- Patients' personal, cultural, social and religious needs were taken into account when plans of care were agreed following assessment. Records confirmed that assessments of these needs took place prior to the person attending the hospital. For example ensuring that male and female lists happened separately, and that staff had a chaperone of their preference.
- There were signs throughout the hospital informing people about chaperoning, and they could request a chaperone as required. Staff told us that the chaperone was always the same sex as the person receiving care or treatment.
- Every person who used the service was given a feedback form to complete. The hospital management team reviewed these regularly, and shared this information with staff as necessary.
- We looked at the results of the feedback forms for the Friends and Family Test from April, May and June 2016 and found that results were consistently positive. The survey asked patients to rate their "overall satisfaction with the care received at Chartwell Hospital". In April 2016 the overall patient satisfaction score was 99.7%.

Understanding and involvement of patients and those close to them

- We observed that extensive information was available to people who used the service which demonstrated that they were involved in their care from initial contact with the hospital and beyond discharge.
- There were video clips on the hospital's website which provided people who used the service with visual information relating to the procedure they were going to be having. This included a flexible sigmoidoscopy video clip which included information about bowel preparation, what the procedure involved and the patient journey.
- In addition to the video clips the hospital had a comprehensive and up-to-date website which clearly informed people who used the service about services available, what procedures involved, diagnostic costing, payment procedures, staff employed at the hospital and patient testimonials.
- Admission paperwork reflected that people understood their care and were involved in planning it. There were numerous patient pathways in place which showed that patients had been asked about their understanding of the procedure, and valid consent had been obtained, including discussion about risk and benefits of procedures.
- On discharge or following attendance at the hospital, there was a range of written information given to patients relating to their procedure or outpatient appointment. For example, if a gynaecology patient had made an informed choice to have a coil (contraceptive device) inserted then they were given detailed

information about the procedure and post insertion information. Furthermore, all clinical pathways for patients undergoing procedures had a section which reminded staff to confirm the patient's follow up appointment details and if applicable, when and how they would receive test results.
- Patients' relatives or those close to them were able to accompany them for consultation and diagnostic testing/procedures where appropriate.
- Staff told us that all people who used the service received information about who to contact and when, so that people knew who to contact if they were worried about their condition or treatment after leaving the hospital.

Emotional support

- We observed that staff were sympathetic and attentive to patients' needs. We saw one patient was very anxious about their procedure and that staff acted in a kind and supportive manner.
- As the hospital was a diagnostic centre, some people who used the service could receive bad news following their procedure. Senior managers told us that they were immensely proud of the cancer pathways that had developed. They informed us that they had worked closely with a nearby NHS trust to establish pathways for those patients who required transfer to the two week cancer pathway. This ensured that referral to the NHS organisation was prompt and seamless.
- In addition to this, patients were given comprehensive information via their consultant and clinical staff as to the next steps, including contact details of the applicable clinical nurse specialist at the NHS trust in relation to their diagnosis.

Are outpatients and diagnostic imaging services responsive?

Good

We rated the responsiveness of outpatients and diagnostics as good because:

- Services were planned and delivered to meet the needs of people who used the service. This included flexible hospital opening times dependent on service demand which demonstrated outstanding practice.
- Each area of the hospital had an environment that was appropriate and patient centred.
- People could access care and treatment in a timely way. Referral to treatment times (RTT) were outstanding with all patients receiving initial consultation or treatment within seven to 10 days.
- The flow of services within the hospital was seamless and people could access next day appointments if their referral was urgent.
- Care and treatment was tailored to meet the needs of different people. Interpreters were available as required, and there was extensive patient literature available in a variety of formats including video clips on the hospital website which were impressive.
- There was an effective complaints system in place with which staff were familiar. People's concerns and complaints were listened and responded to and used to improve service quality.

However, we also found that:

- Staff had not received training in learning disabilities or dementia, and there were no process in place for how patients with these conditions would be supported.

Service planning and delivery to meet the needs of local people

- The Chartwell Private Hospital provided outpatient and diagnostic imaging services to adults from aged 18 years. Outpatient and diagnostic imaging services were provided from three main departments in the hospital and were spread over three floors: the diagnostic imaging, outpatient clinic and endoscopy department.
- There was a limited amount of car parking spaces on site, which the hospital recognised as an issue during busier times. However, hospital managers had arranged alternative parking nearby for staff to free up spaces for people using the service. Staff told us that this arrangement had improved the issue.
- People who used the service received sufficient information in accessible formats before appointments. This included contact details, hospital map and directions, consultants' names and relevant information about the appointment or procedure including pre-procedure requirements. This information was also on the hospital's user-friendly website.

Access and flow

Requires improvement

Outpatients and diagnostic imaging

- People who used the service were either private patients, who self-funded or had private medical insurance cover, or NHS funded, and could access services via GP referral.
- Of the total number of people (3943) who accessed the service, 99.5% of inpatients and 72% of outpatients were NHS funded service users, during April 2015 to March 2016.
- Activity during April 2015 to March 2016 showed that 3943 people received care at the hospital during this period, of which 2248 were admissions for endoscopy procedures and 1695 were outpatient attendances.
- Records demonstrated that referral to treatment times (RTT) were outstanding. Of the patients seen 100% received an appointment for consultation or treatment within 7-10 days following referral. Next-day appointments could be arranged if the referral was urgent.
- There were exclusion criteria used to determine whether referrals were suitable for acceptance, which was decided by a consultant. This process ensured that patients accessed the most suitable service according to their individual need. For example if the patient was under 18 years or required a general anaesthetic, these referrals would be declined and the consultant would give advice to the referrer about an alternative and more suitable provider.
- People could access the service following the hospital's choose and book service or via direct contact.
- The hospital had extended its opening hours to the evenings during weekdays, and operated during the morning on a Saturday according to service demand. A hospital manager told us that this was due to an increased service demand during these times. This meant that hospital services were flexible and offered people choice of appointment.
- We saw that appointments ran on time and in reception people were kept informed of clinic and procedure running times by way of an up-to-date board.
- Staff told us that in the event of a patient receiving bad news in terms of diagnostics, the patient was given all the time they required to allow the patient to ask questions and be made aware of all the information they needed.
- Senior managers monitored cancellation rates of appointments and procedures. We saw that when appointments or procedures were cancelled, sufficient notice was given to minimise inconvenience to patients.
- Records confirmed that 158 procedures had been cancelled for non-clinical reasons in the last 12 months; of these 100% of patients were offered another appointment with 28 days of the cancelled appointment.
- Senior managers told us that the majority of cancellations related to endoscopy procedures, due to their decontamination unit (washer for endoscopies) breaking down. However, we saw that the provider was in process of undertaking building work to improve the endoscopy suite which included two more decontamination units, which would resolve this problem.

Meeting people's individual needs

- All referrals were triaged by a consultant and following this all patients were telephoned by a member of the hospital bookings team for an initial assessment. These assessments allowed individual needs of patients to be identified and services tailored accordingly.
- Staff confirmed that translation services were available and were arranged following initial assessment. The hospital's website also provided further information about translation services available for patients and those close to them.
- All areas of the hospital were accessible to people who were wheelchair users.
- One-hundred per cent of staff had either received, or were due to undertake in August 2015, training on equality and diversity. Staff had not received training on learning disabilities or dementia. Staff confirmed that patients living with a learning disability or dementia had accessed the service before.
- Staff gave us examples where the provider had arranged next-day appointments for patients requiring urgent consultation or procedure.
- Patient non-attendance to appointments was monitored and followed up appropriately. A senior manager gave us an example of multiple non-attendances which related to patients referred from one particular area. We saw that the hospital was taking appropriate action to resolve this issue with the other provider.
- Every department was clearly signposted and accessible via stairs and lift.

Learning from complaints and concerns

Requires improvement

Outpatients and diagnostic imaging

- The provider had a suitable complaints policy in place. Staff we spoke with were familiar with how to handle a complaint in line with this policy.
- A senior manager told us that all complaints were acknowledged in writing within two working days, and once the investigation was completed a full reply was sent within 20 working days to the complainant.
- Staff described the value of dealing with a person's concerns straight away before it developed into a more significant complaint, although they told us they would escalate the concern to a senior member of staff as needed.
- Information for people about how to make a complaint, raise concerns or compliment the service, was displayed where visitors would see it.
- The provider had received three complaints during March 2015 and April 2016, all of which had been resolved and not required referral to the ombudsman.
- We looked at all three of the complaint responses and found that concerns and complaints were regularly reviewed by senior managers, listened and responded to, and used to improve the quality of care.
- For example, one patient had complained about a lack of information on admission regarding sedation for the procedure carried out. Following the complaint the hospital policy for the procedure was amended and further information was given to patients.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated outpatients and diagnostic imaging services as requires improvement for well-led because:

- The hospital's governance framework did not ensure that quality performance and risks were understood and managed effectively. This was in in relation to a weak incident reporting system and a lack of quality measures in place.
- There was a lack of comprehensive assurance system and service performance measures, which were reported and monitored. For example, hospital managers confirmed that an indicator dashboard to measure service quality was not in use.

However, we also found:

- There was a clear service vision and strategy, which staff knew and adhered to.
- The hospital held regular hospital-wide meetings, which were well attended and minuted. Information from these meetings was disseminated to all staff.
- The culture of the service was immensely positive and staff felt valued, respected and well supported by their seniors.
- Patients and staff were encouraged to engage with the service through meetings and feedback forms.
- Where we raised concerns, hospital managers took appropriate action promptly and resolved the issue. This included ensuring that patient records were stored securely.

Vision and strategy for this this core service

- The provider had a documented "philosophy of care" which reflected the vision for the service. All staff we spoke with demonstrated that they upheld the principles of this philosophy.
- There was a robust, realistic strategy that the provider had set for delivering good quality care and achieving set priorities. Progress against the strategy was monitored and reviewed regularly by the board and senior managers.

Governance, risk management and quality measurement for this core service

- We found that the provider's governance framework was not robust. This was because there was a lack of incident reporting, the incident reporting policy was not up-to-date and staff gave us contradicting answers when we asked what the incident reporting process was at the hospital. We have reported on this further under the safe section of this report.
- There was, however, a risk register in place for the hospital which clearly identified risks with details of mitigating actions taken and who was responsible.
- There was a lack of comprehensive assurance system and service performance measures, which were reported and monitored. For example, hospital managers confirmed that an indicator dashboard to measure service quality was not in use.
- Staff were clear about their roles, understood what they were accountable for, and to whom they reported.
- In relation to complaints and audits that had been carried out, there were effective systems in place to identify, monitor and manage risk appropriately.

Requires improvement

Outpatients and diagnostic imaging

- The medical advisory committee (MAC) was responsible for granting new consultants practising privileges, and for monitoring current privileges.
- Where we identified concerns during our visit, or where the provider had known concerns, we found that managers took immediate action to resolve the issues. This included concerns we have reported on under the "safe" domain including emergency equipment not being checked regularly and patient notes not being kept securely.
- There was an audit programme which had been developed recently. However, the majority of audits had not been undertaken at the time of our inspection. Therefore the programme was in its infancy and we could not analyse results. We have reported on this further under the "effective" section of this report.

Leadership / culture of service

- The hospital was led by a managing director and hospital manager, and there were two division managers, one for scanning and another for medical services, and a clinical lead who was a consultant gastroenterologist. Each department had a team leader who was responsible for the daily running of their department, with support from divisional managers.
- There was a display board in reception with managers' names, roles and photos. This meant that leaders were easily identified by patients and visitors.
- The managing director visited the hospital site weekly and met with the hospital manager.
- All staff we spoke with told us that they felt well supported by their seniors, and that managers were accessible, approachable and friendly.
- Staff enjoyed working at the hospital and felt valued. One member of staff told us, "I love working here; we are a close-knit team which works extremely well together", another member of staff said, "Managers are really supportive here and it's a good place to work".
- There were regular hospital-wide team meetings, which were minuted and disseminated to all staff. Staff we spoke with were able to give us examples of what they had learnt from recent meetings.
- When we spoke with senior staff and managers there was a clear alignment between the recorded risk and what these members of staff told us was on their "worry list". These members of staff also recognised that that action was already being taken to address these concerns. This included the endoscopy suite being too small for purpose.
- Staff said they would raise concerns with managers if necessary, in line with the hospital's whistleblowing policy and they felt that they would be listened to.
- Across the hospital there was a positive ethos and staff were proud of the service they offered people. Staff respected one another and worked well together.

Public and staff engagement

- We were informed that regular hospital-wide team meetings took place, which presented an opportunity for staff to engage with the service.
- Staff told us that they were involved in the plans for refurbishment of new departments, including the recently new scanning department and the endoscopy suite, which was being refurbished during our visit.
- Patient feedback forms were given to all people who used the service, and records showed that feedback was monitored and used to improve service quality where possible.

Innovation, improvement and sustainability

- The majority of staff employed by the service worked on a flexible bank contact which allowed for more flexible hospital staffing which in turn meant services could be staff according to demand.
- On the hospital website there were comprehensive and effective patient information video clips about procedures carried out at the hospital. This demonstrated outstanding practice.

Outstanding practice and areas for improvement

Outstanding practice

- Referral to treatment times (RTT) were outstanding.
- Multidisciplinary team working both within the hospital and externally was effective in helping maximise patient outcomes and experience and demonstrated outstanding practice.
- Flexible hospital opening times dependent on service demand demonstrated outstanding practice.

Areas for improvement

Action the provider MUST take to improve

- Must ensure that there are effective systems and processes in place to report, analyse and learn from incidents.
- Must have robust arrangements for assessing and monitoring a patient's clinical condition for signs of deterioration.
- Must ensure that policies and procedures are reviewed regularly.

Action the provider SHOULD take to improve

- Should consider arranging regular audits and improve safe management of medicines.
- Should consider providing training to staff on learning disability and dementia.
- Should consider introducing a system so that service quality and safety can be measured.
- Should monitor and record fridge temperatures to ensure that integrity of medicines.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 - Safe care and treatment** 12(1) and (2)(a) The provider is not assessing the risks to the health and safety of service users of receiving the care or treatment because there is no robust way of monitoring a patient's clinical condition for deterioration 12 (2)(b) The provider is not doing all that is reasonably practicable to mitigate any such risks because policies and procedures are not all up to date and incidents are not being effectively reported or learned from.