The Chelmsford

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Chelmsford is operated by Aspen Healthcare Limited. The hospital provides day surgery, and outpatients and diagnostic imaging. We inspected both these services. Surgery included cosmetic procedures which we do not have a legal duty to rate. Facilities include three general consulting rooms, two ophthalmology consulting rooms, and two physiotherapy consulting rooms. There is a theatre suite comprising a main theatre, procedure room, recovery stage one, and recovery stage two/discharge lounge. The recovery stage one area has five holding bays, and the discharge lounge has five recovery recliner chairs. Other facilities include general x -ray, an ultrasound room, outpatient treatment room, physiotherapy gym, administration offices and store rooms.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 September 2016, along with an unannounced visit to the hospital on 10 October 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

We rated this hospital as good overall.

- There was a positive incident reporting culture, with good evidence of learning from incidents. Complaints were monitored and well managed. Infection control practices were observed to be embedded and used effectively.
- Safeguarding procedures for both adults and children were embedded and in accordance with best practice requirements.
- Policies and procedures followed best practice guidance. There were audits against these requirements with clear action plans to improve the service.
- Appraisal rates were 100%, and mandatory training rates were 100%.
- Feedback from Patients who use the service was consistently positive. People could receive care at the service without delay, there was no backlog of patients in any service.
- There were good leadership processes including good governance, risk management and quality assurance in place. Staff spoke positively about working at the service and of their local and hospital level leaders.

We found areas of good practice in surgery:

- There were robust incident reporting processes and infection control procedures in place. Complaints were monitored and well managed.
- There was a variety of relevant evidenced based policies and guidelines for staff. The hospital monitored patient outcomes and participated in relevant national audits.
- There was a robust process for staff appraisal. Practising privilege processes were well established, embedded and used effectively.

Summary of findings

- Patients and their relatives reported that staff had been kind and compassionate when delivering care. The patient survey showed that 99% of patients would recommend the hospital to their friends and family.
- The management team were visible to staff and there was good engagement with patients and the wider multidisciplinary team.

We found good practice in relation to outpatient and diagnostic services:

- There were robust incident reporting processes and infection control procedures in place.
- Staff appraisal rates and mandatory training rates were 100%.
- People could access the service without delay, there are no backlogs or delays relating to outpatient services.
- The staff spoke highly about their local leaders and support from the management teams.

We do not currently have a legal duty to rate cosmetic surgery services or the regulated activities they provide but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

However, we also found the following issues that the service provider needs to improve:

Following this inspection, we told the provider that it should make improvements regarding the completion of moving and handling assessments in surgery, and improve the quality and completion of patient records, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Professor Ted Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. The hospital offered a range of surgical procedures under local and general anaesthetic to private and NHS patients over 18 years of age. The theatre suite comprised of a non-laminar flow theatre, one procedure room, five recovery bays and a patient lounge with five recliner chairs. Theatres were open Monday to Saturday from 7:30am to 5:30 pm for patient procedures. There were 1,365 day case episodes of care recorded at the hospital in the reporting period April 2015 to March 2016. Of these 35% were NHS funded and 65% were other funded. No patients stayed overnight at the hospital during the same reporting period. The service carried out the following procedures: • 534 pain management procedures • 320 cataract surgeries • 286 podiatric fore foot surgeries • 84 breast augmentations • 70 venous endovascular laser treatments • 33 breast procedures • 22 ocular plastics
Outpatients and diagnostic imaging	Good	The Chelmsford provided a range of specialist consultant clinics including cosmetics, GP services, gynaecology, ophthalmology, pain management, physiotherapy, and psychotherapy (cognitive behavioural therapy). The hospital offered diagnostic services, including onsite magnetic resonance imaging (MRI), x-ray and ultrasound. These services were available to insured, self-funding, NHS Choose and Book and NHS Spot contract patients. During the reporting period from April 2015 to March 2016, there were 6640 outpatient attendances, which consisted of both NHS and private consultations. These comprised 37% (2434) new appointments and 63% (4206) follow-up appointments. NHS new and follow-up appointments represented 26% (1719/6640)

Summary of findings

of outpatient work for the reporting period. Outpatient services saw children and young people and adult patients. Children and young people represented less than two per cent of outpatient work within the reporting period.

Summary of findings

Contents

Good

The Chelmsford

Services we looked at
Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to The Chelmsford

The Chelmsford is operated by Aspen Healthcare Limited. This private hospital is located in Chelmsford, Essex. The hospital first opened in February 2006 as Med-Tel. In 2009, it became The Chelmsford Medical Centre, a day surgery unit run by a group of practising consultants. In 2012 it was acquired by the Aspen Healthcare group and in 2013 it rebranded as The Chelmsford. In June 2015, Aspen Healthcare became a wholly owned subsidiary of Tenet Healthcare.

The hospital has had a registered manager in post since January 2009.

The hospital also offers cosmetic procedures. We did not rate these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,two other CQC inspectors, and two specialist advisors.

Information about The Chelmsford

The hospital is registered to provide the following regulated activities:

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

The hospital employs 59 doctors under practising privileges. There are no registered medical officers (RMOs) due to this being a day surgery hospital with a consultant present during all times treatment is undertaken.

During our inspection, we visited all of the areas of the hospital including the theatre, procedure room, recovery bays and the patient lounge. We spoke to 16 members of staff, the registered manager and the chair of the medical advisory committee (MAC). We spoke with one patient and one staff member in surgery. We were unable to speak to patients about their experience in outpatients because those we asked did not want to speak with inspectors. We reviewed 12 patient records, patient feedback, and documentation relating to the running of the service. We also observed the care staff provided to patients.

There were no special reviews or ongoing investigations of the hospital by the CQC at any time during the 12 months before this inspection. The hospital had been inspected once previously in 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity between April 2015 and March 2016.

- There were 1365 day case episodes of care recorded at the hospital, of these 35% were NHS funded and 65% were other funded.
- No patients stayed overnight at the hospital during the same reporting period.
- There were 6640 outpatient total attendances in the reporting period April 2015 to March 2016; of these 31% were NHS funded and 69% were other funded.
- Of the total outpatient attendances, 82 were children aged between three and 15; a further 39 were 16 or 17 years of age.

The accountable officer for controlled drugs (CDs) was the registered manager and had been the accountable officer since 2010.

Summary of this inspection

Track record on safety (April 2015 – March 2016)

- No never events
- 34 clinical incidents, all of which were graded as no harm.
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C. difficile)
- No incidences of hospital acquired E-Coli
- Six complaints

Services accredited by a national body:

- Association for Perioperative Practice (AfPP) accreditation of theatres

Services outsourced by the hospital:

- Agency staff
- Air conditioning
- BSM and PAT testing
- Catering
- Cleaning services
- Clinical waste
- Decontamination
- Electrical
- Fire safety and alarm
- Fire training
- Gas
- Gas supplies
- Intruder alarm
- Medical physics support equipment
- Nurse call system
- Pathology /microbiology/histopathology
- Pharmacy
- Radiation protection
- Resuscitation training
- Water management

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were incident reporting processes in place. There were robust infection prevention procedures in place
- The mandatory training completion was 100%. Medicines were checked, monitored and managed.
- Venous thromboembolism (VTE) assessments were being utilised. NEWS was being monitored and completed appropriately.
- Safeguarding processes were in place, staff were trained to appropriate levels and had an understanding of safeguarding requirements.
- Nurse staffing levels were appropriate for the service. Medical staff practising privileges were monitored through a robust process to ensure doctors were suitable and safe to work in the service.
- Only low risk patients were treated at the hospital and there was a strict exclusion criterion for patients with high-risk existing medical conditions.

Are services effective?

Good

We rated effective as good because:

- There was a variety of relevant evidenced based policies and guidelines for staff. The hospital monitored patient outcomes and participated in relevant national audits.
- Patient pain levels were well managed and monitored. Patient feedback on pain management was routinely sought.
- There was a 100% appraisal rate for staff.
- The hospital scored above the England average in all three of the four areas identified in the PLACE scores.
- Consent and mental capacity requirements were undertaken well and monitored through audits. Staff knowledge of requirements was also good.

Are services caring?

Good

We rated caring as good because:

- Patients and their relatives reported that staff had been kind and compassionate when delivering care.
- The patient survey showed that 99% of patients would recommend the hospital to their friends and family.

Summary of this inspection

- The service undertook their own patient survey on all patients to obtain feedback 14 days after discharge. The results of this were positive.
- Access to specialist support from clinical nurse specialists or counselling services could be made available upon request.

Are services responsive?

Outstanding 

We rated responsive as outstanding because:

- The service was planned and delivered to meet the needs of patients.
- The hospital did not have a waiting list and there no issues with patient flow.
- The hospital consistently achieved above 97% referral to treatment (RTT) within 18 weeks for NHS patients for surgery and outpatients.
- There was a complaints procedure and staff had feedback about complaints received.

Are services well-led?

Good 

We rated well-led as good because:

- The management team were visible to staff and there was an open and honest staff culture.
- All staff we spoke with were able to tell us about the hospital values.
- There was a clear governance process in place including monitoring of quality assurance through meetings, management of practising privileges through the MAC, and management of risk through the Quality Governance meetings. The risk register for the service was monitored and well managed, and could be accessed by all staff in the service.
- Staff spoke highly of their local managers and the hospital wide senior leaders.
- The service had processes in place for public and staff engagement.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

This was the main service provided by this hospital was surgery. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Incidents

- There were no never events between April 2015 and March 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital reported that there had been no serious injuries or deaths between April 2015 and March 2016.
- The hospital told us that 15 clinical incidents had been reported between April 2015 and March 2016. Data provided by the hospital showed that 100% of the incidents were reported as no harm events. There were four non-clinical incidents reported for surgery in the same time period. We saw the record for all incidents and had no concerns.
- The hospital had an electronic incident reporting system. We spoke to three members of staff about incident reporting and all of them knew how to report incidents and were able to demonstrate the process. All three reported that they had received training in incident reporting.
- The hospital manager reported that there was a process in place for learning from incidents.All incidents from the hospital and other hospitals within the provider group were discussed and fed back to staff across all hospital sites.
- We spoke to the theatre manager who reported that there had been shared learning from another hospital in the Aspen group. Documentation for equipment checks had been changed as a result of an incident where a laser tip had become disconnected.
- One member of staff told us that a response was sent to staff that reported an incident. Incidents were discussed in quarterly team meetings and at the quarterly quality governance meetings. We saw minutes from the department meetings and the quality governance meetings which corroborated what we were told.
- Patient outcomes including mortality, should this occur, were discussed at the medical advisory committee (MAC) meetings. We saw meeting minutes that reflected this.
- We spoke to three members of staff about the duty of candour. The duty of candour is a legal duty on hospitals, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. They all told us that duty of candour was a legal requirement and that they had received training about the process. All of the staff were able to describe the process.

Clinical Quality Dashboard or equivalent

- The hospital did not use the safety thermometer or clinical quality dashboard due to having only day case surgeries.

Cleanliness, infection control and hygiene

- All areas of the hospital were visibly clean and free from clutter.
- There were no cases of methicillin resistant staphylococcus aureus (MRSA) or methicillin sensitive staphylococcus aureus (MSSA) reported between April 2015 and March 2016. We reviewed six patient records and found all patients had been screened for MRSA prior to admission.
- There had been no cases of Clostridium difficile (C. difficile) reported between April 2015 and March 2016.
- There were no reported surgical site infections between April 2015 and March 2016.
- There were policies for infection prevention and control available to staff. We saw that staff were able to access the policies through the electronic system. These policies included the hand hygiene policy, MRSA policy and the standard infection control precautions policy. All of the policies were up to date with a review date and made reference to best practice guidance.
- We spoke to the infection prevention lead for the hospital who confirmed that monthly infection prevention and control audits were undertaken. We saw the electronic audits for cleaning, hand hygiene, MRSA screening, sharp implement usage and disposal and 10 sets of notes were audited for infection prevention and control procedures.
- We saw the results for the hand hygiene audit for May 2016 and July 2016 and both audits achieved 100% compliance with hand hygiene.
- We saw that there were dispensers with disposable aprons and gloves attached to the wall in all clinical areas for use by staff. We observed one member of staff removing an intravenous cannula.The staff member wore gloves however, no apron was used to protect their uniform from contamination.
- There were alcohol hand gel dispensers available for use in all clinical areas. We saw staff decontaminating their hands both with gel and with soap and water before and after providing care.
- We saw that disposable curtains were in use in the clinical areas, these had a date of installation and the date to be changed recorded on each curtain. The curtains were visibly clean and were due to be changed in November 2016.
- Cleaning was outsourced to a contract cleaning company and were on site from 7:30pm until 10:30 pm Monday to Saturday. The infection control lead nurse told us that the theatre was cleaned every day following the final theatre case, which included cleaning of the walls and floor

Environment and equipment

- There was one theatre, one procedure room, five recovery bays and a patient lounge used during day case surgeries.
- Data provided by the hospital showed that environmental and clinical practice audit had scored 96% compliance in April 2016 and 94% compliance in July 2016. The audit included assessment and safety of equipment and ensuring the environment was safe to use for surgical procedures.
- We saw resuscitation equipment trolleys located in recovery and the corridor near the patient lounge. Records for June, July and August 2016 showed these were checked daily and there were no gaps in the records. The trolleys were secured with a breakable tag with a serial number, which was recorded within check records. Stock was also checked weekly and there were clear dates of when stock would need replacement.
- We checked the equipment in the resuscitation trolley located in recovery and found that all specified equipment was in the trolley and all single use equipment was within the expiry date.
- The difficult intubation trolley was checked daily, records reflected this, and all equipment was ready for use in an emergency. However, the trolley was not tamper proof. Staff confirmed that a business case had been made to purchase a new trolley, and this was currently being considered.
- On review of the difficult airways trolley we found a paper copy of guidelines, issued by the difficult airways society, in relation to difficult intubation dated 2004. This meant the guidelines being used were out of

date.However, we brought this to the attention of managers and action was taken to update the procedures in accordance with 2015 guidance by the unannounced inspection.

- There was a service level agreement (SLA) in place for sterile services. We saw that records of dirty equipment and returned clean equipment were kept for traceability.
- There was a machine for laser vein procedures in theatres, which was hired by the hospital. We saw records and a policy were in place for this equipment. We saw the service records for this machine, which were up to date showing servicing, took place annually.
- There was one anaesthetic machine; there was no spare machine in the case of mechanical failure. The theatre manager reported that a transfer ventilator was available and they would use total intravenous anaesthesia in the case of an anaesthetic machine failure.
- We checked a selection of single use equipment and found this was within the expiry dates.
- We saw staff cleaning equipment; green 'I am clean' stickers were applied to identify clean equipment for example clinical trolleys, patient chairs, and monitoring equipment.
- We found a large formalin container with a tap was stored in an unventilated area. This was not in accordance with requirements of COSHH. COSHH stands for 'Control of Substances Hazardous to Health' and under the Control of Substances Hazardous to Health Regulations 2002, employers need to either prevent or reduce their workers' exposure to substances that are hazardous to their health. The storage of formalin posed a risk to staff and we raised this as a concern to the theatre manager. We also found there was no risk assessment in place for the storage of formalin. However, on our unannounced visit theatres had conducted a risk assessment and changed the specimen pots to pre-filled containers and stored in line with COSHH regulations.
- We found risk assessments in the COSHH folder had not been updated since 2011. However we were told that all COSHH risk assessments were held electronically. During our unannounced inspection, we found that all COSHH risk assessments had been updated and there was now a programme for review in place.

Medicines

- Medicines were stored in two locations within the surgical area, a medicines preparation room and the procedure room. We saw that medicines were stored appropriately behind a locked door.
- There was a medicines fridge in the medicine preparation room. We saw records that confirmed fridge temperatures were monitored daily. Temperatures recorded were within the minimum and maximum expected temperature ranges.
- Controlled drugs (CDs) were stored according to legislation and records reflected that the CDs were checked daily. However, we found there were three occasions where the CDs were not checked in the procedure room. The CDs were not checked on 14 July, 19 August and 16 September 2016 when the room was in use for procedures.
- There was a discrepancy between the running stock balances for Midazolam 2mg/2ml, where by the record stated 20 but quantity in the cupboard was 40. Staff confirmed this was an error made when stock was receipted and was able to confirm this with the requisition form that was signed and dated at the time delivery. There was no medicines error, just an error in recording which was quickly rectified.
- When a patient required prescribed medicine to take home, the relevant consultant would write on the discharge summary and the medication is provided with clear explanations of side effects and administration. In line with the Chelmsford dispensing discharge medication policy, all medications were checked by two registered nurses, or if a second registered nurse was not available a senior health care assistant who had completed the medicine management competency was able to check and counter sign for the prescribed medicine.
- We checked 12 medicines in the medicines cupboard and found they were all within their expiry date.

- We saw that medical gas cylinders were stored correctly within a locked compound with full and empty cylinders separated.

Records

- Patient records were in paper format and the hospital had plans to introduce electronic patient records in the future. However we were not given a date for this.
- We reviewed six patient records and found that patient pathways were used. However there were incomplete assessments in the pathway booklet and additional single sheets with the updated assessments at the back of the notes.
- In all six records we saw there were completed venous thromboembolism (VTE) risk assessments. However, there was inconsistencies in document versions, whereby different venous thromboembolism (VTE) charts were in use. This meant that there was the potential for inconsistent care, in relation to VTE, through different processes being used.
- We were unable to find a moving and handling assessment in any of the patient records. One member of staff told us that moving and handling was not assessed. We were concerned that there was a risk to staff and patients especially when patients received a general anaesthetic. We raised this with the management team during our inspection. On the unannounced inspection all moving and handling assessments were updated and practice in theatres had been reviewed. This meant the risk had been mitigated.
- There were no records of first consultant consultation. There was no way for staff to check the planned procedure in the patient records. We were concerned that if a booking error had taken place there were no processes in place for nursing staff to identify this. Following our inspection feedback the hospital implemented a procedure checklist for all patients with the planned procedure to be updated at each stage of the patient journey. We saw that this had been implemented on our unannounced visit. In addition, the hospital had implemented a standard operating procedure for medical records management.
- Pre-operative assessments were recorded in all six patient records that we reviewed. We saw that patients had a nurse led pre-assessment prior to admission for a procedure and were reviewed by an anaesthetist if patients were having a general anaesthetic.
- We saw that medical records were kept in secure locked cupboards when not in use. However we saw that medical records were stored in a rack which was not secured in the patient lounge. The patient lounge had a member of staff present at all times.
- We saw that there was an up to date implant register kept in theatre. Implant traceability was recorded in patient records, consultant notes, the implant register and a card with the implant information and serial numbers was given to the patient. Data provided by the hospital showed that the hospital had scored 100% in the traceability audit in March 2016.

Safeguarding

- We spoke to three members of staff about safeguarding and all of them reported that they had completed training for safeguarding adults and children at level two. The training records for these staff confirmed this.
- The three members of staff we spoke with about safeguarding were able to give examples of when they would raise a safeguard alert.
- The registered manager was the safeguarding lead for the hospital and had completed safeguarding adults and children training to level three. The hospital manager was the only staff member who had completed this training to level three, however the hospital was not providing surgery to any person under the age of 18 years.
- The completion rate for safeguarding children level two for clinical staff was 100% for theatre staff and the nursing staff that cared for patients in the patient lounge.
- The completion rate for safeguarding adults level two for clinical staff was 100% for theatre staff and the nursing staff that cared for patients in the patient lounge.

Mandatory training

- The clinic had a programme of mandatory training for all staff employed by the clinic. Mandatory training

included: Fire safety, health safety and welfare, safeguarding adults level one and two, safeguarding children level one and two, moving and handling, infection prevention and control, basic life support/ paediatric basic life support and intermediate life support (for registered professionals).

- Between April 2015 and March 2016 the hospital showed a 100% completion rate mandatory training for surgical nursing and support staff.
- We saw the training files for four staff members and found mandatory training was up to date in all cases.

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

- The clinic reported that venous thromboembolism (VTE) risk assessments were carried out on all patients and formed part of the pre-operative assessment. We saw completed risk assessments in all six of the patient records we reviewed. There were no reported incidents of VTE or pulmonary embolus (PE) between April 2015 and March 2016.
- The hospital had strict exclusion criteria in place to ensure that procedures were not carried out on high risk patients with complex medical conditions.
- We saw that there was a discharge standard operating procedure (SOP) in place to ensure patients were discharged safely and any risks were mitigated. All patients received a card with a telephone number to call out of hospital opening hours for advice or if they had any concerns.
- The hospital used the national early warning score (NEWS). NEWS is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient observations such as heart rate.
- The NEWS audit undertaken in February 2016 scored 86% and the hospital target score was between 95% and 100%. The areas that had low scores were completion of all required fields (50%) and completion of pain score (60%). The service had a quality improvement plan in place, which consiststed of additional monitoring and training around NEWS to improve the undertaking of assessments.
- In all six records we examined the NEWS scores were appropriately recorded and accurately completed.
- The hospital utilised the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist and staff were observed completing this appropriately during a procedure. The observational audit of surgical safety checklist scored 100% in March 2016. This included rates for Radiology procedures. Radiology procedures were undertaken in theatres.
- The hospital had six staff members who had completed advanced life support (ALS) training. We saw the staffing rotas for August and September 2016 that showed that there were at least two members of staff with ALS training working at all times.
- We saw that the hospital had a service level agreement with the local NHS trust for the transfer of an unwell adult patient. The theatre manager reported that patients were transferred to the local NHS trust via an ambulance in the event of an emergency. Any patients that required an overnight stay were transferred to a local hospital within the group that had overnight facilities.
- One member of nursing staff reported that they would contact the patient's consultant in the event of a deteriorating patient. The staff would also request assistance from an anaesthetist or a consultant in the building in the event of an emergency.
- The service undertook surgical pre-assessment on all patients receving surgery at The Chelmsford.

Nursing and support staffing

- There were 1.6 whole time equivalent nurses, one whole time equivalent operating department practitioner and 0.8 whole time equivalent heath care assistant within the theatre department. A bank recovery nurse was used to cover operating lists where general anaesthetic was required. The theatre manager reported that a further 0.8 whole time equivalent operating department practitioner had been recruited and was due to start work in October 2016.
- For theatres, the ratio of nurse to operating department practitioner and healthcare assistant was two to one, which meant that there was always a sufficient number of staff on duty to provide patient care in surgery.

Good

Surgery

- The theatre manager told us that there was a pool of regular bank staff, which were the preferred choice however agency staff were booked occasionally where bank staff were unavailable.
- Data provided by the hospital showed that the staff sickness rate was 19%. However, due to the low staffing numbers one episode of sickness would give an elevated percentage.
- We asked to see the agency induction checklists but these were not available in the theatre department during our inspection. However we saw that these were in place during our unannounced visit
- The hospital reported that they follow the association for perioperative practice (AfPP) guidelines for theatre staffing and the hospital had (AfPP) accreditation. We saw the AfPP accreditation report for March 2014 and the hospital was meeting the requirements for staffing. We saw the staffing rotas and had no concerns about staffing levels.
- Nurses from the outpatient team staffed the patient lounge.
- There were no shift changeovers due to the opening hours of the hospital.

Medical staffing

- The hospital did not employ resident medical officers as only day case procedures were undertaken at the hospital and doctors were present on site until the patients went home at the end of the day.
- The registered manager followed a formal application process when granting consultant practising privileges. All consultants had to be registered on a specialist register and all applications were discussed with the medical advisory committee (MAC).
- The medical advisory committee also advised the registered manager, in respect of renewal, restriction, suspension, withdrawal or refusal of granting practising privileges. Practising privileges were reviewed on an ongoing basis to ensure required documentation remained up to date. Practising privileges were reviewed every two years.
- As part of the practising privileges, consultants were required to be contactable by the telephone or in person out of hours. Consultants were required to arrange cover if unavailable due to other commitments or annual leave.

Emergency awareness and training

- The clinic had a business continuity plan and a major incident plan in place in the event of fire emergencies or power loss. The plans covered the loss of information technology systems, communication systems, fire and bomb threats. One member of staff reported that fire drills were undertaken and were able to describe the what action they would take in the event of a fire.

Are surgery services effective?

Good

Evidence-based care and treatment

- The hospital had a wide range of policy documents in place that were up to date with a review date specified. The policies were constructed around evidence practice and national guidance documents. Three members of staff we spoke to about policies were able to demonstrate how policies were accessed on the hospital intranet.
- The hospital actively took part in the provider company bench marking process. All hospitals within the provider group were rated within a table for key performance indicators and targets. These are colour coded red, amber and green (RAG) rated against each performance marker.
- The service submitted the HSCIC user registration forms for those who would require access to the National Breast and Cosmetic Implant Registry. The service would then submit to the National Breast and Cosmetic Implant Registry once the registry platform goes live in October 2016.
- The service undertook a range of local audits in respect of their policies, procedures and outcomes. This includes local audits on records, medicines

management and hand hygiene. The hospital also took part in national audits such as a sepsis audit, however the results were not yet published at the time of our inspection.

Pain relief

- We saw that the hospital requested feedback on pain management from patients within the 14 day survey. This showed that people responded positively to pain management with 95% of patients reporting that their pain was well managed. The return rate for the surveys was 35%.
- We saw that pain assessment tools were embedded in national early warning scores that were taken at regular intervals depending on patient acuity. The six medical records we saw reflected that regular pain assessments had been carried out and pain relief had been given.
- Data provided by the hospital showed that the pain audit undertaken in June 2016 had scored 75%.We saw that the result had reduced because staff had not attended pain management training in the previous two years. However, pain monitoring, documentation and patient journey management had all scored 100%.
- We spoke to one patient about pain and they reported that staff had regularly asked about pain, and their pain had been well managed.
- Patients were prescribed pain relief to take home on discharge if this was required. The hospital kept sealed boxes of medication for example antibiotics and pain relief that were given to patients as prescribed by their consultant.

Nutrition and hydration

- The hospital informed patients about fasting times before surgery. One patient told us they had been given easy to understand instructions about last meal and drinks before their procedure. The timings of the patients fasting were appropriate and could be adjusted, should there be any delays in treatment.

Patient outcomes

- The hospital participated in the patient reported outcome measures (PROMS), the national confidential enquiry's into patient outcomes and death (NCEPOD) and patient-led assessments of care environment (PLACE).
- The hospital had no reported deaths or negative outcomes in the NCEPOD, so there was no official mortality information to report on. However, the service continually benchmarked themselves against the NCEPOD outcomes.
- The hospital scored above the England average in all three of the four areas identified in the PLACE scores. These were privacy, dignity and wellbeing, condition appearance and maintenance and dementia. The hospital scored 97% for cleanliness below the England average of 98%.
- The hospital (as part of the Aspen a founding member of the private healthcare information network (PHIN).This network aimed to improve the availability of outcome data in the private healthcare sector. The service submitted all required data to PHIN by 1 September 2016.
- The service, and the provider group, were members of the AIHO Cosmetic Surgery Forum and are aligned with the PHIN work programme, where QPROMS will be published. The service had commenced collating data on QPROMS and will be submitting them as part of this programme in 2017. Patient breast outcomes were monitored through quality indicators known as the No results of outcomes from this data were available at the time of our inspection, however we saw what had been collated.
- The hospital reported that there were no unplanned transfers of an inpatient to another hospital between April 2015 and March 2016.
- There were no unplanned returns to theatre between April 2015 and March 2016.
- The clinic reported that there had been no unplanned readmissions within 28 days of discharge in the period April 2015 to March 2016.
- The service undertook a range of local audits, which have been reported on through each section of this report. These included the monitoring of a deteriorating patient (NEWS), hand hygiene, resuscitation, medicines management, records and consent.

Competent staff

- We saw that 100% of staff from the theatre department had received an appraisal between January 2015 and December 2015.
- The 2016 appraisal programme showed a clear structure for appraisal completed. At the time of inspection appraisal rates were 75% for recovery and patient lounge area staff, 50% for the theatre nursing staff and 100% for the operating department practitioners. All appraisals were scheduled for completion by the end of December.
- Three members of staff reported that they had monthly one to one meetings with their line manager, which was a separate process to the appraisal process and enabled further development.
- Access to further qualifications and development was possible. The service reviewed each case on an individual basis. It was required that staff could demonstrate good performance through appraisal to receive any further qualifications.
- The registered manager of the hospital undertook all appraisals for the heads of department and reported that staff were asked for feedback on the leadership.
- There were 59 doctors with practising privileges working at the hospital. Of those 24 doctors routinely practiced at the hospital.
- The medical advisory committee advised the hospital manager before any Practising privileges were granted to consultants and allied health professionals. All professionals with Practising privileges were reviewed every two years following the submission of documentation of registration, appraisal, indemnity insurance and medical staff revalidation through the professional body.
- All surgeons carrying out cosmetic procedures were required to present their continuing professional development (CPD) files. These files demonstrate the numbers and types of procedures undertaken, supervision comments and appraisal information. All cosmetic surgeons who operated at the service have also worked at the local NHS plastic surgery centre. All were on the GMC specialist register for cosmetic surgery.

Multidisciplinary working

- We saw the surgical team worked closely with radiographers and the radiologists. Radiographers were present in theatre for pain procedures when x-rays were required.
- Minutes of the bi-monthly hospital wide meeting showed that these were well attended by staff and allied health professional working under practising privileges.
- The hospital worked with the local clinical commissioning group and NHS trust to provide surgical procedures for NHS patients.
- The hospital offered physiotherapy and podiatry with professionals working under practising privileges.
- Following the patient's discharge from hospital a letter is sent to their GP detailing the procedure,

Access to information

- All patients received a discharge summary before leaving hospital after a procedure. The patient was responsible for delivering the discharge summary to their general practitioner.
- Patients had access to help and advice over the telephone 24 hours a day following a surgical procedure.
- Access to the records of NHS patients was arranged in advance of the appointments for surgery with notes being sent to the service.
- Staff had access to online records systems including radiology and pathology services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The group quality governance report for quarter two of 2016 showed that 72% of staff had completed training on the Mental Capacity Act 2005, against a target of 70%.
- Three staff we spoke with were aware of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). All of these staff members were able to explain and give examples of the application of the MCA 2005 and DoLS.
- We examined seven completed consent forms,which had been signed by a consultant and the patient.

Good

Surgery

- There was an overall score of 93% for the consent audit completed in March 2016, the hospital target score was between 95 and 100%. Ten consent forms were scored for legibility and the accuracy of completion.
- At our announced inspection there were no records of first consultant consultation and we were unable to ascertain if cosmetic surgery patients had a two week cooling off period, which was recommended for cosmetic procedures. When we returned for our unannounced inspection the records evidence for the patients was provided. The service also provided us with their audit on the two week cooling off period for consent dated July 2016. This showed 100% of patients had the required two week cooling off period.

Are surgery services caring?

Good

Compassionate care

- Staff were observed during inspection to be kind and friendly in their approach to the delivery of patient care, using appropriate language to ensure patients understood what was going to happen.
- One patient stated 'the staff had been helpful and cared for me very well'.
- We saw that patient privacy and dignity was maintained with the use of curtains in the recovery area and in the patient lounge. However, patients had discussions with their consultants or an anaesthetist within the patient lounge. Staff advised us that patients were given a choice of to have a consultation in a private room in the outpatient clinic. Staff also told us that it was unusual for other patients to be in the patient lounge at the time of the consultation. All surgical marking took place in a private consultation in the outpatients clinic.
- The hospital did participate in the friends and family test but used a provider patient questionnaire to gain insight into patient satisfaction. We saw the survey results from April 2016 and June 2016, which showed that 99% of patients would recommend this hospital to a friend or relative.
- We saw that the hospital asked patients complete a questionnaire 14 days after any procedure to monitor patient outcomes, and understand about patient experience, feedback from this was positive.
- The hospital had an accreditation for excellence in customer service. World Host is a suite of customer service training programmes that covers all the essentials of service – from making a good first impression through to creating an outstanding experience to customers with disabilities, welcoming customers from different cultures, to driving sales through service and more.

Understanding and involvement of patients and those close to them

- We saw that patients were given an opportunity to ask any question prior to their surgical procedure.
- One patient told use that staff regularly asked if they were comfortable or if there were any questions.
- We saw one member of staff explaining the expected results of a lumber spine pain procedure. The patient was supported around what symptoms to expect in the following few days and how to manage those symptoms.
- One patient's relative reported that staff had kept her informed of what was happening. She had been updated when the patient came out of theatre so she could be in the patient lounge for the patient's return.
- The hospital held regular open evenings for patients to learn more about health conditions and surgery. We were given an example of a recent varicose vein open evening where people could meet a vascular surgeon who gave information and answered questions.
- Fees and costs of treatments were displayed on the notice board in the service, in patient leaflets, in their consultation packs, sent out with their appointment letters and displayed on the service's website. The consultant would also discuss fees with the patient during consultation.

Emotional support

- One relative told us that staff had been reassuring and comforting when either her or her husband had been unsure about treatment or had concerns. She reported

that staff had been very supportive while her husband had been in theatre and made her cup of tea and reassured her until her husband returned to the patient lounge.

- Counselling support could be made available through the local NHS trust if required, and patients can be referred to private counselling for support if needed.
- Should any specialist nurse support be required for patients this could be arranged through the local NHS trust on request.

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital offered services for private and NHS patients. For surgical procedures 35% of procedures were for NHS patients. The other 65% were self funded or through insurance.
- The theatre suite comprises a main theatre, procedure room, recovery stage one, and recovery stage two with discharge lounge. There were five recliner chairs in recovery.
- Privately funded patients had access to treatment by general practitioner referral or by self-referral for treatment. All patients were offered bookings for their procedure at a time that suited them.
- All surgeries and procedures were planned and booked in advance, which allowed the hospital to meet the needs of the patients.
- The hospital manager reported that the hospital opened for longer hours during busy times, or times of high demand to ensure there were no waiting lists.

Access and flow

- There was a clear criterion in place for adults who could have treatment at the hospital. The service did not operate on children or young people. There was a comprehensive exclusion criteria set by the hospital to ensure high risk patients were not accepted for surgical procedures.
- The clinic reported that there had been no cancelled procedures in the last 12 months.
- The hospital reported that there was no waiting list due to their business model. The service would flex and add lists based on demand to ensure that there was no waiting lists.
- All admissions were agreed with the admitting consultant and patients were health screened in a nurse led pre-assessment consultation prior to the procedure.
- All surgical procedures were planned and the hospital reported there were no issues with patient flow. We spoke to one patient who told us that he had waited two weeks for a procedure. However the delay was reported to have been caused by the patient's insurance provider and not the hospital.
- The hospital achieved 97.6% referral to treatment (RTT) within 18 weeks for NHS patients.

Meeting people's individual needs

- The hospital opening hours were adjusted to meet the needs of the patients. For example if it was more suitable for the patient to have an operation on a Saturday the service would book the patient for a weekend list to meet their needs.
- Surgical admissions were booked at a time to suit the patients' preference. We spoke to one patient who confirmed this and reported that there had been no problems arranging a suitable date for their procedure.
- The hospital catered for patients with food allergies and had a choice of sandwiches and salads that were pre-ordered by patients before their procedure.
- The hospital had access to a telephone translation service for any patient whose first language was not English and were able to have patient information leaflets translated. We spoke to one member of staff about translation services and they told us that they had not needed to use this service. They also told us that patient information leaflets took one week to turn around through the service used.
- The hospital treated patients with additional needs such as those living with dementia and learning disabilities. One member of staff told us that they

encouraged the family or carers to be present with these patients during admission. They also told us that staff prepared for these admissions by talking to family and carers about the patients normal routine.

Learning from complaints and concerns

- The hospital had received six complaints between April 2015 and July 2016. Of those three related to surgery services. These related to a patient being identified as under 18 years of age, the second related to arrival times for surgery not being staggered. The third related to a discrepancy with information around payments. The service categorised all concerns on their complaints log even if they had not been raised by the patient but were identified internally.
- No complaints were referred to the independent sector complaints adjudication service (ISCAS) or the parliamentary health service ombudsman (PHSO). The level of complaints was about the same as other independent acute hospitals we collect data for.
- The registered manager was responsible for the management of complaints and was assisted by the business support executive.
- All complaints received by the hospital were discussed at the quality governance meeting and within team meetings. Any complaints relating to consultants or their practice were discussed at the medical advisory committee. Two members of staff we spoke to about complaints told us that they received feedback from the hospital managers about complaints and any learning from complaints.
- We saw that there were patient leaflets containing complaints information in the waiting room. The information leaflet explains the complaints procedure and information about ISCAC and the PHSO if patients were not happy with the local resolution process.
- We spoke to one member of the nursing staff about managing complaints. They reported that staff received training in how to handle a complaint and they felt comfortable with dealing with patient complaints. The member of staff felt able to escalate verbal complaints to management if required.

Are surgery services well-led?

Good

Vision and strategy for this this core service

- The hospital had a document called 'quality strategy 2015-2016'. This was clear, concise, and focused on the delivery of a good service.
- All of the staff we spoke to knew the organisational values. These values were, beyond compliance, personalised attention, partnership and teamwork, investing in excellence and always with integrity. We saw that these values were important to all staff and this was displayed during our visit.
- Staff attended a 'values workshop' as part of the induction process of new staff. We saw the presentation given to staff and found that it was clear and well presented.

Governance, risk management and quality measurement

- There was a clear organisational structure in surgery with a theatre manager supported by the ophthalmic lead who worked 25 hours per week. The theatre manager reported directly to the hospital manager.
- We raised concerns to the hospital manager following our inspection for example medical records and the storage of formalin. On our unannounced inspection, we saw that robust measures had been put in to place to rectify these issues.
- The hospital manager had a clear understanding of the business and clinical risks for the hospital. There were risks on the risk register for the service for both clinical and business reasons.
- All entries on the risk register were reviewed and updated each month. These were discussed at the clinical governance meeting and management team meeting. We saw minutes of these which confirmed what we were told.
- The risk register was stored on a central drive, which staff could access through the service intranet page. All staff could access and view the current risk register at any time. This demonstrated an open governance process in the service.

Good

Surgery

- The provider undertook unannounced 'deep dive' inspections of theatre annually. The 'deep dive' was a process of checking equipment, the environment and risk assessments to see if they were suitable.
- We saw minutes of the quarterly medical advisory committee (MAC) meetings and could see that the risk register and practising privileges were discussed at each meeting. The medical advisory committee (MAC) meeting approved all doctors with practising privileges to work at the hospital. There were 59 doctors with practising privileges at the time of our inspection. Of these 24 were practising routinely at the service.
- We reviewed the process for practising privilege reviews. These were undertaken every two years and any actions were signed off through the medical advisory committee (MAC). Between April 2015 and March 2016, six consultants had their practising privileges (PP's) removed due to infrequent practice or no practice. One doctor had their practising privileges suspended due to not providing their annual appraisal from their NHS practice. They were not able to operate until the required documentation was provided and it was completed to a satisfactory level for the MAC.
- The heads of department attended the clinical governance meeting which the hospital manager chaired. The staff were updated in department meetings of any changes, risks and complaints. We saw meeting minutes for the governance meetings and the theatre department team meetings, which reflected this.

Leadership / culture of service related to this core service

- The service was led by a theatre manager who reported to the hospital manager.
- The theatre manager reported that the senior management team were visible to staff and the registered manager visited theatres daily. The hospital manager knew all staff and referred to them on first name terms.
- All of the staff we spoke to reported that there was strong team working with a focus on patient care and enjoyed their work as a result. They felt well supported by their managers and felt able to raise concerns to the hospital management team.
- The hospital manager reported that there was a clear open no blame culture and felt this was supported by the provider management team.
- All staff received training about whistleblowing and the duty of candour. The hospital manager was able to describe historic incidents where duty of candour had been applied.

Public and staff engagement

- We saw notice boards in the staff rest room, with information about key topics. One notice board had information about incident reporting, infection control, safeguarding, patient feedback, health and safety, and the last quality report.
- There was a notice board with information about the information governance code, careers, staff newsletters, values and the mission statement.
- There were whole hospital meetings held every quarter with staff representation from all departments. We saw from the minutes that all staff grades could attend on behalf of their department. The purpose of these meetings was to develop processes and behaviours, giving staff the opportunity to communicate new initiatives and developments.
- The hospital actively sought the opinions of patients through a patient satisfaction questionnaire given to all patients using the hospital.
- The hospital held regular open evenings for patients to learn more about health conditions and surgery. We were given an example of a recent varicose vein open evening where people could meet a vascular surgeon who gave information and answered questions.

Innovation, improvement and sustainability

- The theatre manager reported they were proud of the Association for Perioperative Practice (AfPP) accreditation. The Association for Perioperative Practice (AfPP) works to enhance skills and knowledge within operating departments, associated areas and sterile services departments. The accreditation process demonstrated the service's commitment to high standards of perioperative care. The hospital manager informed us that the hospital were striving to maintain this.
-

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

The main service provided by this hospital was surgery. Where our findings on surgery also apply the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as Good.

Incidents

- We spoke with four members of staff who were aware of their responsibilities to report incidents through the hospitals reporting system. Each member of staff gave appropriate examples of the types of incident, which required reporting.
- There had been no never events reported for outpatient and diagnostic services from April 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Outpatient and diagnostic imaging services had reported 18 clinical and 11 non-clinical incidents in the period April 2015 to March 2016. Incidents were discussed within clinical governance and department meetings. We had no concerns regarding incident reporting levels.
- Hospitals are required to report any unintended or over exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisations, including the Care Quality Commission (CQC). There were no IR(ME)R reportable incidents between April 2015 and March 2016
- There was a duty of candour process within the service. Duty of candour is a legal duty on hospitals to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers. Staff we spoke with were able to give examples of where duty of candour would be appropriate, and how they would provide this to the patient.

Cleanliness, infection control and hygiene

- No cases of hospital acquired infections for MRSA, Clostridium difficile (C. difficile) or E-Coli were reported by the hospital from April 2015 to March 2016.
- The areas visited during inspection were visibly clean and tidy. There were cleaning schedules in place and records confirmed that these cleaning schedules were practised. We observed that 'I am clean' green stickers were in use.
- We observed outpatient and radiology staff practised good hand hygiene, and all staff used personal protective equipment appropriately. We observed staff in outpatients and radiology were bare below the elbows in accordance with service policy.
- We observed that clinical waste was disposed of appropriately and in line with the hospital's clinical

waste policy and procedures. Yellow clinical waste bags were used, there were foot-operated waste bins, and sharps bins, which were signed and dated and not over-filled throughout departments.

- Hand hygiene audits were carried out every quarter using the 'World Health Organisation Five Moments for Hand Hygiene' observational audit tool. We reviewed the audit results of the last four quarters, which showed 100% compliance rate.
- Infection control training was part of mandatory training. Records showed that 100% of staff had completed mandatory training in the past year.

Environment and equipment

- There were two main departments spread over two floors. The MRI suite and theatre were on the ground floor, the outpatient clinic, general x-ray and ultrasound room was on the first floor. All areas were accessible by stairs or lift.
- Resuscitation equipment was readily available in every department. We reviewed the resuscitation trolley and the associated checklist. Daily check records for the resuscitation trolley were reviewed from 1 June to 19 September 2016, and were all completed appropriately. The trolley was sealed and secure and there was a process for undertaking stock checks on the equipment.
- We saw a maintenance log which showed that outpatient and diagnostic imaging equipment was regularly checked and serviced appropriately.
- Radiology staff were required to use lead aprons to protect themselves against unintended radiation exposure. Lead aprons were in good condition and were checked on a regular basis.
- Radiology staff all carried film badge dosimeters whilst working clinically which registered the amount of personal radiation exposure they had been subjected to and these were reviewed regularly to ensure staff safety.
- Records confirmed that equipment throughout the hospital had been serviced recently and electrical equipment had been safety tested. There were contractual arrangements in place with suitable persons from outsourced services for servicing and electrical safety testing.
- There was a service level agreement (SLA) in place with a NHS trust which was an authorised radiation protection centre, and provided the hospital with ongoing radiation protection support services. This meant that the imaging service at the hospital had easy access to expert radiation advice.
- Throughout the imaging department there were signs and information displayed warning people about where radiation exposure takes place and not to enter certain areas. There were also lights that warned people not to enter due to procedures taking place. Staff also confirmed that patients were escorted from reception to the imaging department.

Medicines

- Medicines for outpatients were stored in the clinical area. We have reported this iunder the surgery section of the report.
- Contrast media was kept in a locked wall mounted cabinet in the imaging room. The keys to this cupboard were only accessible to radiologists, radiographers, consultants or managers.
- Allergies were clearly documented in patient pathway documents.

Records

- We reviewed six sets of records for patients who attended outpatient department. The outpatient consultation page was not completed in three out of the six records. Although consent forms where signed in all six records, tick boxes regarding discussion prior to signing were not ticked.
- Of the six sets of records we reviewed, in two the notes by the consultant were not legible, we could not clearly understand what the doctors had written in the records.
- Outpatient consultations within the hospital were consultant led. All patients attend outpatients with a GP referral letter or their current medical records from a previous appointment or admission were available at the hospital. Should a referral letter not be available at the time of appointment the outpatient reception staff contact the consultant's medical secretary or the

consultant to obtain the referral letter. If the referral letter had not arrived from the GP, outpatient staff would contact the GP practice and request it prior to starting the consultation.

- Outpatient records were held securely on the Chelmsford patient administration system. Paper records were held securely by the hospital in medical records.
- Records availability and completion for outpatients was raised as an issue to the registered manager during the announced inspection. This was because when we looked records were not always available for private insured or self funded patient appointments. During the unannounced inspection we were informed by the hospital manager that the situation had improved and 100% of records had been checked in the two weeks since inspection and these had been completed. A directive had been issued to all consultants and the manager reported that so far all were complying.
- The most recent audit of records, which was undertaken in September 2015, showed a 98% compliance with records completion. This included how legible the records were. However, the audit did not cover the availability of records in outpatients. The service was amending their audit to include this.

Safeguarding

- No safeguarding concerns had been raised for the period April 2015 to March 2016.
- All staff we spoke with were aware of their responsibilities to raise safeguarding concerns and provided examples of situations in which this might occur.
- At the time of inspection, the registered manager told us that the hospital was in the process of stopping the children's outpatient services by September 2016. This service had ceased by the time our unannounced inspection had concluded. The hospital had a target of 90% compliance for all mandatory training. In September 2016 100% of staff had undertaken safeguarding adults and children's training both at level one and two.
- The hospital lead for safeguarding children and adults was the hospital manager who was trained to level three for safeguarding adults and children. The manager was always on site when children's clinics were being run to ensure the requirements were maintained.

Mandatory training

- Mandatory training was provided by a combination of e-learning and face to face training sessions. The hospital had a target of 90% completion of mandatory training on an annual basis for its staff.
- Four members of staff told us that they had recently received mandatory training. Records confirmed that 100% of staff had either received mandatory training in the past year or were scheduled to complete this by October 2016.
- Mandatory training consisted of health and safety, risk management, fire, manual handling, infection control and basic life support (BLS). For all registered professionals such as nurses and radiographers, immediate life support (ILS) training was also mandatory.

Nursing, support and radiology staffing

- The outpatient department's senior nursing staff would assess clinic schedules on a weekly basis to ensure that sufficient staff were on duty to safely manage outpatient and diagnostic imaging clinic lists.
- There were no vacancies in the outpatient department, and there was one whole time equivalent (WTE) vacancy in radiology, which had been recruited to.
- The diagnostic imaging department was staffed by four senior radiographers, one of whom was the imaging department manager.
- The outpatient department was staffed by one whole time equivalent and three part time registered nurses and one whole time equivalent and two part time health care assistants. Bank members of staff were used to cover holidays and sickness cover where this could not be flexibly covered by other staff members.
- The rate of sickness for nurses working in outpatient departments was lower than the average of the 55

independent acute providers that we hold this type of data for. During the reporting period of April 2015 to March 2016, with the exception of April, July and August 2015.

- There was a 0% sickness rate for health care assistants working in outpatient departments during the same reporting period.
- Based on the 56 records of other independent acute hospitals, the rate of use of bank and agency nurses working in outpatient departments was above the average in the reporting period of April 2015 to March 2016. However, when we explored this with the manager this was linked to the additional clinics being held to support increased demand. The service utilised a bank rota to support the running of increased or flexible clinics to meet patient needs.
- The rate of staff turnover for nurses was above the average of the 58 independent acute providers that we hold this type of data for, at 25%, in the reporting period April 2015 and March 2016. However, due to the small staff numbers employed by the service any staff member leaving would generate a higher than expected percentage. We had no concerns regarding staff turnover.
- Records confirmed that new staff and bank staff underwent a comprehensive programme of induction, which included orientation to the hospital.

Medical staffing

- Medical staff were predominantly employed by other organisations (NHS organisations) in substantive posts and had practising privileges to work at The Chelmsford. A practising privilege is defined as 'permission to practise as a medical practitioner in that hospital'.
- There was no resident medical officer (RMO) employed by the service. This was because the service provided a day surgery and outpatient service only. At any time of any activity in the hospital there was always a doctor on site.
- There were 59 doctors who have Practising privileges at the hospital, of which 24 routinely provided a service at the hospital.
- Practising privileges at the hospital were all approved and monitored by the medical advisory committee (MAC).

Emergency awareness and training

- There were up-to-date policies and procedures for emergencies in place.
- Diagnostic imaging staff told us that there was a contingency plan in place in preparation for a major incident in case of a radiation or radioactive incident.
- The service being located on the upper floors had undertaken fire evacuation training sessions. There was a fire risk assessment in place for the service.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We have not rated effective because we do not have sufficient evidence to rate outpatient and diagnostic services at the time of this inspection.

Evidence-based care and treatment

- Staff had access to policies in hard copy and on the hospital intranet. Policies were based on national guidance, for example National Institute of Health and Care Excellence (NICE). We saw an example of a policy for infection prevention and control, which was in date and referenced a 2013 NICE quality statement about surgical site infections.
- Policies were regularly reviewed to ensure that they were aligned to best practice guidance.
- Staff received details of patient safety and medical device alerts through clinical effectiveness and clinical governance meeting papers. Managers confirmed if alerts were relevant to them, they were monitored and details minuted in clinical governance meetings.
- An example of a national safety alert being discussed in the March 2016 clinical governance minutes relating to the risk of death or severe harm due to inadvertent injection of skin preparation solution was recorded in

the meeting minutes. A plan was put in place to action the alerts recommendation, including reviewing current procedures and drafting standard operating procedures where appropriate.

- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross-referenced to national audit levels and if they were found to be high, a report to the radiation protection advisor would be made.
- The hospital had policies and guidelines for the diagnostic imaging department which included details on "local rules", radiation protection supervisor (RPS) and radiation protection advisor (RPA) in line with Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).
- The hospital had access to a radiation protection advisor (RPA) through an agreement with another provider.
- The diagnostic imaging department manager was the radiation protection supervisor (RPS) for the diagnostic imaging department in line with IR(ME)R. The main role of the RPS was to ensure that staff complied with requirements of IRR99 and the local rules. IRR99 are the main legal requirements for the use and control of ionising radiation in the United Kingdom.

Patient outcomes

- There were a number of local audits undertaken for outpatient and diagnostics. These included auditing of consent, Practising privileges, records and imaging safety.
- Results from audits in consent (March 2016) showed a 93% compliance rate, the traceability of equipment for procedures audit (March 2016) showed a compliance rate of 100%. The NEWs audit, which links to outpatients and surgery, scored 86%.
- The imaging safety audit (January 2016) showed 100% compliance with ensuring procedures for safe diagnostic imaging were followed.
- The last IRMER report for the service, undertaken in 2015 showed no concerns with regards to diagnostic imaging in the department.
- Local audit results were discussed in department team meetings, and reported at clinical governance meetings and the medical advisory committee if relevant.
- Action plans were developed following the undertaking of all audits. We reviewed the provider quality governance reports and action plans from February and August 2016, which showed what improvements were required. We reviewed the clinical governance meeting minutes for November 2015 and March 2016, which showed that action plan monitoring and progress was discussed.

Competent staff

- All members of staff received an induction prior to starting work in the hospital, which covered staff's mandatory training requirements.
- Nursing staff said that they took part in monthly one-to-one meetings with their manager in a supervisory capacity and reported feeling supported by managers.
- In the outpatient department, 100% of nursing staff and care assistants had an appraisal between January 2015 and December 2015. In 2016 to date 75% of appraisal had been completed with the remaining 25% of staff scheduled for appraisal before December. Staff knew about the appraisal process and gave us examples of their objectives.
- Staff went on training suited to their individual needs. Staff gave examples of training they had been on including leadership courses.
- Information about nurse revalidation was available on the staff intranet and was discussed within March 2016 clinical governance meeting.
- All consultants employed by NHS trusts provided the service with a copy of their annual appraisal and revalidation information. Individual consultant dashboards relating to their practice at the hospital were provided to each consultant for use for their annual appraisal.
- Consultant revalidation dates were requested from each consultant in writing and evidence of General Medical Council (GMC) revalidation was required to ensure they maintained their rights to work at the hospital (practising privileges).

Good

Outpatients and diagnostic imaging

- There were 59 consultants at the service, of which 24 were Practising routinely at the service. Practising privileges were reviewed every two years and outcomes and decisions approved by the medical advisory committee (MAC).

Multidisciplinary working

- Multidisciplinary working with the local NHS trust and clinical commissioning group took place frequently regarding outpatients and radiology regarding NHS patients.
- We saw consultants, nursing and administrative staff working alongside each other. We observed that there was a good rapport between staff and specialties.

Access to information

- Staff could access scans and imaging reports using secure electronic systems from other providers.
- Staff could access policies and procedures through the intranet.
- Transfer of NHS patient notes between the local trust and The Chelmsford was done through a secure courier service in a purpose made secure note transportation boxes and delivered to the clinic staff on either site.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In outpatients, staff we spoke with could describe how mental capacity was checked and could identify when it would be appropriate to test a patient's capacity.
- Mandatory training compliance in September 2016 for clinical staff completing Mental Capacity Act and Deprivation of Liberty Safeguards training was at 72%.
- Consent for radiology patients was taken on the day of diagnostic testing. Part of the consent process included asking women for pregnancy status and offering pregnancy tests for safety prior to proceeding with an imaging test.
- The recording of consent was documented in patient records. Completion of appropriate consent was audited routinely by the service. An audit dated June 2016, showed a compliance rate of 96%.

Are outpatients and diagnostic imaging services caring?

Good

We have rated caring as Good.

Compassionate care

- We observed that staff consistently acted in a friendly and caring manner with people who used the service and those close to them. The reception area was the first area of the hospital people saw. Staff welcomed them with a smile and were attentive to their needs.
- Outpatient staff told us about a recent incident of a patient who had minor surgery done. Following discharge and leaving the hospital premises, the patient's car broke down in the hospital car park. Although this happened after hours and the hospital was shut, the staff took the patient back into the discharge lounge and made them comfortable until the recovery company arrived and the patient was able to get home safely.
- Every person who used the service was given a feedback form to complete. The hospital management team reviewed these regularly, and shared this information with staff.
- We looked at the results of the outpatient feedback forms for quarter two 2016 and found that results were consistently positive. The survey asked patients to rate their "overall satisfaction with the care received at The Chelmsford", and 98% rated it 'very good' or 'excellent'.
- The service undertook a 'sit and see' audit of the waiting room in May and October 2015. The interactions recorded between staff and patients was recorded as mostly positive. There were no negative interactions recorded during the observation.

Understanding and involvement of patients and those close to them

- We observed that extensive information was available to people who used the service which demonstrated that they were involved in their care from initial contact with the hospital and beyond discharge.

Good

Outpatients and diagnostic imaging

- Patients' experiences of using the service were also reviewed regularly throughout the hospital. This was by way of patient surveys, which were audited regularly in terms of overall scores relating to patient experience.

Emotional support

- Staff spent time with patients before and after their medical procedure, to check on patients' well-being. Staff supported and reassured patients about their treatment throughout their time in the hospital.
- We observed that staff were sympathetic and attentive to patients' needs.
- Counselling support could be made available through the local NHS trust if required, and patients can be referred to private counselling for support if needed.
- Should any specialist nurse support be required for patients this could be arranged through the local NHS trust on request.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

We have rated the responsiveness of outpatients and diagnostic imaging as outstanding.

Service planning and delivery to meet the needs of local people

- There were 6,640 outpatient total attendances in the reporting period April 2015 to March 2016; of these 31% were NHS funded and 69% were funded through other means.
- There were specialist outpatient clinics running that included cosmetics, gynaecology, ophthalmology, pain management, physiotherapy, and psychotherapy (cognitive behavioural therapy).
- The outpatients department had three general consulting rooms, two ophthalmology consulting rooms and two physiotherapy consulting rooms. Other facilities included general x ray, an ultrasound room, outpatient treatment room, and a physiotherapy gym.'

Access and flow

- There was no waiting time for outpatient and diagnostic imaging referral. New patients were given the option of being seen on a day and time of their choice and convenience. This could in some occasions be on the same day or within 24 hours.
- There were clear criteria for NHS patients to be seen at The Chelmsford for outpatient appointments. This was agreed and arranged with the NHS trust and commissioners.
- Of the outpatient appointments held cosmetic surgery (5%), ophthalmology (8%) and musculoskeletal conditions (7%) were the most frequently used outpatient functions.
- Within radiology MRI (36%), x-ray (12%) and ultrasound (12%) accounted for a large proportion of the service activity.
- There were processes for booking NHS and privately funded patients into the hospital either via the booking team located within the hospital or via the consultant's secretaries. NHS patients could choose the service on the choose and book system.
- Referrals were reviewed daily by the booking's team and patients were allocated an appointment
- The provider reported that there were no cancelled procedures for non-clinical reason in the last 12 months.
- There were no delays or backlogs of outpatient appointments. Data shown to us on inspection demonstrated that for the previous year RTT rates for the service have been consistently 100% with the exception of two months where 98% was achieved.
- The service will add additional clinics to the rota to ensure that there is no backlog of patients in the service. This includes provision of clinics on Saturdays.
- There was no backlog or waiting lists for radiology services. There was no backlog or delay for outcomes of diagnostic reporting.

Meeting people's individual needs

- The main outpatients department ran clinics into the evenings to enable patients to attend the clinic outside of working hours.
- We asked nursing staff how the needs of patients with learning disabilities or patients living with dementia

would be met by the department. Staff confirmed that reasonable adjustments in terms of extended appointment times and allowing relatives to attend consultations appointments were made.

- The hospital manager told us that a business plan was being put together to improve the environment, namely a reception area to allow privacy to patients when talking with the receptionist. This was still under review.
- The hospital had disabled parking available close to the hospital entrance. The outpatient's reception desk had a lowered area for ease of wheelchair access, and there was adequate room to enable wheelchairs to access disabled toilet facilities and move around the hospital using lifts for access to the first floor ward areas.
- An induction loop was available to support patients with hearing difficulties.
- Translation services were accessible through a telephone service at all times for appointments.
- Information regarding fees and payments were clearly detailed on the information boards, and prior to appointments. There was also clear information regarding service fees on the service's website.
- Every department was clearly signposted and accessible via stairs and lift.
- Patients were provided with appropriate information to inform them about their hospital visit including a hospital letter and any relevant patient information leaflets.
- Leaflets and information on conditions, procedures and radiology were available for patients to read and were provided to patients prior to their appointments. Staff told us that all people who used the service received information about who to contact and when, so that people knew who to contact if they were worried about their condition or treatment after leaving the hospital.

Learning from complaints and concerns

- There was a complaints policy in place and staff we spoke with were familiar with how to handle a complaint in line with this policy. All complaints were logged and uploaded securely to the electronic reporting system
- Between April 2015 and July 2016, the hospital received six complaints of which three related to outpatient services. The complaints related to an incorrect date on an appointment letter, a vaccine not being available for an appointment and one regarding chaperones in radiology. All complaints had an appropriate apology in writing and the complaints were resolved.
- Complaints were discussed at medical advisory committee (MAC) and quality governance meetings. We reviewed minutes of both meetings for the last three quarters and saw that complaints was a standard agenda item, and any complaints received in that quarter and the actions taken as result were reviewed .
- The provider collated an annual report of complaints, and pulled out themes and actions to learn from what went wrong and improve patient experience.

Are outpatients and diagnostic imaging services well-led?

Good

We have rated well led as Good.

Vision and strategy for this this core service

- There were a set of core values in place for staff to follow which included; beyond compliance, personalised attention, partnership and teamwork, investing in excellence and always with integrity. Staff we spoke to were aware of the values.
- Heads of department were responsible for cascading the 2016 vision to staff, and staff we spoke with were aware of the key objectives.

Governance, risk management and quality measurement

- Where our findings on surgery also apply to the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section. We identified no concerns regarding governance, quality or risk management relating to outpatients or radiology services.

Leadership and culture of service

Good

Outpatients and diagnostic imaging

- Where our findings on surgery also apply to the outpatient and diagnostic services, including how the hospital was led, we do not repeat the information but cross-refer to the surgery section. We identified no concerns regarding leadership of the outpatients or radiology services.
- Locally there was a senior radiographer who managed the radiology service. The outpatient service was led by an outpatient service manager. Staff we spoke with about the leadership of the services were very positive and supportive of their local leaders.
- Staff spoke highly of the management team and felt there was a clear 'open door' culture.
- Staff spoke of a strong team ethos across the hospital and felt well supported by their managers, and that managers were accessible, approachable and friendly.
- Bimonthly hospital-wide team meetings took place; these were minuted and the minutes shared through email with all staff and were also accessible from the hospital shared drive. Staff we spoke with were able to give us examples of what they had learnt from recent meetings.

Public and staff engagement

- Where our findings on surgery also apply to the outpatient and diagnostic services, including how public and staff engagement was managed, we do not repeat the information but cross-refer to the surgery section. We identified no concerns regarding public or staff engagement of the outpatients or radiology services.

Innovation, improvement and sustainability

- Aspen Healthcare had introduced in June 2016 a new patient safety programme called STEP-up to Safety. The STEP-up programme recognises that a culture of safety is multi stranded: a culture of reporting, a culture of openness, a culture of justice and a culture of improvement. STEP-up was being rolled out through a group-wide training and development programme
- The provider also produced other newsletters such as the ophthalmology newsletter which had recently been introduced in January 2016. These were for other providers, staff and patients which informed about up and coming events, referrals etc.
- There were regular educational events for local general practitioners. We were shown a recent example of the teaching session provided 'current concepts in low tension glaucoma' power point presentation.

Outstanding practice and areas for improvement

Outstanding practice

- There were no delays or backlogs of outpatient appointments. For the previous year RTT rates for the service have been consistently 100% with the exception of two months where 98% was achieved against an indicator of 92%.
- The service will add additional clinics to the rota to ensure that there is no backlog of patients in the service. This includes provision of clinics on Saturdays.
- There was no backlog or waiting lists for radiology services. There was no backlog or delay for outcomes of diagnostic reporting.
- There was no waiting time for outpatient and diagnostic imaging referral. New patients were given the option of being seen on a day and time of their choice and convenience. This could in some occasions be on the same day or within 24 hours.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should improve the quality and completion of patient records.
- The provider should ensure that risk assessments on moving and handling are undertaken prior to surgery.
- The provider should ensure medicines within outpatients are consistently and accurately recorded and maintained to prevent discrepancies in the medicines records.