Chartwell Private Hospital and Diagnostics Limited

Chartwell Hospital

Inspection report

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Date of inspection visit: 01 March 2022 10 March 2022
Date of publication: 06/05/2022

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

This was the first time the hospital had been inspected at individual core service level.

We rated it as requires improvement because:

- We rated three of the hospital's core services as requires improvement. We rated the hospital as requires improvement for safe and inadequate for being well-led.
- The service did not control infection risk well.
- The service did not store all medicines safely.
- Staff did not always follow guidance when completing the surgical safety checklist.
- The provider did not manage safety incidents well and did not share learned lessons from them.
- The provider did not make sure that all medical staff had completed mandatory training.
- Staff did not always record that patients had consented for their care.
- The service's governance structure did not ensure performance and risks were managed effectively.
- Staff did not always feel respected, supported and valued.
- Staff were not always clear about their roles and accountabilities.
- The provider did not have a clear vision and strategy.
- The provider did not have effective assurance system in to monitor referrals to the GMC by other organisations for consultants working under practicing privileges.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Requires Improvement 	This was the first time the service had been inspected at individual core service level. We rated it as requires improvement because: • The service had not made sure that all medical staff had received mandatory training. They did not effectively assess all risks to patients as surgical safety checklists were not always completed in line with guidance. • The service did not ensure that all medicines were stored correctly which could impact on the medication's effectiveness. • The service did not ensure that incidents were managed well and lessons learned were shared. • Staff did not always follow the most up to date guidance to provide evidence based care and treatment. • Managers did not always monitor the effectiveness of the service and make sure staff were competent for their roles. • The service did not have a strategy with a credible plan of actions to achieve a vision. • Leaders did not operate effective governance processes and risks were not managed well. However: • The service had enough staff to care for patients and keep them safe. Nursing staff had training in key skills, understood how to protect patients from abuse. The service controlled infection risk well. Staff kept good care records. • Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Staff worked well together for the benefit of patients. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients'

Summary of findings

individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Outpatients

Requires Improvement

This was the first time the service had been inspected at individual core service level. We rated it as requires improvement because:

- Leaders had not ensured that the environment was safe for patients and staff.
- The service did not manage safety incidents well and ensure they shared learned lessons from them.
- The service did not always control infection risk well, including clinical waste.
- Managers did not monitor the effectiveness of the service.
- Leaders did not run services well using reliable information systems and did not support staff to develop their skills.
- Staff did not understand the service's vision and values, and how to apply them in their work.

However:

- The service had enough staff to care for patients and keep them safe. Nursing staff had training in key skills and understood how to protect patients from abuse. Staff assessed risks to patients, acted on them and kept good care records.
- Staff worked well together for the benefit of patients and supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Outpatients is a small proportion of hospital activity. The main service was endoscopy reported under Medical care. Where arrangements were the same, we have reported findings in the Medical care section.

Diagnostic imaging

Requires Improvement

This was the first time the service had been inspected at individual core service level.
We rated it as requires improvement because:

- The service did not control infection risk well.
- The service did not manage safety incidents well.
- The service did not have a robust audit programme to monitor the effectiveness of the service.
- Staff did not always feel respected, supported and valued.
- Staff were not always clear about their roles and accountabilities.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse. Staff assessed risks to patients, acted on them and kept good care records.
- Managers made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity,

Summary of findings

took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Staff were focused on the needs of patients receiving care.

Summary of findings

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Summary of this inspection

Background to Chartwell 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.

Chartwell Private Hospital is an independently run Diagnostic and Treatment Centre.

The Hospital offers

- Outpatient consulting rooms with phlebotomy facilities on the ground floor
- An endoscopy unit covering diagnostic scopes of all types, including colonoscopy and sigmoidoscopy.
- A diagnostics suite is situated in the basement comprising:

Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) scanning, Ultrasound Scanning, and X-ray. At the time of our inspection the service was only providing an MRI service.

The hospital centre offered services 7 days a week. They provided services for both NHS and private referrals for adults over the age of 18.

The diagnostic imaging department performs 500-600 MRI scans per month. 60% are for the NHS and 40% private referrals. The endoscopy department performs 200-300 procedures per month. 95% are for the NHS and 5% private referrals.

The hospital had a registered manager in post and was registered for diagnostic and screening procedures and treatment of disease, disorder or injury.

The hospital was previously inspected in July 2016 when outpatients and diagnostic imaging were inspected as one core service. The inspection resulted in Regulation 12- safe care and treatment requirement notices.

This was the first time the hospital had been inspected at individual core service level.

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

How we carried out this inspection

We carried out an unannounced inspection visit on 1 March 2022 and a follow up unannounced inspection on 10 March 2022. During the inspection we visited all areas of the hospital and spoke with members of staff including the registered manager, registered nurses (RGN), radiographers and support staff. We also reviewed 20 healthcare records for people who used the service and analysed data provided during and after the inspection. We observed how staff interacted with people and we offered people the chance to speak with us regarding their experience. We reviewed the written feedback they provided to the hospital.

Summary of this inspection

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

Areas for improvement

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

Action the hospital MUST take to improve:

Hospital wide:

- The provider must ensure patient safety checks are completed in line with guidance. Regulation 12(1)(2)(a)
- The provider must ensure that all medical staff have received mandatory training. Regulation 12(1)(2)(c)
- The provider must ensure that there are effective systems in process to monitor and audit the quality of the service. Regulation 17(1)(2)(a)(b)(f).
- The provider must ensure that incidents are recorded and thoroughly investigated to minimise the risk of reoccurrence and identify opportunities for learning. Regulation 17(1)(2)(a)(b)
- The provider must ensure there are effective systems and processes in place to manage risk. Regulation 17(1)(b)
- The provider must ensure they have a vision for what they want to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Regulation 17(1)(e)
- The provider must ensure all medicines including medical gases are stored safely. Regulation 12 (1)(2)(g)
- The provider must ensure that the World Health Organisation (WHO) checklist (or equivalent surgical safety checklist) is used correctly and processes in place to monitor compliance. Regulation 12(1)(2)(a)(b)
- The provider must ensure that there are effective assurance processes in place to manage referrals from external organisations, for example, from the general medical council (GMC). Regulation 17 (1)(2).

Action the hospital SHOULD take to improve:

- The service should ensure clinical areas have effective infection prevention and control processes in place. (Regulation 12)
- The service should ensure the design, including flooring and skirting in, clinical areas comply to national guidance following refurbishment. (Regulation 15)
- The service should ensure they review policies and guidance on a regular basis to ensure they are using the most up to date guidance. (Regulation 12)
- The service should ensure they conduct hand hygiene audits. (Regulation 12)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Inspected but not rated	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement
Diagnostic imaging	Requires Improvement	Inspected but not rated	Good	Good	Inadequate	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Inadequate	Requires Improvement

Requires Improvement

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Requires Improvement

This was the first time the service had been inspected at individual core service level.

We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to nursing staff and made sure they completed it. However, medical staff mandatory training was not completed.

Nursing staff received and kept up-to-date with their mandatory training. Staff completed online mandatory training and the hospital dashboard showed that all nursing staff (100%) were up to date with training requirements.

The mandatory training was comprehensive and met the needs of patients and staff. The training included safeguarding, manual handling, information governance, fire safety, medication awareness, mental health and disability awareness, dementia, health and safety, incident reporting, control of substances hazardous to health (COSHH) regulation, infection control and equality and diversity.

Training was provided by an external company and completed annually or as in line with guidance. This included face to face and online e-learning courses. For example, basic adult and paediatric life support was completed annually and equality, diversity and inclusion training were completed every two years.

Managers monitored mandatory training and alerted staff when they needed to update their training. The hospital dashboard used a traffic light system to identify when training was due and expired.

Doctors working under practicing privileges arrangements completed mandatory training at their NHS Trust, however not all records were up to date. Our review of records demonstrated that 40% of consultants working at the hospital had evidence of completed mandatory training.

Requires Improvement

Medical care (Including older people's care)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the safeguarding lead was not trained to the appropriate level.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff completed online training on safeguarding adults and children level 2 as part of their mandatory training. The hospital dashboard showed that all nursing staff were up to date with safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with told us they would contact the safeguarding lead nurse and registered manager if they had safeguarding concerns.

The service made sure new starters completed Disclosure and Barring Service (DBS) checks before they started in role. When necessary managers allowed staff to work while waiting for the result of the DBS and completed a risk assessment where supervision was a condition of approval.

The service had a newly appointed safeguarding lead, but they were not yet trained to safeguarding level 3, which was not in line with guidance. We told the registered manager and when we re-inspected on 10 March 2022, we found that the safeguarding lead and registered manager had completed safeguarding level 3 training.

Staff completed equality, diversity and inclusion training and could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff training compliance was 100%. However, the service did not provide Prevent (safeguarding against radicalisation) training.

The service did not offer appointments to patients under the age of 18 years. The service did not have facilities for children accompanying adults.

Cleanliness, infection control and hygiene

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

The environment and equipment were visibly clean. Staff cleaned equipment after patient contact. We saw a daily checklist which included cleaning of equipment in patient contact, resuscitation trolley, linen cupboard, coffee machine and admission and recovery couches and chairs. The recovery bay underwent a deep clean twice a week.

Staff followed infection control principles including the use of personal protective equipment (PPE). The unit provided staff with PPE such as gloves, aprons and face masks. We observed staff wearing PPE.

The service had a policy of testing patients for COVID-19 using polymerase chain reaction (PCR) tests 72 hours prior to their appointment and requiring them to isolate following this. PCR test results were checked prior to the appointment and if negative, the procedure could go ahead. All patients were phoned seven days after their procedures to check they had not developed symptoms of COVID-19. There had not been any COVID-19 positive patients identified following their procedures. This had been audited throughout the year and a 100% rate of no infection was achieved.

The service had an endoscope decontamination policy which defined the roles and responsibilities of staff for decontamination.

Requires Improvement

Medical care (Including older people's care)

The service used an independent authorising engineer in decontamination to advise and audit the endoscope washer disinfectors and to review and witness documentation on validation of this equipment.

Endoscopes were kept in a moist environment until reprocessed in a washer disinfector in line with the provider's process.

The service had processes in place for water and protein testing. We saw evidence of weekly water testing in line with guidelines Health Technical Memorandum (HTM 01.06).

We saw an infection control audit with action log dated May 2021.

We saw external cleaning company monthly cleaning audits from November 2021 to January 2022 which identified areas requiring improvement.

Hand washing facilities were available in clinical areas. Reception staff ensured patients and visitors used sanitising gel on arrival. However, the service did not conduct hand hygiene audits to ensure that staff were following guidelines.

The service did not dispose of clinical waste waiting to be collected safely. The chemical waste bins were stored in an unsecure compound next to the building and general waste bins were stored outside the compound.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patients. There was a waiting room and admission room on the ground floor, a patient changing room and toilet, one procedure room and a two bay recovery room on the first floor. There were lifts to the first floor. There was a drinks machine in the recovery room.

Doors to clinical and decontamination areas were not secured with locks, however there were 'staff only' signs on these doors.

The service had a preventative maintenance and service schedule for endoscope decontamination equipment, however the schedule displayed in the decontamination room was the 2021 schedule. This had been changed to the 2022 schedule by our second unannounced visit and we saw the preventative maintenance had been carried out on the endoscope washer disinfectors in January 2022.

The service used a tracking and tracing system that recorded each stage of the decontamination process for each endoscope, the person responsible and the patient involved. This meant the decontamination process, specific procedure and patient were logged to each endoscope.

The service had a decontamination unit. This unit had separate dirty and clean rooms for endoscope decontamination and storage and there was flow of dirty to clean instrumentation within the decontamination area to minimise cross contamination during the decontamination process. We saw that staff used a daily checklist for decontamination equipment.

Decontamination staff had attended manufacturer decontamination training courses.

There was protective equipment available to staff working within decontamination. We saw that staff were wearing this during our inspection.

Resuscitation equipment was readily available and stored in a purpose-built trolley and was visibly clean. Single-use items were sealed and in date. Staff completed a daily check of resuscitation trolley equipment to confirm it was ready for use.

Electrical equipment was tested by an external contractor. We checked the test dates for medical equipment in patient areas and found them to be within their test dates. We saw a current annual safety test and inspection and annual preventative maintenance agreement with the external contractor for medical equipment.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. However, they did not always follow processes to minimise risks. Staff had some processes to identify and quickly act upon patients at risk of deterioration.

The service had risk assessment processes in place. An exclusion criteria was used to help ensure the service treated patients who were suitable for the level of care available and that the service did not admit patients who may require a higher level of care than could be provided.

Booking staff completed an assessment form when patients were referred for procedures. This process checked the exclusion criteria and identified any conditions requiring further assessment by clinical staff, such as the management of patients on anticoagulants. Endoscopy nurses reviewed these and escalated queries to the endoscopists. However, we saw that the anticoagulant sections were not always fully completed. The service had an anticoagulants policy and flowchart, however this was based on the 2016 guidance, not the latest 2021 update to the British Society of Gastroenterology endoscopy in patients on antiplatelet and anticoagulant therapy guidelines.

Staff used a nationally recognised tool called NEWS2 to monitor patients and identify deteriorating patients. The service did have a deteriorating patient policy which included early warning score guidance. The service had an 'Emergency Transfer of Patients policy' and a 'Resuscitation policy'. Healthcare assistants (HCA) were trained to basic life support, nursing staff were trained to immediate life support and endoscopists to advanced life support level. Nursing staff completed an admission process with patients before the procedure which involved checking information and measuring vital signs to check that patients were suitable to proceed as planned and used red wrist bands for allergies.

Staff had a daily meeting to discuss staff endoscopy roles and roles in the event of an emergency, review scope numbers and to identify potential problems and information to be handed over to the team.

The service used an adapted endoscopy safety checklist as a World Health Organisation (WHO) surgical safety checklist before each procedure. However, we saw that not all staff involved in the procedure stopped what they were doing and listened to this checklist in line with WHO checklist requirements.

The service did not have specific policies covering complications such as Gastro-Intestinal (GI) bleeding and perforation (which is a potential risk in some endoscopic procedures). It did not have a major haemorrhage protocol. However, there were systems in place to manage bleeding complications such as diathermy and clips.

The service had arrangements in place for the prompt escalation of significant findings at endoscopy that required urgent attention. Staff would contact the relevant person at the NHS hospital to make a referral on the same day.

Requires Improvement

Medical care (Including older people's care)

Patients having sedation for their procedure were required to have an escort for the journey home and were given advice about the effects of sedation. There was a lift to the endoscopy suite which meant sedated patients did not have to use stairs and they were escorted by staff in the lift.

The service does not provide out of hours endoscopy cover for emergencies, and patients experiencing complications after their procedure are advised to seek treatment at NHS hospitals.

Nurse staffing

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

There were three permanent members of nursing staff, three permanent HCAs and one permanent clinical assistant. The HCAs were also responsible for carrying out endoscope decontamination. The service also had four regular bank staff, who were familiar with the service. The service did not use agency staff. At inspection the service was staffed by two nurses in the endoscopy procedure room, a nurse and clinical assistant in recovery and a nurse for the patient admission process. This was appropriate staffing for the planned activity.

Bank staff were required to complete an induction process, clinical competencies and mandatory training. We saw records showing bank staff had completed competencies and mandatory training. Bank staff we spoke with told us they had completed an induction programme; however, the service kept no record of this.

At the time of our inspection, the service was actively recruiting to three nursing vacancies. Staff shortage was discussed at the endoscopy meeting minutes in February 2022. This was also reflected in the staff survey, where staff said there were not enough nursing staff.

Rotas were made available to staff via a Whatsapp group and posted on the staff room noticeboard.

Medical staffing

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

The hospital had 10 consultants who worked at the hospital under practicing privileges. In endoscopy, there were four consultant gastroenterologists performing endoscopies.

The senior management team meeting minutes from February 2022 demonstrated that the service was reviewing the endoscopy medical staffing levels. This was in order to plan to meet the requirements of the local population.

Endoscopists had set days when they completed procedure lists. If these lists were cancelled, some of the endoscopists would rearrange the list for the following Saturday.

Records

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

Records at the main hospital location were stored securely. Staff stored patient records in lockable cupboards behind reception. The reception lead had introduced a checklist which prompted staff to ensure confidential information was locked away.

The bookings staff prepared comprehensive notes for patients due to attend endoscopy, and staff could access them easily. Records comprised GP referral letter, completed telephone pre-operative assessment and care pathway paperwork to be completed on the day of procedure.

There was a process in place to identify patients with pre-existing mental health conditions and learning disabilities. The bookings team reviewed referrals prior to performing the telephone pre-operative assessment to identify patients who may need additional support. These patients were referred to the endoscopy nurses who completed the telephone pre-operative assessment themselves prior to admitting on the day of procedure to ensure continuity of care.

When patients transferred to a new team, there were no delays in staff accessing their records. On the day of procedure reception staff gave endoscopy nurses the patient notes, endoscopy list and histology book. After the procedure the reception staff scanned the paper notes on to an electronic patient record and shredded the hard copy.

The service provided the patient and the referring doctor with a copy of the endoscopy report.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines; however, they were not always stored correctly.

The service did not always store and monitor medicines safely. On inspection we observed prescription bowel preparation medicines stored in boxes on the floor of an unlocked room. The room was not temperature controlled. Medicines should be stored under conditions that assure their quality and stored within the manufacturer's recommended temperature range.

The royal pharmaceutical society of Great Britain guidance states cupboards or rooms in which medicines are stored are lockable and locked when not being accessed.

Controlled drugs used for sedation and pain relief during endoscopy were kept in a separate locked cabinet, and the key to this cabinet was locked away.

Staff kept a controlled medicines register of controlled medicine usage with the medicine dose supplied, administered and discarded, patient used for and signatures of the endoscopist and witness in line with legal requirements for controlled medicines.

Staff kept a checklist of endoscopy medicines expiry dates. Nursing staff from endoscopy would sign out medication from endoscopy when required. For example, when the orthopaedic consultant required a steroid for injecting into joints.

The service used medical gases, stored externally with separation of empty and full cylinders and secured by a lockable metal door. There were insufficient chains to safely secure stored cylinders and prevent risk of injury to staff. All medical gases were within expiry date.

The service had a service level agreement with a local NHS Trust for drugs supply, medicines information and advice and medicines management audits.

Requires Improvement

Medical care (Including older people's care)

Controlled drugs were externally audited by a pharmacist from a local NHS Trust.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers did not always investigate incidents fully and share lessons learned with the whole team and the wider service. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

The service had an incident policy and staff we spoke with knew how to report incidents in line with this policy.

The service did not have a clear process for managing incidents and ensuring lessons were learned. The hospital had an electronic incident reporting system and an incident log. The registered manager signed off all incident investigations before they were recorded electronically on the cloud-based incident management system. Our review of incidents demonstrated that they were not always investigated thoroughly to determine the root cause factors. This meant that there may have been missed opportunities for learning and making improvements.

Our review of the incident log demonstrated that there were 16 incidents reported from January to December 2021. There were no incidents reported for endoscopy in the 2022 incident log. We also saw that incidents and resulting actions were also reported on a risk register.

Staff we spoke with reported there had been one serious incident in endoscopy and that actions were taken, changes were made and learning distributed as a result of the incident. This incident occurred on 27 February 2020 and appeared on the risk register but not on an incident log. This meant we could not be sure that all incidents were being recorded and monitored consistently and systematically to identify risks and areas for learning.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. The service did not have regular team meetings or other systematic process to share learning.

Staff understood the duty of candour. They were aware of the requirement to be open and transparent and give patients and families a full explanation when things went wrong.

Are Medical care (Including older people's care) effective?

Inspected but not rated

We do not rate the effectiveness of endoscopy services; however, we found the following during our inspection.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance.

Staff could access policies and procedures electronically. Staff we spoke with knew where to find policies and procedures.

Requires Improvement

Medical care (Including older people's care)

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The Sedation in Endoscopy guidance had an expiry date of October 2021 and referenced guidelines which were significantly out of date and had been updated more than once since then. The anticoagulant policy had not been updated with the latest guidance.

At the time of our inspection, the hospital did not have a comprehensive audit programme to monitor performance or compliance to standards. Some audits were conducted in endoscopy. We saw a schedule of endoscopy audits for 2021 and 2022. For 2021, not all audits were showing as complete on the schedule. We did not see comprehensive results of these audits so we could not be sure what compliance with the standards was. After our inspection the provider told us that they had implemented a new audit plan in January 2022 which included consent and cancellations and identified re-audits.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before a procedure were not without food for long periods. Staff gave patients enough food and drink to meet their needs.

Patients were given fasting instructions before their appointment so they could arrive suitably fasted for their procedure. Fasting times were checked during the admission process on the day of the procedure to make sure it was safe to proceed.

After procedures patients were offered a choice of drinks and snacks in recovery.

Patients with diabetes were identified during the pre-assessment process prior to booking their appointment. The service did not offer appointments to insulin dependent diabetic patients as this was part of the exclusion criteria. It was procedure to book non-insulin dependent diabetic patients on to a morning list.

Pain relief

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

Staff assessed patients' pain using an adapted numeric pain scale, for example 0 for none, and 3 for severe, during the procedure and documented this and the actions taken. The discharge checklist completed by recovery staff included a check for pain and discomfort, however recovery staff told us that patients rarely required any pain relief in recovery.

Staff prescribed, administered and recorded pain relief accurately. Pain relief was available during the procedure and staff recorded the administration of pain relief on a medicines administration chart.

Sedation was available and staff worked with patients to identify whether patients wanted sedation or not, and if so, which type was most appropriate for the patient and the procedure.

The admission process included a check for nitrous oxide (mixture of nitrous oxide and oxygen breathed in for pain relief) gas contraindications which the service required patients to read and understand and sign to confirm this.

The colonoscopy discharge information contained advice on management of discomfort from trapped air.

Requires Improvement

Medical care (Including older people's care)

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They did not always use findings to make improvements and achieve good outcomes for patients. However, the service had been accredited under the Joint Advisory Group (JAG) on GI endoscopy accreditation scheme.

Managers and staff carried out a limited programme of audits to improve care and treatment. The hospital did not conduct a comprehensive programme of repeated audits to check improvements over time.

The service collected data for individual endoscopist scores for the Global Rating Scale (GRS) quality improvement tool. The GRS data was linked to the National Endoscopy Database so performance could be reviewed externally. However, there was no evidence of processes in place for the periodic review or appraisal of individual endoscopist GRS scores, so we could not be sure that consistent standards of care were being monitored. The 2022 audit schedule showed that an annual GRS audit was planned.

Patients were advised of complications requiring medical attention on the discharge information and requested to let the service know if they experienced any complications after their procedure or if they required admission to hospital. Staff routinely called patients seven days after their procedure but staff told us they would call patients sooner than this if they were concerned about them. Staff told us the number of patients needing NHS admission and deaths within a month of endoscopy would be reported at the medical advisory committee (MAC) meeting but was not audited. This meant we could not be assured that the service had robust systems in place to monitor and act upon mortality and readmission resulting from procedures.

The service achieved Joint Advisory Group (JAG) accreditation in September 2021 and will be required to maintain accreditation annually. JAG accreditation is a patient-centred and workforce-focused scheme based on principles of independent assessment against recognised standards and is a formal recognition that a gastrointestinal endoscopy service has demonstrated competence to deliver against criteria set out in the JAG standards.

The patients we spoke with during inspection gave positive feedback on the service. After our inspection the provider told us, in February 2022, 620 patients provided feedback with a 98% satisfaction rate.

The service provided patients with the results of their procedure immediately afterwards, which meant patients could review their treatment options with their referring doctor at their next appointment. For pathology results, the service provided information on when patients could expect these.

The service had arrangements in place for the prompt escalation of significant findings at endoscopy that required urgent attention. Staff would contact the relevant person at the NHS hospital to make a referral on the same day.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them but did not always provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All health care staff were registered with their appropriate professional bodies.

The service had a policy for granting and reviewing practising privileges. However, the service did not always ensure it received evidence annually from doctors about appraisals, professional registrations and medical indemnity as part of their practising privileges.

Requires Improvement

Medical care (Including older people's care)

Data for the GRS monitored information on individual endoscopist performance.

Managers had access to a grievance and dispute policy and human resources team at the provider head office to support them with the management of poor performance.

The service required that nursing staff completed a programme of clinical competencies based on their role and responsibilities.

Decontamination staff underwent manufacturer training in use of decontamination equipment.

Control of substances hazardous to health (COSHH) training was part of the mandatory training programme.

Nursing staff said they received an induction, however we did not see evidence of what was included in the induction process. Bank staff told us they received an induction, mandatory training and competencies training. However, there was no record kept of bank staff's inductions.

We saw evidence of annual appraisals for permanent nursing staff, however bank staff did not receive appraisals. The staff survey showed that some staff did not always have enough time to prepare for their appraisal.

Staff survey results showed that staff did not always feel their suggestions and ideas were discussed and acted upon

Nursing staff we spoke with reported that they attended monthly team meetings.

Multidisciplinary working

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. There was a daily team meeting to discuss the list, patient's needs, equipment and staff roles.

Staff worked across health care disciplines and with other agencies when required to care for patients. A copy of the endoscopy report was sent to the patient's GP and the referring doctor (if different from the GP). The service had an arrangement in place for pharmacy and pathology services with the local NHS Trust and for referrals requiring urgent attention.

Seven-day services

The service was not available seven days a week but a number of out of hours appointments were available.

The endoscopy service ran from 8am to 6pm Monday to Friday. There were sometimes lists on Saturdays which ran from 8am to 4.30pm.

We did not see evidence of a formal triage system for referrals, however staff told us that urgent referrals would be offered an appointment as soon as possible.

Health promotion

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

Requires Improvement

Medical care (Including older people's care)

The service had information in recovery for conditions relevant to endoscopy which it supplied to patients at discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always evidence that they supported patients to make informed decisions about their care and treatment. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff also received training on mental health and disability awareness and dementia as part of their mandatory training. Staff we spoke with said that for patients they felt may lack capacity, they would escalate this to someone more senior and would not carry out a formal capacity assessment themselves. Therefore, we did not receive assurance that all staff we spoke with understood how and when to assess patient capacity to make decisions about their care and how to document this.

We observed the consent process for endoscopy procedures. Staff gained consent from patients for their procedure in line with legislation and guidance. Staff recorded consent in the patients' records on dedicated consent forms. However, some of the documentation on consent forms we looked at in patient records was incomplete, with endoscopists not always documenting all risks associated with the procedure on the consent form and some patient signatures not dated. This meant that we could not be sure that all risks had been fully explained to patients in these cases.

Staff explained that for patients who are unable to consent to investigation or treatment, it was procedure to require a specific consent form for adults who are unable to consent to investigation or treatment to be completed by the patient's GP on the basis that the GP knew the patient better than the service.

Are Medical care (Including older people's care) caring?

Good

This was the first time the service had been inspected at individual core service level.

We rated it as good.

Compassionate care

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

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

Patients we spoke with gave positive feedback about the care they received. The results of the 2021 patient satisfaction survey showed that the service consistently scored highly on the helpfulness and efficiency of staff, monitoring comfort, maintaining privacy and dignity, overall satisfaction and willingness to recommend the service to others. The results of the 2022 patient satisfaction surveys so far continue to score highly in these areas.

Requires Improvement

Medical care (Including older people's care)

Emotional support

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

Staff understood the anxiety and distress associated with the procedure and supported patients through this. We looked at patient satisfaction survey comments from the last three months and found numerous references to staff helping to make patients feel more relaxed and at ease.

The service had a process for discussions with patients who had significant findings that required urgent attention, which involved support from staff and those close to the patient.

Understanding and involvement of patients and those close to them

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

Staff talked with patients in a way they could understand. Patients we spoke with felt the explanations given enabled them to understand the procedure and that they had time to ask questions. The service also had a translation service for non-English speaking patients.

Patients were advised about the different options of sedation they could decide on before the procedure.

Patients were given a discharge information sheet with advice about the procedure they had, sedation, what to expect and when to seek advice.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed that patients were given a feedback form to complete after their procedure.

Patients gave positive feedback about the service. The 2021 patient satisfaction survey showed that the service consistently scored highly for the question of were you informed of what the procedure involved and any possible complications.

Are Medical care (Including older people's care) responsive?

Good

This was the first time the service had been inspected at individual core service level.

We rated it as good.

Service planning and delivery to meet the needs of the local people

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

Facilities and premises were appropriate for the services being delivered.

Requires Improvement

Medical care (Including older people's care)

The service was open five days a week and provided elective endoscopy procedures by appointment only. There were out of hours appointments available during the day on some Saturdays.

Appointments were arranged on the telephone. At booking patients were assessed for individual requirements such as an interpreter, hearing aid support such as an induction loop facility and whether they have any visual impairment. Patients were also informed of their appointment by letter and sent a text reminder.

GP's could make urgent referrals to the service and the provider told us these would be prioritised.

The service booked appointments so that morning and afternoon lists were of one gender only to avoid mixed sex care.

The service provided information and instructions for the procedure before appointments. This was both paper-based and electronic by email. Booking staff told us they would also call patients five days before their appointment to check that they had received the information they needed.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

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

There was a comfortable seating area and disabled toilet facilities for patients and visitors.

Wheelchair access was available and there were lifts to the first floor where the endoscopy procedure room was located.

Managers made sure staff, and patients, could get help from interpreters when needed. A hearing loop was available to assist patients wearing a hearing aid.

Access and flow

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

The service provided elective endoscopic procedures. Patients were offered a choice of appointment times and could telephone the hospital to rearrange this if not convenient.

Managers monitored patients who 'did not attend' DNAs and cancellations with quarterly audits. It was policy for patients who DNA to be offered a second appointment.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. It was policy for the service to operate within the national waiting list times target of 6-week RTT diagnostic target times and data showed that this target was being met.

Endoscopy reports were given to the patient after their procedure. Urgent referrals to other services for findings requiring urgent attention were made on the same day.

Requires Improvement

Medical care (Including older people's care)

The service had an arrangement with the local NHS Trust pathology services for assessment and reporting of pathology samples.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, but did not always investigate them fully and share lessons learned with all staff. The service included patients in the investigation of their complaint.

The service had a complaints policy and clearly displayed information about how to make a complaint in patient areas. Staff we spoke with were able to explain to patients how to make a complaint.

The service monitored complaints on a complaints register. However, we did not see robust evidence that these were fully investigated and that feedback from complaints was shared and learning was achieved to improve patient experience.

Are Medical care (Including older people's care) well-led?

Requires Improvement

This was the first time the service had been inspected at individual core service level

We rated it as requires improvement.

Leadership

Leaders did not all understand and manage the priorities and issues the service faced. They were not visible and approachable in all areas of the service for patients and staff. They did not support all staff to develop their skills.

The registered manager was supported by an operations manager, an endoscopy lead nurse and non-clinical imaging lead and maintenance engineer. The reception lead and administrative staff reported to the operations manager. The outpatient service was informally managed by the endoscopy lead nurse and a health care assistant (HCA). The lead endoscopy consultant engaged under practicing privileges arrangements was the clinical governance lead

The senior management team did not meet as frequently as planned and issues raised during meetings were left unresolved for several months (please see Governance section for more detail).

We requested an interview with the endoscopy clinical lead, however we did not have the opportunity to speak with them either during or following the inspection. This meant we were not able to assess the clinical leadership of the endoscopy service and how they assessed the performance of individual endoscopists.

Leaders did not hold meetings for staff and staff told us that their views were not always heard and acted upon. We told the leadership team and when we re-inspected on 10 March 2022 team meetings across all departments had been introduced, but these were not embedded.

The registered manager was not always visible in all departments for staff and patients.

Requires Improvement

Medical care (Including older people's care)

Staff told us they did not see senior leaders such as the board of directors and owner, so they were unsure if their voices or feedback was heard at that level.

Leaders did not always support staff to develop their skills and take on new roles.

Staff told us that local leaders did not always act upon concerns raised, however they were supportive and staff felt comfortable approaching any of the managers with concerns.

There was a clear management structure. Managers described a flat management structure to enable whole team involvement. Staff across services worked together to provide good care for patient's and a supportive environment for their colleagues.

Leaders were passionate about the service and worked well with staff to deliver good outcomes for patients despite the poor working environment.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff were therefore unable to apply actions and monitor progress.

The hospital did not have a clear vision for what it wanted to achieve.

The registered manager and service leads all told us that they wanted to improve the existing environmental standards and patient experience but had no clear strategy to do so.

The hospital had a set of values, but leaders and staff could not tell us what the values were.

Culture

Staff felt supported and valued by local leaders and the service had an open culture where patients, their families and staff could raise concerns without fear. Staff were focused on the needs of patients receiving care. However, the service did not always provide opportunities for career development.

Staff we spoke to told us that they loved working at the hospital and felt like a family. Staff talked about not wanting to work anywhere else, because they enjoyed helping patients and appreciated their colleagues. They told us they felt supported by the hospital local senior leadership but did not always feel valued by the owner and board of directors as they did not see them or receive feedback about concerns.

Staff were focused on the needs of patients; this was evident from the positive patient feedback. However, staff were frustrated with the lack of action taken by the senior leaders to improve the environment following water damage in April 2021.

Staff development was inconsistent. Staff in some services told us that they were supported to develop, whereas other staff reported no development opportunities.

The senior leadership team appreciated staff commitment through the COVID-19 pandemic and immediately following the water damage in April 2021, where they reported staff were flexible and committed to supporting the clean-up operation.

Requires Improvement

Medical care (Including older people's care)

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not all have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate effective governance processes and systems of accountability to support the delivery of good quality service and high standards of care.

The hospital did not have effective data collection processes to provide the management team with service level assurance. Managers did not audit staff compliance against process and policy in outpatients, administration and diagnostic imaging. We told managers and when we re-inspected on 10 March 2022 managers had created an audit programme to include all services. However, this had not commenced and was not embedded.

The hospital service had committees which included the clinical governance committee (CGC), health & safety committee (H&S) and medical advisory committee (MAC) as well as an endoscopy user group (EUG), however meetings were not held at the agreed frequently.

The registered manager told us the hospital held two-monthly (every two months) CGC and EUG meetings and monthly H&S meetings. We reviewed the last three meeting minutes and found large gaps between meetings. For example, the most recent EUG meeting was 29 July 2021 and there had been a seven month gap between the last two CGC and H&S meetings.

The registered manager told us the hospital held three-monthly (quarterly) medical advisory committee meetings (MAC). The most recent was 29 Sept 2021 and there was a six month gap between the previous meeting.

Meeting minutes lacked detail of incidents, complaints and audit and did not give managers and staff the ability to learn from the service performance.

Meetings were not effective, because managers did not take accountability for resolving issues reported. For example, damaged flooring in MRI was reported as an issue at the H&S meeting on 23 February 2021 (prior to the water damage of April 2021). This was still unresolved on 9 June 2021. On 6 January 2022 a renewed walkway was reported to have been installed, but the remaining floor remained a concern. When we inspected on 1 March 2022 the floor was identified to be unsafe.

When we re-inspected on 10 March 2022 the floor had been repaired to a safe condition.

A compressor was reported as required to provide adequate pressure to the endoscopy washers at the H&S meeting on 23 February 2021. It was recorded as ‘due to arrive soon’ on both 23 February 2021 and 9 June 2021 and ‘due to be fitted within the next month’ on 6 Jan 2022. When we inspected on 1 March 2022 the compressor was in place but not yet connected and functional.

Managers did not hold team meetings for staff working in diagnostic imaging, outpatients, reception and administration. However, an endoscopy team meeting was held the day before inspection on 28 February 2022. We told managers and when we re-inspected on 10 March 2022 meetings with structured agendas had been introduced, however these were not embedded.

The service did not discuss lessons learned from incidents and complaints through the meeting structure.

Requires Improvement

Medical care (Including older people's care)

The hospital did not have effective processes in place to ensure that consultants hold up to date medical indemnity and appraisal. On the first day of our inspection, we found that three out of six consultants did not have appropriate records. This meant that the hospital lacked assurance that patients requiring compensation in the event of consultant failings were appropriately covered. On our return visit, we found that all records were up to date. After our inspection, the provider told us that they had introduced a new method of ensuring these records were up to date; however, this was yet to be embedded.

Endoscopy audits were discussed at the CGC and EUG meetings and the endoscopy lead and staff attended a daily huddle where staff discussed the procedure list, equipment issues and any specific patient risk factors.

Management of risk, issues and performance

Leaders did not identify and escalate relevant risks and issues and did not identify actions to reduce their impact. However, they did however have plans to cope with unexpected events.

Managers did not have clear processes for identifying, recording and reviewing risk.

Managers had not introduced effective controls to reduce the impact of risk. Risks identified did not always have controls and mitigations. Risks had been identified by the service, however, the risk descriptors were not always clear or accurate. For example managers had identified lack of backup generator to be a risk in the event of a power failure and had installed an uninterrupted power supply (UPS) to mitigate the risk, however loss of power was not identified as a risk on the risk register and the UPS was not recorded as a control measure.

Not all risks we identified were included in the risk register, for example, the infection prevention control (IPC) risk associated with the exposed plaster and damaged skirting boards due to water damage. The risk register we reviewed did not identify potential risks to the service and the control measures necessary to mitigate risk. The risk register was a retrospective review and the control measure required to prevent re-occurrence of an unexpected event.

This demonstrated that senior managers lacked understanding of the use of a risk register to manage risk.

Managers told us that the service received safety alerts, however the service had no policy relating to the management of safety alerts.

The hospital did not have effective processes in place to ensure that when notifications or referrals were received from external organisations, for example the general medical council (GMC), they were acted upon and any ongoing risk to patients was mitigated.

However, managers did maintain a log of non-clinical incidents, adverse incidents (defined by the policy as an event that directly causing harm to patients) and an accident log in line with the hospital adverse incident policy. Incidents were investigated and signed off by the registered manager.

Managers monitored performance against internal key performance indicators using a performance dashboard, this fed into provider board meetings.

Requires Improvement

Medical care (Including older people's care)

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were not always consistently submitted to external organisations as required.

Staff across the hospital accessed information from the hospital shared drive which included policies and reporting systems. Staff knew how to access information in the areas we visited.

The hospital used written patient records which we scanned to an electronic patient record after procedure. Patient records were securely secured in lockable cabinets.

After the flood, the hospital had moved some patient records to a temporary location off-site. However, the registered manager had failed to notify CQC which is a requirement of registration. We discussed this with the registered manager and the statement of purpose has since been updated.

After the inspection the service told us they provided a monthly quality report to Castleford and Rochford CCG.

Engagement

Leaders and staff did actively and openly engage with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, they did not hold regular staff team meetings and they did not act on the results of the staff survey.

The service participated in patient surveys. Patients and their relatives could provide additional feedback through links on the hospital's public website. The public website also provided information and news about the hospital and the provider for service users.

The hospital attended meetings with local NHS providers and clinical commissioning groups to discuss opportunities for collaboration and review service provision.

Staff surveys were held annually. The 2021 survey had a 50% response rate and 50% of staff said that they felt valued and happy working for the service.

The service did not hold regular staff team meetings.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Leaders had introduced an electronic governance platform and were working towards a combined governance record.

The service was proud to have achieved JAG accreditation in September 2020.

After the inspection the service told us they had gained National Community Diagnostic Hub status.

Requires Improvement

Outpatients

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Requires Improvement

Are Outpatients safe?

Requires Improvement

This was the first time the service had been inspected at individual core service level.

We rated it as requires improvement.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. The training for non-clinical staff comprised 15 modules, topics such as manual handling, fire safety awareness, control of substances hazardous to health (COSHH) and infection prevention and control. Overall compliance of reception staff was 95%, administrative booking staff was 92%.

Staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The introduction of this training had been an action from the last inspection of 2016.

Staff were automatically alerted when training was due. They could access their own training certificates and said there were no barriers to completing mandatory training.

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

Registered nurses (RN) and health care assistants (HCA) working across outpatients reported to endoscopy, findings are reported under medical services.

For our detailed findings on mandatory training, please see under this sub-heading in the medicine report.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse and all other staff were trained to level 2 safeguarding for vulnerable adults and children. Safeguarding training included Deprivation of Liberty Safeguards (DoLs) and Mental Capacity Act (MCA) and compliance was 91%.

Staff completed equality, diversity and inclusion training and could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff training compliance was 100%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had access to the local authority safeguarding team through a dedicated safeguarding phoneline.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service had a chaperoning policy which staff knew how to access. The outpatient health care assistant (HCA) routinely chaperoned patients when required and were aware of their responsibilities when doing so. Patients were informed of the chaperone service by signage in consulting rooms and the waiting area. Doctors were easily able to access chaperones using a nurse call bell located in the consulting room.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Staff had access to an up to date infection prevention and control policy to help control infection risk. Additional protocols were in place in response to the COVID-19 pandemic. There were visible adaptations for the arrival of staff, patients and visitors at the hospital to minimise the risk of cross infection, including a screen in place at reception.

Patients completed a COVID-19 test prior to procedure and reception staff checked results prior to the day of procedure. Staff checked temperatures, provided face masks and asked patients, staff and visitors to gel hands on arrival.

The service had well-placed seating in the waiting area with signs indicating which seats were available to use. Visitors were reminded of the need for social distancing and the importance of good hygiene.

The service had signed up to the government staying COVID-19 secure in 2020 campaign and complied with the five steps for safer working together.

Staff completed infection prevention control (IPC) training as part of their mandatory training, this included awareness of healthcare associated infections (MRSA and Clostridium Difficile). The service had a designated IPC lead.

The service had a schedule for cleaning and cleaning was provided by an external company. Cleaning records were up-to-date and areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff disposed of clinical waste safely. The sharps bin was correctly assembled, labelled and not over filled. Clinic rooms had pedal controlled clinical waste bins which were not over filled.

The clinical areas were clean and had suitable furnishings that were clean and well maintained. However, one examination couch in outpatients had been repaired using tape. We told the registered manager and found when we re-inspected on 10 March 2022 that this had been replaced.

Nursing and support staff were 'arms bare below the elbows'; however, managers did not complete hand hygiene audits for the service to ensure staff were compliant with best practice.

For our detailed findings on cleanliness, infection control and hygiene please see under this sub-heading in the medicine report.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not manage clinical waste well. However, staff were trained to use equipment.

Managers had not adequately repaired the environment following severe water damage in April 2021. Repairs to ceilings, walls and skirting boards in the corridor leading to the consulting rooms were needed. The ceiling to the rear of reception needed to be repaired and new plastering and skirting was needed in the waiting area. The dirty utility and third consulting room had been taken out of use.

Managers had not repaired the building heating system and staff were forced to use temporary oil filled electric heaters to heat the reception area.

The design of the environment did not follow national guidance. The two consulting rooms in use were in adequate repair, however the skirting did not meet national guidance and needed to be replaced. There should be a continuous return between the floor and the wall. For example, coved skirtings with a minimum height of 100 mm allow for easy cleaning Health Building Note 00-10 (Part A). We discussed this with the senior leaders and were advised that this would be considered with new refurbishment plans.

The service did not dispose of clinical waste waiting to be collected safely. The chemical waste bins were stored in an unsecure compound next to the building and general waste bins were stored outside the compound.

Medical equipment was tested annually under a service level agreement with the local NHS Trust medical equipment maintenance (MEMS) department. Portable electrical appliance testing (PAT) of non-clinical equipment was completed by a contracted electrical engineer. However, the hearing booth in consulting room two was not in date and was last tested in January 2021. The registered manager told us this would be raised with engineers.

The service had suitable facilities to meet the needs of patients' families, the disabled toilet had a baby changing unit and a wash hand basin with sensor control non-touch taps.

Patients and staff could reach emergency call bells in the disabled toilet and consulting rooms. This meant that if staff or patients needed assistance there was a way to summon help. Staff carried out daily safety checks of the emergency call bells.

Staff stored single use consumables neatly in a trolley in the consulting room, all were in date.

Staff reported maintenance issues to the service engineer in a log at reception.

Reception and bookings staff had been trained to use patient administration and referral systems.

The service did not have a dedicated resuscitation trolley, staff accessed emergency equipment in endoscopy or diagnostic imaging.

A first aid box and eye wash station were in the outpatient corridor, all contents were within expiry date.

For our detailed findings on environment and equipment please see under this sub-heading in the medicine report.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. A dedicated bookings team completed a telephone pre-operative assessment for patient's due to attend endoscopy.

Staff prepared a patient pack comprising GP referral letter, completed pre-operative assessment and paperwork to be completed on the day of admission and during the procedure. This was signed off by the consultant before confirming the patient's appointment. On the day of procedure nurses admitted patients in the outpatient department before escorting the patient to the endoscopy consenting room.

Staff shared key information to keep patients safe when handing over their care to others. The service used cloud based patient administration systems to manage appointments, COVID-19 screening and histology test results. The reception team printed outpatient clinic lists and checked COVID-19 and histology test results daily, ensuring results were available to the requesting clinician.

The service had a deteriorating patient policy to guide staff in responding promptly to any sudden deterioration in a patient's health. The health care assistant (HCA) was able to explain how they would identify and quickly act on a patient at risk of deterioration.

Bookings staff put diabetic patients at the start of the procedure list to reduce their fasting period.

Shift changes and handovers included all necessary key information to keep patients safe. The reception lead had introduced a daily checklist to improve the quality of handover.

The service did not have access to mental health liaison and specialist mental health support, however, the admission criteria made it unlikely that patient's requiring this support would be referred to the service.

For our detailed findings on assessing and responding to patient risk please see under this sub-heading in the medical care report.

Nurse staffing

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

Requires Improvement

Outpatients

The service had enough nursing and support staff to keep patients safe. Outpatient activity was limited to four clinics a week which did warrant full time nursing support staff.

Outpatients did not employ any nurses or health care assistants (HCA) directly but had access to a designated HCA from endoscopy for chaperoning and phlebotomy. The endoscopy lead organised HCA cover for outpatients and was available to staff for nursing advice. Nurses from endoscopy admitted patients in outpatients as part of the endoscopy patient pathway.

The number of administrative staff matched the planned numbers for the current activity. The service employed a reception lead, three full time equivalent (FTE) receptionists, five staff responsible for bookings and telephone pre-operative assessment and two finance staff.

The reception lead accurately calculated reception staffing levels. The small team worked a set shift pattern to cover the weekday opening hours of 8am to 8pm and alternate Saturdays. The lead ensured rotas were arranged so staff were able to take a meal break, this meant that patients were always greeted by a receptionist.

The lead reviewed expected patient attendance numbers on the patient administration systems in advance of clinics and lists and could adjust staffing levels daily according to the needs of patients.

The service had low vacancy rates.

The service had low turnover rates; one member of staff had been employed for 16 years.

For our detailed findings on staffing please see under this sub-heading in the staffing report.

Medical staffing

The service had three consultants working under practicing privileges providing orthopaedic, ear nose and throat (ENT) and dermatology outpatient consultations to self-funding and privately insured patients.

Consultants working in endoscopy used outpatients for private consultation as necessary, although most endoscopy patients were direct access NHS funded patients, which meant the patient saw the consultant and had procedure on the same day.

For our detailed findings on medical staffing, please see under this sub-heading in the medical services report.

Records

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

Bookings staff stored patient records at a temporary off-site location before securely transporting to the main hospital.

For our detailed findings on records, please see under this sub-heading in the medical services report.

Requires Improvement

Outpatients

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medical gases were not safely stored.

The service did not store medicines and did not hold prescribing documents in outpatients.

For our detailed findings on medicines, please see under this sub-heading in the medical services report.

Incidents

The service did not always manage patient safety incidents well. Managers investigated incidents but not always thoroughly. Managers did not always share lessons learned with the whole team and the wider service. The service did not have a process to ensure that actions from patient safety alerts were implemented and monitored. Staff recognised incidents and near misses and reported them. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff raised concerns and reported incidents and near misses.

Staff knew what incidents to report. For example, reception staff reported an incident were the pathology bag had been given to the wrong courier by an unsupervised new staff member. The bookings staff reported that the wrong pre-procedure information had been sent to a patient, this resulting in the patient unnecessarily taking bowel preparation.

There was evidence that changes had been made as a result of feedback. For example, following the pathology incident, the manager ensured that new staff were supervised until competent. Following the incorrect information incident, the manager amended the referral form on the patient administration system and introduced a manual check by booking staff to ensure patients received the correct information before a procedure.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service.

For our detailed findings on incidents, please see under this sub-heading in the medical services report.

Are Outpatients effective?

Inspected but not rated

This was the first time the service had been inspected at individual core service level.

We inspected but did not rate effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, managers did not always check to make sure staff followed guidance.

Requires Improvement

Outpatients

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There was a process in place which allowed policies to be reviewed regularly, the service maintained a policy index which included review dates.

The service did not have a robust audit programme which reviewed staff compliance to policy. We told managers and when we returned on 10 March 2022 managers told us they had designed new audit programmes to measure compliance against reception policies including, checklists, key logs, scanning of notes, fire alarm tests, permit to work logs, timesheets. A second audit measured compliance against booking policies including, checklists, bowel preparation stock levels, storage of patient notes, caseloads, DNA (did not attend) and cancellation rates and reasons. However, neither audit had been commenced.

For our detailed findings on evidenced-based care and treatment, please see under this sub-heading in the medical services report.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before a procedure were not without food for long periods.

Patients were informed of any dietary requirements before attending the service for a procedure. We saw that patients requiring conscious sedation were informed of the need to fast in advance of attending the service.

All patients who received conscious sedation were required to eat and drink before leaving the service and given advice on dietary needs following procedure. Bookings staff discussed this with patients as part of the pre-operative assessment call, it was repeated in the pre-procedure information sent to patients. Staff considered whether patients were on a morning or afternoon list when giving fasting instructions to ensure patients were not without food for longer than necessary.

For our detailed findings on nutrition and hydration, please see under this sub-heading in the medical services report.

Patient outcomes

At the time of inspection, the service had no audit programme in place to monitor effectiveness of care and treatment provided to private patients attending outpatient consultation.

The service did not participate in national clinical audits.

For our detailed findings on patient outcomes, please see under this sub-heading in the medical services report.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance. However, managers did not hold team meetings for staff and medical staff appraisals were not always up to date.

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

Requires Improvement

Outpatients

Managers gave all new staff a full induction tailored to their role before they started work, this included the use of patient administration and referral systems. The health care assistant (HCA) working across endoscopy and outpatients completed competencies within endoscopy.

Managers supported staff to develop through yearly, constructive appraisals of their work. Four of 11 staff had an annual appraisal, the remaining seven were new starters in 2021 and due an appraisal later in 2022.

Staff completed mandatory training in mental health and learning disabilities as well as dementia awareness. This meant staff had the skills, knowledge and experience to identify and manage patient issues. Staff compliance was 100%.

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

Managers made sure staff received any specialist training for their role. For example. the HCA had completed phlebotomy training.

Managers did not hold team meetings for reception and bookings staff. We told managers and when we re-inspected on 10 March 2022 meetings had been introduced.

Medical staff working under practicing privileges arrangements did not have up to date appraisals.

For our detailed findings on competent staff, please see under this sub-heading in the medical care report.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked with colleagues to discuss patients and improve their care.

Staff shared facilities to support one-stop patient pathways for example, direct access endoscopy patients were pre-admitted in outpatients by endoscopy nurses before being escorted to endoscopy to see a consultant and have a procedure on the same day.

Staff worked across different teams to benefit patients. For example. the endoscopy HCA worked in outpatients providing chaperone and phlebotomy services.

For our detailed findings on multidisciplinary working, please see under this sub-heading in the medical care report.

Seven-day services

Key services were available to support timely patient care.

The service operated Monday to Friday 8am to 8pm and alternate Saturdays.

Staff could call for support from doctors and other disciplines, including diagnostic tests.

Staff informed patients of post treatment care and how to escalate concerns in and out of hours.

Requires Improvement

Outpatients

For our detailed findings on seven-day services, please see under this sub-heading in the medical care report.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas, including the benefits of bowel cancer screening.

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

For our detailed findings on health promotion, please see under this sub-heading in the medical services report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They told us that when patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. The service informed patients of procedure specific complications in the pre-procedure information. This included likelihood, for example the flexible sigmoidoscopy letter advised patients of abdominal discomfort or pain and a very small risk of bowel perforation occurring in 1 in 15,000 examinations. The information contained explanations of what to expect during the procedure and included diagrams to support understanding.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards by completing adult safeguarding level 2 mandatory training. Compliance for the service was 100%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

However, the service safeguarding policy did not include Deprivation of Liberty Safeguards.

For our detailed findings on consent, mental capacity act and deprivation of liberty safeguards please see under this sub-heading in the medical care report.

Are Outpatients caring?

Requires Improvement

Outpatients

Insufficient evidence to rate

We did not rate this service because we did not speak to any patients or see any patient care

Compassionate care

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection we saw staff treat patients with warmth and care, they were courteous, professional and demonstrated compassion to all patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We were told how staff had liaised with a family member to ensure a patient living with a learning disability was appropriately supported.

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

Staff treated patients with dignity and respect. Staff took care to ensure dignity during consultations. Clinic rooms had vacant / engaged signs on the doors, we observed staff knocking and waiting before entering the clinic room.

Staff followed policy to keep patient care and treatment confidential. We saw reception staff being discreet with their interactions with patients and computers were angled so that others in the room could not casually see the display.

Staff wore name badges which enabled patients to easily identify the staff member providing care or support.

Patients said staff treated them well and with kindness. Outpatients did not have an individual patient satisfaction survey, but the endoscopy survey asked specifically about the helpfulness of the bookings and reception staff. From April 2021 to November 2021 the bookings staff scored 100%, reception staff score ranged from 96% to 100%.

Patient feedback was positive, and patients said “Everyone from reception to the clinical team were fantastic and put me at ease, thank you all.”, “Staff were brilliant from the moment I walked into reception, a big thank you to you all.” and “All staff including receptionists, nurses and consultant were very informative, patient and kind throughout my whole stay.” One negative comment related to telephone conversations at reception being overheard. Staff told us that they were aware of the need to be discrete when handling calls.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed reception staff routinely speaking with patients in the waiting area and the bookings team providing reassurance when completing the telephone pre-op assessment.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us that they would take patients away from reception into a private room to offer support if distressed.

Requires Improvement

Outpatients

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Reception staff told us the most enjoyable aspect of their work was reassuring patients who were anxious before procedures and seeing the patient afterwards, relieved and pleased to have gone ahead. Reception staff told us patients would consistently say how wonderful and caring the endoscopy and MRI staff had been.

Patient feedback was positive, "All the way from (staff name) on reception to the recovery room, the staff were excellent and extremely comforting."

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed the bookings staff making telephone pre-operative assessment calls. They provided clear information and answered patients' questions.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were prompted to ask whether patients had specific communication needs during pre-operative assessment and admission. We observed bookings staff explaining clinical terminology in a way patients could understand.

Staff supported patients to make informed decisions about their care. Nursing staff from endoscopy pre-admitted patients in outpatients before escorting them to the endoscopy consenting room where they were consented by the consultant.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had separate patient satisfaction surveys for endoscopy and MRI which also captured patient feedback around the helpfulness and efficiency of booking and reception staff.

Patients gave positive feedback about the service. However, the service did not have a feedback mechanism for patients attending the outpatient department for private outpatient consultations.

Are Outpatients responsive?

Good

This was the first time the service had been inspected at individual core service level.

We rated it as good.

Service delivery to meet the needs of local people

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

Requires Improvement

Outpatients

Managers planned and organised services, so they met the changing needs of the local population. Patients attending the outpatient service for consultation were mainly privately insured or self-funding, appointments were organised to meet the needs of patients. Patients attending the outpatient service as part of the endoscopy pathway were predominantly NHS funded patients referred by their GP.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. The service offered direct access endoscopy, this meant that most patients needed to attend the hospital only once.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Bookings staff booked patients on single sex half-day lists in line with the service endoscopy operational plan.

Managers monitored and took action to minimise missed appointments. The service had introduced pre-procedure phone calls and text messages to remind and reassure patients. This was to help reduce the number of patients who did not attend or cancelled their appointments.

Managers ensured that patients who did not attend appointments were contacted. Staff offered patients a second appointment and only if the patient did not attend that appointment, were they referred to their GP.

The registered manager had regular contract meetings with commissioners to discuss service performance.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were trained to support patients living with dementia, mental health illness and learning disabilities. Dementia training compliance was 100%, mental health and learning disability awareness compliance was 91%.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss, a hearing loop was available at reception.

The service had information leaflets available in large print, information included diagrams explaining procedures.

Managers made sure that staff, patients and carers could get help from interpreters when needed. Staff told us they could access translators for appointments if necessary. Staff were reminded to ask patients whether they needed assistance with communication by a prompt on the pre-operative assessment and admission checklists.

The service was accessible to people who used mobility aids, with services on the ground floor and accessible consulting room and bathroom facilities. Patients could access other services by lifts to all floors.

Access and flow

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

Requires Improvement

Outpatients

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

Managers worked to keep the number of cancelled appointments to a minimum. Staff called and texted patients before the procedure to remind patients of appointment times.

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

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff told patients the time they should expect to be at the clinic in advance of procedures.

Managers and staff started planning each patient's discharge as early as possible.

Staff supported patients when they were referred or transferred between services. The service did not normally transfer patients between services, although they may refer to alternative services. We were given examples of where patients past medical history required further review and how these patients were transferred to other providers.

For our detailed findings on access and flow please see under this sub-heading in the medical services report.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously. Managers investigated complaints but did not always share lessons learned with all staff.

Patients knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in the reception area.

Staff understood the policy on complaints and knew how to handle them. We saw the complaints register which confirmed that complaints had been responded to within the required timeframes.

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

Managers did not always share feedback from complaints with staff and learning was not always used to improve the service.

For our detailed findings on learning from complaints and concerns please see under this sub-heading in the medical services report.

Requires Improvement

Outpatients

Are Outpatients well-led?

Requires Improvement

This was the first time the service had been inspected at individual core service level.

We rated it as requires improvement.

Leadership

Leaders mostly had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. However, leaders had failed to take effective actions to ensure the safety of the premises.

The service was overseen by the senior management team comprising of the registered manager and an operations manager. A dedicated outpatient lead had previously managed the outpatient service but following the water damage in April 2021, this post had been considered unnecessary due to a reduction in outpatient activity to a maximum of four clinics a week.

A health care assistant (HCA) employed by the endoscopy service worked part time in outpatients and acted as chaperone and provided phlebotomy services. They were supported by the endoscopy lead, a registered nurse. A reception lead provided leadership to the team of three receptionists. The bookings, administrative staff and the reception lead reported into the operations manager.

Staff told us that the hospital leadership team were visible and approachable and that they felt supported.

Leaders supported staff to work together as one team to provide the best care for their patients.

For our detailed findings on leadership please see under this sub-heading in the medical services report.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff were therefore unable to apply actions and monitor progress.

The hospital did not have a clear vision for what it wanted to achieve.

Managers told us that they wanted to improve the existing environmental standards and patient experience but had no clear strategy to do so.

The hospital had a set of values displayed throughout staff and patient areas, however, some staff we spoke with were not aware of what they were.

For our detailed findings on vision and strategy please see under this sub-heading in the medical services report.

Requires Improvement

Outpatients

Culture

Staff felt supported and valued by local leaders and the service had an open culture where patients, their families and staff could raise concerns without fear. Staff were focused on the needs of patients receiving care. The service did not always provide opportunities for career development.

Staff spoke positively about working in the department. They told us that they loved working at the hospital and felt like a family. Staff talked about not wanting to work anywhere else, because they enjoyed helping patients and appreciated their colleagues. They told us they felt supported by the hospital local senior leadership and colleagues.

Staff were focused on the needs of patients and told us the most enjoyable aspect of their work was reassuring patients who were anxious before procedures and seeing the patient afterwards, relieved and pleased to have gone ahead; this was reflected in positive patient feedback.

Staff felt comfortable raising concerns and had access to a freedom to speak up guardian.

For our detailed findings on culture please see under this sub-heading in the medical services report.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not all have regular opportunities to meet, discuss and learn from the performance of the service.

Managers did not have effective data collection processes to provide them with service level assurance. Managers did not audit staff compliance against process and policy or hold team meetings for staff. We told managers and when we re-inspected on 10 March 2022 managers had created audit programmes. However, this had not commenced and was not embedded.

The service did not discuss lessons learned from incidents and complaints through the meeting structure.

For our detailed findings on governance please see under this sub-heading in the medical services report.

Management of risk, issues and performance

Leaders did not identify and escalate relevant risks and issues and did not identify actions to reduce their impact. However, they did however have plans to cope with unexpected events.

Managers did not have clear processes for identifying, recording and reviewing risk.

However, managers did maintain a log of non-clinical incidents, adverse incidents (defined by the policy as an event that directly causing harm to patients) and an accident log in line with the hospital adverse incident policy.

For our detailed findings on management of risk, issues and performance please see under this sub-heading in the medical services report.

Requires Improvement

Outpatients

Information Management

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

Staff had access to secure information systems and submitted information on their systems to share where appropriate with colleagues internally and externally.

Staff across the hospital accessed information from the hospital shared drive which included policies and reporting systems.

The hospital used written patient records which were scanned to an electronic patient record after a procedure. Patient records were securely secured in lockable cabinets.

Staff were trained in information governance, data protection, handling patient information, record keeping and Caldicott protocols, compliance was 100%.

For our detailed findings on information management please see under this sub-heading in the medical services report.

Engagement

Leaders and staff did actively and openly engage with patients and the public to plan and manage services However, they did not hold regular staff team meetings and they did not act on the results of the staff survey.

The service participated in patient surveys. Patients and their relatives could provide additional feedback through links on the hospital's public website. The public website also provided information and news about the hospital and the provider for service users.

Staff surveys were held annually.

The service did not hold regular staff team meetings. When we re-inspected on 10 March 2022 a staff meeting had been held, however meetings were not embedded.

For our detailed findings on engagement please see under this sub-heading in the medical care report.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

For our detailed findings on learning, continuous improvement and innovation please refer to this sub-heading in the medicine report.

Requires Improvement

Diagnostic imaging

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

Are Diagnostic imaging safe?

Requires Improvement

This was the first time the service had been inspected at individual core service level.

We rated it as requires improvement.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed online mandatory training which included safeguarding, manual handling and mental and disability awareness and dementia. The inclusion of learning disability and dementia training in the mandatory training programme was an action from the previous inspection in July 2016. Staff confirmed they were up to date with the training. The hospital dashboard indicated the imaging team were up to date with training requirements

Managers monitored mandatory training and alerted staff when they needed to update their training. The hospital dashboard was monitored and the team lead ensured staff completed their training. The dashboard operated on a traffic light system, with green indicating training was in date, amber expiring in one month and red expired.

For our detailed findings on mandatory training please see under this sub-heading in the medical care report.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff completed safeguarding training as part of their mandatory training. Clinical staff completed adult and children training to level 2. Data supplied by the hospital after the second visit indicated there was 100% compliance in the imaging department.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to describe what would constitute a safeguarding concern and could give examples of situations that would require a safeguarding referral. Staff knew who the safeguarding lead was and how to make a referral. The local procedure and contact numbers were clearly visible on the control room noticeboard.

Requires Improvement

Diagnostic imaging

Staff followed safe procedures for children visiting the department. The department did not scan any service users under the age of 18. All service users were informed that the department could not supervise accompanying children. This was clearly documented on the appointment letter.

For our detailed findings on safeguarding please see under this sub-heading in the medical care report.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Clinical areas were not all clean and well-maintained. The service had a flood in April 2021 and the imaging department was severely affected. The department was missing ceiling tiles in both patient waiting areas and clinical areas. The department had missing skirting boards and visible damage from the flood. This affected the ability to maintain effective and thorough cleaning.

The patient waiting areas had suitable furnishings which were visibly clean and well maintained. The posters were laminated to facilitate easy cleaning. The disposable curtain in the control area had been changed in February 2022.

Cleaning records were not up-to-date and did not demonstrate that all areas were cleaned regularly. The service had external contractors to complete the environmental cleaning. The contractors completed a checklist to demonstrate the areas were cleaned. The patient toilets had a cleaning record on the door and this indicated they were regularly cleaned. A review of the cleaning checklist from the week of 17 January 2022 demonstrated the daily checks were completed, Monday to Friday, in all areas except for the scanning room which was not cleaned at all. The weekly checks were only completed in the patient toilets and changing rooms. On our return unannounced visit, we saw evidence the service had conducted a department deep clean.

Staff did not always clean equipment after patient contact and did not label equipment to show when it was last cleaned. The staff used disposable paper towel on the scanning couch and this was changed between patients. The staff wiped down surface areas between service users, however, the scanning room and equipment was visibly dusty. The scanning couch was visibly dirty with debris under the mattress, this was escalated to the department lead on inspection. The service did not have a cleaning schedule in place for the clinical equipment although the cleaning procedure stated the radiographers are responsible for wiping down surfaces and mattress at the end of the session. On the first day of our inspection, we told the provider they must take immediate actions to ensure that the area was effectively cleaned. The provider responded and a deep clean was carried out after our first visit. On our return unannounced visit, we found the scanning area and couch were visibly clean. The department lead informed us they had now implemented a cleaning schedule which included daily and weekly tasks. This needed to be embedded into practice and will then be regularly audited to ensure effectiveness.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed staff wore the correct PPE including face masks and non-sterile gloves. Staff did not always dispose of the non-sterile gloves correctly and we observed staff disposing of gloves in the household waste bin and not the clinical waste bin. No bins were overflowing, and all were pedal bins. On our return unannounced visit, the department lead informed us they now had an audit process to monitor infection control. This needed to be embedded into practice.

Diagnostic imaging

All staff were wearing correct uniform, including closed toe shoes. All staff were clean and tidy with long hair tied back. However, staff were not always 'arms bare below the elbow' in clinical areas and since the current name badges were not magnetic resonance imaging (MRI) compatible we observed staff had identified themselves on a sticky label. The department lead informed us MRI compatible name badges had been requested.

Above each basin there was a sign about hand washing and hand sanitizer was available, however, not all staff coming through the department used hand sanitizer. The hospital infection control policy stated effective hand hygiene is the single most important measure to prevent the spread of infection and the use of hand sanitisers should be encouraged in all staff and patients.

For our detailed findings on infection prevention and control please see under this sub-heading in the medical care report.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well.

The service operated from a self-contained department in the basement of the hospital. The signage to the department from the main reception was satisfactory. The instructions given to patients on how to find the scanner by the reception were clear. The department could be reached by a patient lift or by stairs. The stairway was visibly clean and well maintained.

The stairwell was clear from clutter and housed a fire extinguisher, fire marshal vest and patient evacuation mat. The fire extinguisher was dust free and in date. The department doors were held open with acoustic hold open devices. Acoustic fire door devices are fitted to fire doors and hold fire doors open until the sound from a smoke alarm or fire alarm system triggers it to release allowing the door to close.

The hospital had suffered a severe flood in April 2021 and the diagnostic imaging department was badly affected. The service had suspended the x-ray, ultrasound and computerised tomography (CT) services and was only offering a magnetic resonance imaging (MRI) service. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

At the time of inspection, the department was still missing ceiling tiles, skirting boards and was in a poor state of repair. The MRI scanning room had a temporary repair to the flooring which had blistered, this represented a trip hazard. The scanning room was poorly lit making it difficult for the operator to effectively observe the patient during a scan. At the time of the inspection, the provider was unable to provide assurances that the building was safe for use. We told the provider that they must take immediate actions to provide assurances of the safety and integrity of the building. After our inspection, we received evidence that demonstrated that the provider had taken specific actions to make urgent repairs and the building was safe for patients and staff. This included specialist safety reports in relation to fire, electrical and structural safety.

The follow up visit to the service demonstrated repair and refurbishment work had been undertaken. We found ceiling panels in the department had been replaced, the MRI scanning room floor had been replaced and the lighting in the scanning room rectified. The registered manager informed us of an ongoing re-decoration programme.

Requires Improvement

Diagnostic imaging

The scanning tunnel had a camera which allowed the operator to monitor the patients during the scan. On the follow up visit the department lead informed us the radiographer's workstation was to be moved to improve the visibility of the patient during a scan.

The design of the environment followed national guidance. However, we were not assured that access to controlled areas was strictly monitored in line with guidance. The medicines and healthcare products regulatory agency (MHRA), safety guidelines for MRI equipment in clinical use, recommended MRI equipment is housed in a controlled area. The department did have the appropriate controlled access area, with warning signage, although the door to the control area was not self-locking which the guidance recommended. Free access to the controlled area should be given only to MRI authorised personnel, all other staff and visitors must be screened and given permission to enter the control area. On inspection we were asked to complete safety questionnaires before entering the scanning room, however, on the follow up visit the specialist MRI engineers confirmed they had not been asked to complete safety questionnaires.

Staff told us they carried out daily safety checks of specialist equipment. The radiographers told us they completed quality assurance checks on the equipment, however this was not logged. A review of the workstation quality assurance records provided by the independent engineer indicated the unit was functioning within the correct parameters and safety checks were completed. On the follow up visit the department lead had implemented a quality assurance schedule. The schedule was a four week rotation ensuring each scan specific coil was checked. The results would be audited once the new schedule was embedded into practice.

The service had a maintenance contract with a specialist company for the servicing and repair of the MRI equipment in the event of breakdown. The department had a service schedule in place with the service dates booked every three months up to March 2023.

The technical room which housed the equipment to control and support the MRI magnet operation was cluttered and untidy. This was escalated to the department lead to action.

The service had enough suitable equipment to help them to safely care for patients. The department had two toilets, one for disabled patients which included a handrail. The washbasins had sensor control non touch taps.

The MRI scanning room contained the dedicated MRI scanner, scanning couch and coils. Coils are scan specific antennae which relay the radiofrequency signal, for example a different coil is used for knee scans and spine scans. The room also housed an MRI safe patient trolley for emergency evacuation and support cushions and pillows for patient positioning and comfort. However, the patient head support cushion was ripped and exposed bare sponge. This was escalated to the department lead. On the follow up visit we were informed replacement support cushions have been requested.

The control area housed the resuscitation and first aid equipment. The equipment was correctly and clearly labelled that it was not MRI compatible. The oxygen cylinder was full and in date however, the defibrillator, suction unit and patient monitoring equipment did not have in date portable appliance testing (PAT). This was escalated at the time of the first inspection and was seen to have been completed on our follow up visit.

The first aid box was dated as expiry May2017, however, the consumables were checked and were found to be in date with the exception of the anti-bacterial wipes, which expired in 2020. This was escalated to the department lead and they were changed immediately.

The resuscitation trolley consisted of five clearly marked drawers and was security sealed. The trolley was visibly clean and was included on the department daily checklist. A random check of consumables indicated all were in date and in good condition. The emergency drugs were in a sealed container and were found to be in date. The department had a guide to the drawer content which included a pictorial guide for easy reference.

The department had a wheelchair labelled for MRI use, however it had a ripped paper label and not a recognised MR safe or MR conditional marking. This was escalated to the department lead who confirmed appropriate labels would be requested.

All patients were given earphones during the scan due to the noise. Ear plugs were also available.

Patients could reach call bells during the scan and the radiographer or assistant would explain to the patient how to use it. Call bells were also available in the changing cubicles and toilets which the radiographer or clinical assistant would respond to if called.

We observed staff dispose of clinical waste safely. The sharps bin on the resuscitation trolley was correctly assembled, labelled and not over filled. The unit had appropriate clinical waste peddle bins all closed and were not over filled.

For our detailed findings on environment and equipment please see under this sub-heading in the medical care report.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. Staff trained in intermediate life support were always on duty and would respond to any patient who became acutely unwell. The service had a daily huddle to determine roles and responsibilities in the event of a medical emergency. In the event of a medical emergency the patient is transferred from the scanning table to the MRI compatible trolley and moved into the control area for treatment. The emergency equipment is not MRI safe and cannot be used in the scanning room. Staff confirmed the training for patient extraction is practised. Data received demonstrated the emergency evacuation of a patient was practiced in March 2022.

The MRI department had an in-date version controlled deteriorating patient and emergency transfer of patients policies. In the event of a medical emergency the service would call for an emergency 999 ambulance. The department was housed in the basement with either stair or lift access, however, staff did not know if a patient trolley could fit into the lift for the transfer of a deteriorating patient.

The service had an unexpected finding procedure in place. If a potential urgent finding was observed by the scanning radiographer, they would flag the scan for urgent reporting by the NHS trust or external reporting service. The patient would be advised to follow up with their GP or attend the emergency department. If the external reporting service flagged an unexpected or urgent finding the report would be fast tracked to the patients GP for urgent review.

Staff completed risk assessments for each patient on arrival using a recognised tool, and reviewed this regularly, including after any incident.All MR patients completed an MRI safety questionnaire and consent form. This health questionnaire was to ensure the patient did not have any contra-indications to the MRI scan including pacemakers, brain surgery and implants. All people who enter the room must complete a safety questionnaire. The powerful

magnetic field of the MR system can attract objects made from certain metals which can pose a risk to patients and staff. We observed staff checking the safety questionnaire and previous medical history with the patient prior to the scan. The service used different safety questionnaires depending on the route of referral, NHS or private. All the forms required a patient signature and the private patient form required a radiographer signature.

Staff consistently followed the society of radiographer 'pause and check' checklist to ensure the right patient was having the right scan. We observed that patient details were checked. The patient was shown to a changing room with lockers to secure any valuables and to prepare for the scan.

Staff knew about and dealt with any specific risk issues. MRI scanning required the use of a powerful magnet. The department had exclusion criteria in place. A review of the document demonstrated the exclusion criteria included medical conditions and implants that were not MRI compatible. The risk to the patient from the magnetic field was explained as part of the patient safety questionnaire and the patient received an information leaflet prior to the scan. Patients were asked to remove all metal items and to place them in the locker provided.

The department had comprehensive local rules, local rules are safe working practices. The local rules included contact details, electric and magnetic fields (EMF) risk assessment, fire brigade guidelines and training requirements. The staff had to sign to confirm they have read and understood the local rules as part of their induction competency checks. All MRI staff required to enter the scanning area had completed a safety questionnaire.

Staff shared key information to keep patients safe when handing over their care to others. The radiology department assistant, (RDA), completed the initial safety and health checks with the patient. The RDA would confirm with the radiographer if there was any cause for concern or discrepancy. We observed the RDA discuss with the patient the area to be scanned, when this was not as expected the RDA informed the radiographer. The radiographer reviewed the referral and amended the scan parameters.

The department had a daily huddle before the scanning list started to share any updates, risks or relevant information.

Staffing

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

The service had enough staff with an appropriate skill mix to keep patients safe. A regular MRI scanning list required one radiographer and one radiology department assistant (RDA). The service had two contracted radiographers with the backup of four bank radiographers and two RDA's with the backup of two bank RDA's. The staff told us they always follow their safe staffing model and if they were short of a member of staff and a replacement was not available patients would be re-booked to maintain a safe service.

The service had low vacancy and reducing turnover rates. The department lead explained staff retention was important to maintain the service. The department lead was reviewing the working day and appointment structure to improve the work environment by ensuring staff had breaks. The department lead explained they would like to increase the number of staff available and understood the importance of recruiting the appropriate people into a small team.

Managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service. The service lead explained bank staff had a full induction and up to date competencies prior to working in the service.

Requires Improvement

Diagnostic imaging

Records

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

The service used a secure electronic system, which was password protected, to maintain patient records. Paper records such as the booking forms and associated patient confidential information were scanned, uploaded to the electronic system and then disposed of in a confidential waste bin. Confidential waste was collected and disposed of securely by an external contractor. All patient and clinical information was recorded on the organisation's electronic patient record system. A review of ten patient records confirmed all documentation was completed and scanned into the radiology information system.

The scan images were uploaded onto the dedicated image transfer system. The service downloaded the images directly into one of the referring NHS hospital's picture archiving and communication system (PACS), for the trust radiologists to report. The other referring NHS hospital received the images by disc which was then uploaded onto the hospital PACS system for the trust radiologists to report. Private patient images were uploaded onto the secure electronic image transfer system for the external image reporting service to access and report on the scan.

For referring clinicians who could not access the trust systems, the images could be burnt onto a disc. Reports for the private MRI scans were sent out electronically by secure email to the referring clinician.

Each staff member used a secure log-in to access the patient's information.

The booking of patient referral depended on the patient pathway. The NHS hospitals informed the patient of the appointment date and time and sent all the relevant information to the patient. The service was then informed of the appointment schedule, patient details and referral. The patients were then registered on the service booking system.

Private patients could be booked via electronic transfer or paper referral and the administrative staff contacted the patient directly. Confirmation of the patient details and information was checked, and an appointment date agreed. Any additional information was recorded at that time, this included issues which may impact on the scan. Staff could send out an appointment letter by post with an information leaflet.

Patient notes were comprehensive and all staff could access them easily. A review of ten patient records demonstrated that staff had access to patient referrals and safety questionnaires. On the follow up visit the department lead had implemented a post scan sign off form, this included scan time, area scanned, image count and radiographer sign off. This needed to be imbedded into practice and will be audited monthly.

Medicines

The service used systems and processes to safely store medicines.

The service did not currently perform contrast scans. MR contrast is like a colourless dye and helps to highlight the areas of the body being examined.

The service did have a stock of MR contrast, this was stored in a locked cupboard in the control room. The cupboard was temperature controlled and a review of the documentation demonstrated this was recorded. All stock was in good condition and in date.

Requires Improvement

Diagnostic imaging

Incidents

The service did not always manage patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff knew they had to apologise and give patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff confirmed they knew how to report incidents and were able to give examples of the type of incident they would report. Staff were encouraged to report and record all incidents.

Staff understood the duty of candour. They were aware of the requirement to be open and transparent and give patients and families a full explanation if and when things went wrong. Staff we spoke to understood duty of candour and were able to give examples of situations when it should be applied.

Staff reported serious incidents clearly and in line with the service's policy. The service was in the process of implementing a new reporting system. Not all staff had training or access to the system. Incidents were reported to the senior management team who investigated and inputted the information into the incident management system.

Staff told us they did not always receive feedback from investigation of incidents. The department lead had recently introduced a formal agenda to the staff meetings. This included complaints and incidents and staff had the opportunity to discuss the feedback and look at improvements to patient care. The staff meeting frequency, format and agenda needed to be embedded into practice. Staff did confirm that they could access the governance updates on the hospital computer system.

There was evidence that changes had been made as a result of feedback. As direct result from patient feedback about the noise of the scanner, the service displayed information posters in the waiting area and staff explained how loud the scanner was as part of the safety checks.

The team lead informed us that actions from patient safety alerts were shared by the senior management team and disseminated to the relevant staff.

For our detailed findings on incidents please see under this sub-heading in the medical care report.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate the effectiveness of diagnostic imaging services; however, we found the following during our inspection.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Requires Improvement

Diagnostic imaging

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.We reviewed policies, procedures and guidelines produced by the service. These were based on current legislation, national guidance and best practice, these included policies and guidance from professional organisations such as Society and College of Radiographers (SCoR) and Medicines and Healthcare Products Regulatory Agency (MHRA), Safety Guidelines for Magnetic Resonance Imaging in Clinical Use.

Patients had their needs assessed and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. The referral for each patient was protocolled to ensure the scan requested was justified and within the unit remit and criteria. The service had an in date guide to signing off referrals.

A review of ten patient safety questionnaires demonstrated full compliance with local procedure.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with were able describe the correct process for best interest decisions when a patient was unable to give consent. All staff had additional dementia training as part of the mandatory training programme. Due to the nature of the service the patient needed to be able to cooperate with the scan and to lie quietly for the rest period and the scan. Procedures were in place for a comforter or carer to accompany a patient if required.

For our detailed findings on evidence based care and treatment please see under this sub-heading in the medical care report.

Nutrition and hydration

Patients were not required to fast prior to scanning as the service did not currently perform contrast enhanced scans.

The patient waiting area had an accessible water cooler and service users were able to drink freely.

Patient outcomes

Managers did not always monitor the effectiveness of care and treatment.

The service had a limited audit programme and did not participate in national clinical audits. The department lead had started a new audit schedule which needed to be embedded into practice.

All private MRI scans were reported in accordance with agreed local practice by an external reporting service to deliver accurate and effective radiological and clinical interpretation of images. The service had a specified report turnaround timescale, to ensure minimised delays for patients. The senior management team had recently requested copies of the external company's report audits to ensure the quality and consistency of the reports. This needed to be embedded into practice.

The NHS scans were reported directly by the trust and were not part of the service's turnaround key performance indicator.

The new staff meeting agenda included a department update which would allow the team lead to share and discuss information from the audit programme with the staff. This needed to be embedded into practice.

For our detailed findings on patient outcomes please see under this sub-heading in the medical care report.

Requires Improvement

Diagnostic imaging

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service operated a mandatory and statutory training programme which ensured relevant knowledge and competence was maintained and updated throughout the lifespan of employment with the organisation. All radiographers were Health and Care Professions Council (HCPC) registered. The practising privileges for the supporting radiologist were available and reviewed.

Managers gave all new staff a full induction tailored to their role before they started work. The service had a radiographer competency checklist, which included safe operation of the equipment, safety procedures such as fire and cardiac arrest and was signed by the member of staff and the assessor. There was also competency checklist in place for the RDA staff.

Managers supported substantive staff to develop through yearly, constructive appraisals of their work. The department lead confirmed all contract staff had an annual appraisal. A review of the staff appraisal data indicated the imaging department did not have any overdue appraisals, however the radiographers, although new in post and not due for appraisal, were not listed on the schedule.

Bank staff had regular one to one meetings with the team lead to offer support and development. This was confirmed by staff we spoke to.

Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role, for example horizontal patient evacuation from the scanner.

For our detailed findings on competent staff please see under this sub-heading in the medical care report.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff on site told us there was good multidisciplinary team (MDT) working with their colleagues. In addition, they had regular interaction with the referring trust and supporting radiologist. Staff would contact referrers directly for clarification on referrals, urgent reports or unexpected findings. This facilitated a streamlined service for the patients.

For our detailed findings on multidisciplinary working please see under this sub-heading in the medical care report.

Seven-day services

Key services were available to support timely patient care.

The unit was open seven days a week. The department was open 7am-7.30 pm Monday to Friday and 7.30am -5pm Saturday and Sunday. Patients who required urgent scans could be prioritised to enable rapid diagnosis in line with national guidance.

For our detailed findings on seven day services please see under this sub-heading in the medical care report.

Requires Improvement

Diagnostic imaging

Health promotion

Information leaflets about what to expect and how to prepare for their MRI scan were available for the patients.

The service had access to a private GP if patient's wanted information about healthy lifestyle or smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The patient safety forms were completed by all patients prior to their scan. The MRI safety form required the patient to sign a confirmation that they had received an explanation of the procedure and wished to proceed. A review of the private patient safety questionnaire and consent form demonstrated requirement for the radiographer to counter sign to confirm the procedure had been fully explained and verbal consent had been given.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had received training on mental and disability awareness. Staff knew how to access the policy and guidance and who to ask for support.

Staff were aware of what to do if they had concerns about a patient and their ability to consent to the scan. Staff told us if, for example, a patient with a learning disability or a person living with dementia was due to attend, they would be advised to attend with a relative or carer to provide the necessary support. They said this information was usually available in advance.

For our detailed findings on consent and MCA and DoLS please see under this sub-heading in the medical care report.

Are Diagnostic imaging caring?

Good

This was the first time the service had been inspected at individual core service level. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff were encouraging, sensitive and supportive to patients and those who accompanied them. Staff treated patients with dignity, kindness, compassion, courtesy and respect. We heard them introduce themselves prior to the start of the scan explaining their role and what the patient was likely to experience during their appointment.

Patients did not routinely need to change into a hospital gown for the scan and could wear their own clothes.

Requires Improvement

Diagnostic imaging

Patients said staff treated them well and with kindness. A patient on the day of inspection confirmed staff were polite and kind, gave full instructions and treated them with dignity. A review of 14 feedback forms from the waiting area dated between 10 February 2022 and 28 February 2022 all gave positive feedback.

Staff followed policy to keep patient care and treatment confidential. The service was paper light and all documentation was scanned onto the patient's electronic record. All paper documentation was disposed of into a secure confidential waste bin. We observed all staff locking computers when leaving their workstations.

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Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were aware patients who attended the service were often feeling nervous and anxious. Staff explained how they provided support, demonstrating a calm and reassuring approach to a nervous patient and would hold the hand of a claustrophobic or nervous patient. We were told that patients known to be nervous or had additional needs were allowed to bring a relative or carer with them. Staff would ensure the relative or carers had completed a safety questionnaire prior to entering the scanning room.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their diagnostic procedure. Patients who used the service were sent information in advance of their scan which included the date, time, scan type, examination preparation, duration and safety questionnaire. Staff took the time to explain the procedure and what would happen during their appointment.

Staff talked with patients, families and carers in a way they could understand. Staff recognised when patients and their relatives needed additional support to help them understand. This included, for example, access to language interpreters.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service positively encouraged all patients to provide feedback. Feedback forms were freely available in the waiting area and were part of the private patient information pack.

Patients gave positive feedback about the service. Patients gave positive feedback about the service. Data provided by the inspection manager after the inspection included positive feedback from patients which cited the quality of the care they received. February 2022 data collated results from 620 patients and demonstrated over 98% rated the service as excellent in all categories including care and staff.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging responsive?

Good

This was the first time the service had been inspected at individual core service level.

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. The service provided magnetic resonance imaging (MRI) services for private patients and supported the local trust. The provider had a service level agreement with the local trust to deliver a scanning service for two local NHS hospitals, this was to relieve the pressure on the trust waiting lists. The service worked extended hours to increase appointment availability as a response to increased demand for MRI services.

The unit had sufficient seating, toilets and private changing cubicles. The unit was in the process of being refurbished following water damage in April 2021.

The service was centrally located, near to public transport services and so was accessible to a range of people who may have opted to utilise transport other than a car. The department could be accessed via stairs or a lift which enabled patients with reduced mobility to use the services on offer.

Managers monitored and took action to minimise missed appointments and ensured that private patients who did not attend appointments were contacted. A review of the MRI 'did not attend' audit indicated the service had on average 30 patients a month who did not attend for their appointment. Referrals for NHS patients who did not attend for appointments were returned to the trust.

For our detailed findings on service delivery please see under this sub-heading in the medical care report.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff had received training in equality, diversity and inclusion and had a good understanding of the cultural, social and religious needs of the patient and demonstrated these values in their work. A review of the hospital training records demonstrated all the imaging staff were up to date with this training.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. The service had access to language line and could arrange for the language line to explain the process to the patient by telephone. The service was usually aware in advance if a patient needed assistance and would request a family member or carer attended the appointment with them.

Requires Improvement

Diagnostic imaging

Staff understood the need to meet the information and communication needs of patients with a disability or sensory loss. Staff told us they had clear visors available instead of face masks which allowed patients to lip read if required. Anxious patients and patients with dementia or memory loss could have a relative or carer with them. The staff had all completed dementia awareness training. All patients were given headphones to wear during the scan and music or the radio was played. We observed a member of staff asking a patient if they had a preference. Ear plugs were also available for patients with sensitive hearing.

Staff explained how they could stay with a claustrophobic patient during the scan to provide reassurance and in cases where the patient could not tolerate the scan they could direct them to an alternative provider location for an open scanner.

For our detailed findings on meeting people's individual needs please see under this sub-heading in the medical care report.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.. It was policy for the service to operate within the national waiting list times target of 6-week RTT diagnostic target times and data showed that this target was being met.

The service had some appointment slots reserved, for example, for urgent scans and private patients. Private patients were offered the first available appointment and there was flexibility for patient convenience and availability. The NHS scans were booked, and reported, by the local trust, in accordance with an agreed schedule, the unit only provided scanning services.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. Routine servicing of equipment was always planned in advance to avoid disruption. The service was also able to direct patients to an alternative provider location if there was significant disruption to the service.

For our detailed findings on access and flow please see under this sub-heading in the medical care report.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. All patients had the opportunity to complete a patient satisfaction survey. The survey results were collated and audited.

The service clearly displayed information about how to raise a concern in patient areas. The service had information posters detailing how to raise a concern or complaint in the patient waiting areas, toilets and changing cubicles.

Requires Improvement

Diagnostic imaging

Staff understood the policy on complaints and knew how to handle them.Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were able to describe how they dealt with face to face complaints or feedback, for example offering an apology, explaining to the patient how to make an official complaint and to log as an incident. All complaints were investigated by the registered manager who contacted the complainant by telephone and if required an outcome letter was sent to the patient.

Managers investigated complaints, shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with confirmed feedback from complaints was shared and discussed at the team meetings. The new staff meeting agenda has complaints as a fixed agenda item.

Staff could give examples of how they used patient feedback to improve daily practice. Patient feedback was received about the noise of the MRI scanner. Posters are now displayed in the waiting area and the patient information pack clearly describes the noise levels.

Are Diagnostic imaging well-led?

Inadequate

This was the first time the service had been inspected at individual core service level.

We rated it as inadequate.

Leadership

Leaders did not all understand and manage the priorities and issues the service faced. They were not visible and approachable in all areas of the service for patients and staff. They did not support all staff to develop their skills.

At service level the radiology department lead was new in post. They had been employed as a radiology department assistant and had taken on the role of department lead very soon after starting. They had a good knowledge and understanding of the patient pathway, referral and booking processes, however, they lacked support and training from the senior leadership team in the governance and oversight requirements of the role.

On our return visit the department lead had implemented many changes to improve the quality and safety of the service. These changes needed to be embedded into practice. The governance lead had offered support and guidance over the development and minuting of the new staff meeting agenda.

Staff told us the local senior leadership team were visible and approachable but as a department felt isolated and 'left to it'.

Senior leaders did not understand and manage the priorities and issues the service faced. This was evidenced by the failure to address the serious issue of outstanding repairs within a timely manner. On the first day of our inspection, the provider was unable to provide evidence that the building and all clinical areas were safe for patients and staff following on from the flood in April 2021. This meant that we could not be assured that people were not at risk of avoidable harm. We told the provider that they had to take immediate actions to ensure the safety of the building or we would use our enforcement powers to cancel or suspend their registration. The provider responded immediately and voluntarily

suspended parts of the service whilst urgent repairs were made. After our inspection and before our second visit we received assurance reports from external agencies and contractors that the necessary changes had been made. This was confirmed when we returned for our second unannounced visit. Whilst the service had responded well, senior leaders had failed to manage the risk and had been slow to make necessary changes to ensure patient safety.

For our detailed findings on leadership please refer to this sub-heading in the medicine report.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff were therefore unable to apply actions and monitor progress.

At service level the radiology department staff knew the hospital values and were keen to develop the service to provide good quality care for all their patients.

For our detailed findings on vision and strategy please refer to this sub-heading in the medicine report.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

At a service level, the radiology department staff, did not always feel respected, supported and valued, this was discussed at the recent staff meeting and escalated to the senior management team. The staff did feel they could raise concerns without fear. The hospital had Freedom to Speak Up Guardian and staff knew how to contact them if they wanted to raise concerns.

For our detailed findings on culture please refer to this sub-heading in the medicine report.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not all have regular opportunities to meet, discuss and learn from the performance of the service.

At a service level, the radiology department staff, were not always clear about their roles and did not always understand what they were accountable for. All clinical staff were professionally accountable for the service and care that was delivered within the unit. The new department staff meeting agenda and audit programme should improve staff knowledge and understanding once they are embedded into practice.

For our detailed findings on governance please refer to this sub-heading in the medicine report.

Management of risk, issues and performance

Leaders did not identify and escalate relevant risks and issues and did not identify actions to reduce their impact. However, they did have plans to cope with unexpected events.

Requires Improvement

Diagnostic imaging

At a service level, the radiology department specific risk assessments, for example the electromagnetic field (EMF) risk assessment were completed.

The risks associated with the water damage of April 2021 were recorded separately, rather than as a whole and a number of risks were not recorded, for example the poor quality of the floor in diagnostic imaging and infection prevention control (IPC) risk associated with the exposed plaster and damaged skirting boards.

For our detailed findings on management of risk, issues and performance please refer to this sub-heading in the medicine report.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were not always consistently submitted to external organisations as required.

At a service level, the radiology department, had a limited audit programme. The implementation of a new audit programme should enable the staff to understand performance and make improvements to the service one it is fully embedded into practice.

Staff were aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. Staff viewed breaches of patient personal information as a serious incident. Information governance was part of the annual mandatory training programme for all staff.

The provider used a secure image transfer portal to upload the images for the radiologists to report. Electronic patient records were kept secure to prevent unauthorised access to data. However, authorised staff demonstrated they could be easily accessed when required.

For our detailed findings on information management please refer to this sub-heading in the medicine report.

Engagement

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

At a service level, the radiology department staff, gathered patients' views and experiences and used the information to shape and improve the service and culture. Patient feedback surveys were in use, with the questions sufficiently open ended to allow patients to express themselves.

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust. The radiology department also used an external radiology reporting service which the leadership team engaged with to ensure the quality and turnaround times of the scan reports.

For our detailed findings on engagement please refer to this sub-heading in the medicine report.

Requires Improvement

Diagnostic imaging

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

At a service level, the radiology department, clinical staff, have been booked onto a cannulation course. This will allow the department to develop the range of MRI scans that they can offer as they will be able to offer contrast enhanced scans. MRI contrast makes certain tissues and blood vessels show up more clearly and in greater detail.

For our detailed findings on learning, continuous improvement and innovation please refer to this sub-heading in the medicine report.

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 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure that there are effective systems in process to monitor and audit the quality of the service. Regulation 17(1)(2)(a)(b)(f). • The provider must ensure that incidents are recorded and thoroughly investigated to minimise the risk of reoccurrence and identify opportunities for learning. Regulation 17(1)(2)(a)(b) • The provider must ensure there are effective systems and processes in place to manage risk. Regulation 17(1)(b) • The provider must ensure they have a vision for what they want to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Regulation 17(1)(e) • The provider must ensure that there are effective assurance processes in place to manage referrals from external organisations, for example, from the general medical council (GMC). Regulation 17 (1)(2).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure patient safety checks are completed in line with guidance. Regulation 12(1)(2)(a) • The provider must ensure that all medical staff have received mandatory training. Regulation 12(1)(2)(c) • The provider must ensure all medicines including medical gases are stored safely. Regulation 12 (1)(2)(g)

This section is primarily information for the provider

Requirement notices

- The provider must ensure that the World Health Organisation (WHO) checklist (or equivalent surgical safety checklist) is used correctly and processes in place to monitor compliance. Regulation 12(1)(2)(a)(b)