Chase Lodge Health

Quality Report

Chase Lodge Health
Chase Lodge
Page Street
Mill Hill
London
NW7 2ED
Tel: (020) 8358 7100
Website: http://www.chaselodgehealth.com

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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Chase Lodge Hospital is operated by Chase Lodge Health Limited. It is an independent hospital in Mill Hill London. The hospital is primarily a GP service and offers imaging and diagnostic services. There is also a site pharmacy.

Chase Lodge Health opened in 2007. The hospital has had a registered manager, Sarah Lotzof, in post since October 2010.

Chase Lodge Health Limited at the time of the inspection was registered to provide following regulated activities; diagnostic and screening procedures, personal care, surgical procedures, and treatment of disease, disorder or injury. As of June 2017 the provider removed personal care from their registration. The organisation provided services for children and adults of all ages.

The provider had agreements with other professionals who operated within the hospital; services included dentistry, psychology and osteopathy. This report refers only to services provided by Chase Lodge Health Limited.

We inspected Chase Lodge Health as part of our schedule for independent hospitals.

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.

We have not provided ratings for the service. CQC does not currently have a legal duty to award ratings for acute non hospital services. Amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this. In this report we highlight good practice and issues that service provider needs to address to improve the service as well as any regulatory actions necessary.

We said that the provider MUST take following actions in order to meet the regulations:

- Ensure there is a robust governance structure in place to improve patient safety, learn from patients' experience, and improve clinical effectiveness.
- Ensure appropriate management of medicines including controlled drugs and administration of travel vaccinations
- Ensure that appropriated recruitment checks are completed for all staff including appropriate checks through the Disclosure and Barring Service (DBS).
- Ensure there is a radiation protection supervisor (RPS) which is a requirement of Regulation 17 of the Ionising Radiations Regulation 1999 (IRR99).
- Ensure ionizing radiation is measured and monitoring instruments are fit for purpose.
- Ensure medical records for all patients are maintained within the hospital.
- Ensure staff receives appropriate level of safeguarding training as required by current guidance.

We also said the provider SHOULD:

- Ensure that policies are reviewed regularly and version control system is implemented.
- Ensure that clinical waste is managed safely.
- Ensure the environment, including the radiators, is assessed to prevent risk of harm to children.
- Ensure that GP's undertake mandatory training and that record of staff training is maintained.

Summary of findings

- Ensure all staff, including medical staff working under practicing privileges, are appraised and record of it is maintained.
- Ensure there is an effective system to communicate with NHS GP's about the management of patients with long term conditions.
- Ensure there is an up to date policy for Deprivation of Liberty Safeguards and that staff receive training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.
- Endeavour to improve the patient satisfaction survey response rate.

Professor Edward Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients and diagnostic imaging		Outpatients and diagnostic imaging was the main service provided by the hospital. We regulate clinics that provide treatment on an outpatient basis but we do not currently have a legal duty to rate them.

Summary of findings

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Summary of this inspection

Background to Chase Lodge Health

Chase Lodge Health is operated by Chase Lodge Health Limited. The services provided were outpatient, and diagnostic imaging. The outpatient service was primarily a GP service. There were 5,547 outpatient total attendances in the reporting period January 2016 to December 2016 of these 100% were funded by other means, none were NHS funded. Of these 1297 attendances were attributed to children under the age of 17 years.

The provider also undertook 12 mole removals, 23 biopsies, and 5 cryotherapy procedures in 2016.

The hospital offered GP appointments, access to consultants and diagnostic imaging services to children and adults. Only procedures which did not require general anaesthesia were performed at the hospital. The hospital services were provided by GP's, nurses, health care assistants, pharmacists, allied health professionals and administrators. GP associates and consultants worked under practising privileges.

The hospital provides a range of services including mostly a GP service but patients had also access to psychiatry and psychology, physiotherapy and osteotherapy, sports massage, dermatology, acupuncture,and cardiology. The diagnostic imaging department provided x-ray and ultrasound services.

The hospital was open Monday to Thursday from 8am to 7pm, on a Friday from 8am to 6pm, on a Saturday from 9am until 12pm.

During our inspection we spoke with 10 members of staff: senior managers, nursing staff, consultants, a pharmacist, health care assistants (HCAs), and administrators. We also spoke with nine patients and relatives. We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including 16 patient records. Before and during our inspection we also reviewed performance information about the service.

Our inspection team

The team that inspected the service comprised of CQC inspectors, specialist advisors with expertise in primary medical services, outpatient services, pharmacology and radiography.

The inspection team was overseen by Max Geraghty, Inspection Manager.

An expert by experience was also a member of the inspection team. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

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?

- Employment records were not complete, including appropriate checks through the Disclosure and Barring Service (DBS).
- Incidents were not used to improve the quality of the service and it was not clear what learning was undertaken in response to incidents.
- Controlled drugs were not managed appropriately as it was not always clear who the prescribing doctor was.
- Patient specific direction (PSD) for travel vaccinations were not being administered appropriately, they were signed by a doctor after administration.
- Not all patients records were stored securely on site as some of the consultants used their personal computers.
- Quality of records was not consistent and in many cases important information was not recorded.The provider did not routinely monitor the quality of records.
- Children were routinely seen at the hospital but staff were not provided with pediatric life support training.
- The hospital reported 11 significant events, however it was not clear what action plans had been put in place and how information had been disseminated, or if learning had been shared.
- Mandatory training completion for GP's was low.
- Clinical waste was not stored securely.
- A radiator in a consulting room used for children was very hot and had not been identified on the hospital risk register.
- The hospital did not have a radiation protection supervisor (RPS) within its service which is a requirement of Regulation 17 of the Ionising Radiations Regulation 1999 (IRR99).
- The dose counter on the X ray unit was broken, this is a safety tool used to measure radiation.
- The hospital did not have a named professional trained to safeguarding level four, and did not recognise or report potential safeguarding concerns.

However

- The hospital did not use bank or agency staff and there was sufficient number of staff to meet patients needs.
- The hospital had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

Summary of this inspection

Are services effective?

- Not all the policies were dated or had a review date indicated. This meant that staff could be working with policies and procedures that did not reflect the latest professional guidance.
- The hospital did not have a clinical audit programme in place which would have helped them to identify the majority of improvements to the service.
- There was no evidence of appraisals for doctors working under practising privileges.
- The hospital did not have an effective process in place to communicate with NHS GP's about the management of patients with long term conditions
- Staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training.The hospital did not have a policy for Deprivation of Liberty Safeguards.

However

- The hospital's policies and procedures referred to professional guidance produced by the National Institute for Health and Care Excellence (NICE), and the Royal College of Radiology.
- Staff surveys were used to understand staff knowledge of current procedures. We saw where staff knowledge was not acceptable training had been scheduled.

Are services caring?

- We observed staff interactions with patients were courteous and professional.
- Patients told us they were happy with the care provided and they were treated with dignity and respect.
- Patients we spoke with told us they were able to see the doctor of their choice; they felt well informed about their care including any investigations were planned.
- Chaperones were available if required.
- The hospital undertook its own patient satisfaction survey. The results showed 90% (27) patients were extremely likely or likely to recommend the service to others. However the response rate was low with 30 patients completing the survey.

Are services responsive?

- Patients were able to book appointments with a GP directly with the hospital.
- Appointments were offered at times to suit patients.
- Complaints were acknowledged and responded to within the hospitals target of 28 days.

Summary of this inspection

- Staff could access a dedicated language line service.

However

- The hospital did not have a separate waiting area for children.
- Most treatment rooms did not have curtains or a privacy screen.
- There was a lack of sound proofing between rooms which meant patient conversations could be overheard.

Are services well-led?

- There was a lack of governance oversight; and there were few processes in place to improve patient safety, to learn from patients' experience, improve clinical effectiveness and the patient experience.
- The hospital's risk management was not effective and the risk register did not reflect all risks we found during the inspection.
- The Medical Advisory Committee had minimal role in providing professional guidance and advising on issues related to management of the hospital.
- There was a lack of understanding of regulatory requirements among the senior management team in regards to reporting and formal notifications.
- The hospital did not have effective systems in place for recruitment and selection of staff which ensured appropriate recruitment checks had been undertaken prior to employment.

However

- Staff described the culture as open and transparent where staff supported each other.
- Staff enjoyed working at the hospital; they were enthusiastic about the care and services they provided for patients.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are outpatients and diagnostic imaging services safe?

Incidents

- There were no 'never events' reported for the hospital during the reporting period January 2016 and December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- No serious incidents were reported involving the hospital during the reporting period January 2016 and December 2016.
- No clinical or non-clinical incidents were reported involving the hospital during the reporting period January 2016 and December 2016. However the hospital reported 11 significant events between March 2015 and June 2017. Significant events are any event (positive or negative) which is important or unusual and provides an opportunity to identify an area for learning, improvement or the dissemination of good practice.
- Staff were aware of how to report incidents and told us they reported incidents such as falls and that incidents were investigated. The hospital provided clinical meeting minutes for January 2015, January, March and April 2017. It was not clear from the minutes what action plans had been put in place, how the information was disseminated or if learning had been shared. We noted in the minutes of the March 2017 a significant event from August 2016 was discussed.
- We are aware of an incident were the hospital undertook a procedure it was not registered or regulated to perform (September 2015). The incident was not formally investigated by the hospital and it was not clear what lessons the provider and staff learnt from it to improve patient safety, experience, and clinical effectiveness. Root cause analysis (RCA) was not undertaken to identify what, how, and why incident occurred. It was not used to identify areas for change and to develop recommendations which deliver safer care for patients.
- No radiation incidents were reported to the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) during the reporting period January 2016 to December 2016.
- From November 2014, NHS providers were required to comply with the duty of candour regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of their responsibilities under the duty of candour, which ensured patients and/or their relatives were informed of incidents which affected their care and treatment and they were given an apology. We saw evidence where a patient had received an apology following an incorrect diagnosis.

Cleanliness, infection control and hygiene

- On visual inspection we found dust on high levels including picture frames, tile grouting around sinks in clinical rooms was also dirty.
- In one consulting room where children were seen we saw a checklist which indicated toys were cleaned daily and on visual inspection we saw these were clean.

Outpatients and diagnostic imaging

- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- In clinical rooms we found supplies of personal protective equipment (PPE) such as gloves and aprons were readily available. We observed all staff wore PPE where necessary. We noted not all staff adhered to the 'bare below the elbows' protocol in clinical areas.
- The hospital undertook local audits such as sharps bin and sharp box audits, infection control, hand washing and hand washing observation audits. The hand hygiene audit for April 2017 showed that five staff had been observed and they scored between 85% and 100%. Staff that scored more than 95% were to be reviewed in 12 months and the member of staff who scored 85% was to be reviewed on the following month. Hand hygiene formed part of the mandatory training programme for staff. Data provided by the hospital showed 100% of all nursing and administrative staff (15), and 56% of the GP's (5) had completed their mandatory training.
- Infection control formed part of the mandatory training programme for staff. Data provided by the hospital showed 93% (14) of all nursing and administrative staff and 56% (5) of the GP's had completed their mandatory training.

Environment and equipment

- Clinical waste was stored for collection in designated bins situated in the car park behind a wooden lockable fence. We found clinical waste was not stored securely. The outside storage was open and was unlocked. Two of the three yellow clinical waste bins were unlocked.
- In one consulting room on the first floor (Room 5) used for children's consultations we found the radiator was very hot and there was no radiator cover. This could be potentially dangerous to a child.
- In the imaging department the dose counter on the x ray unit was broken, this is a safety tool used to measure radiation. Staff told us this had been broken for some time but was in the process of being fixed; this had been delayed due to cost.
- The hospital had a defibrillator available on the premises and oxygen with adult and children's masks. We found the oxygen and defibrillator were checked regularly. The resuscitation equipment was located in the reception area and was some distance from the imaging department which was on another floor.
- We saw electrical medical equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw safety check labels were attached to electrical systems showing they were inspected and were safe to use.

Medicines

- There were appropriate arrangements for obtaining medicines. Patients had their medicines dispensed from the onsite pharmacy via private prescriptions. Normal opening hours of the pharmacy were 8.30am to 6.30pm Monday to Friday. Staff said this was flexible if there were early or late consultations. The pharmacy was staffed by a qualified pharmacist and was registered with the General Pharmaceutical Council (GPhC). A GPhC inspection in March 2016 showed the pharmacy was of a satisfactory standard in all areas.
- The pharmacy kept a near miss error log, which showed there had been 2 near misses in the last 12 months and had completed 3 untoward incidents in the same period. Any areas for improvement were identified and actioned.
- Medicines were stored appropriately and records showed medicines were kept at the correct temperature. The location was a 'yellow fever centre' and all vaccines used at the location were stored in the pharmacy. We saw the pharmacy kept a computer log of the daily temperatures of the three medicines refrigerators at the hospital. Yellow fever is only given at designated Yellow Fever Vaccination Centres (YFVCs).
- The hospital used PSD (patient specific directions) for children's immunisations and travel vaccinations. Patient specific direction (PSD) is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. However, we found the PSD for travel vaccinations were signed by a doctor after administration. This was raised with the hospital at the time. The hospital has since the

inspection provided a new protocol for administering travel vaccinations dated May 2017 which required the duty doctor to authorise the prescription prior to administration.

- If a doctor needed to administer a medicine to a patient during a consultation these were ordered in advance from the pharmacy via a signed medication request form. Any stock requested was stored in the pharmacy prior to administration and no medicines were stored in consulting rooms.
- The hospital had a controlled drug protocol which was due to be reviewed in February 2017 and had not been updated. The protocol identified one of the doctors as the main authoriser. However, during the inspection we found one schedule 2 controlled drug prescription had been issued in the main authorisers name, however, the doctor who was the main authoriser had not prescribed this medicine. This meant controlled drugs were not being managed appropriately.
- Emergency medicines, such as medication to administer in case of anaphylactic shock, were available and in date. There was oxygen, emergency drugs and defibrillator in the reception area and anaphylaxis kits in the consulting rooms.
- There was a safe and secure process in place for the management of prescription pads. We saw blank prescription forms were stored securely in locked drawers, in locked rooms. We found the prescriptions did not have serial numbers but were printed on security marked paper. Private prescriptions were generated by the doctors, these were then printed off, signed by doctor and taken to the pharmacy to be dispensed.
- The hospital provided audits for vitamin D, controlled drugs, antibiotic's and pain relief. Those were lists of what had been prescribed; there was no analysis of outcomes or actions. The hospital did not use those audits to promote appropriate prescribing.

Records

- The hospital used electronic records; paper records would be scanned onto the system and then shredded. GP's and nurses used the electronic record system. Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins.
- Consultants working in the hospital did not use the same records systems used by the GP's. Consultants with practising privileges (whereby a medical practitioner is granted permission to work in an independent hospital or clinic) used electronic and paper based records. One consultant we spoke with told us they used a paper based record and the records were held securely on site. Another consultant told us they used their own computer which meant their records were not held on site and if the hospital needed access to a patient record this could be arranged via their secretary. Consultants were required to maintain a set of medical records within Chase Lodge Hospital under the terms of the hospital's practising privileges. However, this was not adhered to.
- The hospital had process to identify vulnerable patients that the staff were familiar with. For example, patients diagnosed with dementia had the letters 'DM' typed next to their name on the electronic records system, but this was not a searchable field. Staff needed to query records or monitoring outcomes for patients according to conditions or other variables.
- We looked at 16 sets of electronic patient records. 12 of the records had not been completed consistently. For example, not all the records had the details of patients address, GP, contact details or next of kin or medical history. Patients had to complete a paper registration form before being seen at the practice. The provider told us that those forms included information missing in the electronic patients' record. Records were completed for each visit and where medication had been prescribed, details of what had been prescribed, and frequency of administration was recorded. Laboratory results were also recorded.
- The provider did not undertake audits to determine that records were available at all times, to check if quality of records was of satisfactory standard, records were stored securely ,and if patients confidentiality was maintained at all times.

Outpatients and diagnostic imaging

- Nurses and doctors told us they had arrangements in the event of their electronic records system not being available. Paper consultation form would be used and later scanned into the system.
- Data protection training formed part of the mandatory training programme for staff. Data provided by the hospital showed 100% (15) of all nursing and administrative staff and 56% (5) of the GP's had completed their mandatory training.

Safeguarding

- The hospital had a lead doctor and nurse for safeguarding. The safeguarding lead nurse for children attended bi-monthly safeguarding committee meetings for the London Borough of Barnet. However, the hospital did not have a named professional trained to safeguarding level four. The intercollegiate document for Safeguarding Children and Young People: roles and competences for health care staff March 2014 states 'In England providers of NHS funded health services including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding children.'
- Safeguarding adults and safeguarding children training formed part of the mandatory training programme for staff. Data provided by the hospital showed 77% (7) of nursing and administrative staff and 100% (9) of GP's had completed safeguarding children training and 100% of all staff had completed safeguarding adults training. The administrative staff and health care assistant were trained to safeguarding level 1 and doctors and the lead nurse were trained to safeguarding children level 3.
- The hospital had a safeguarding policy dated March 2017 which covered children and adults. This did not follow best practice guidance, as the legislation and statutory guidance is very different for children and adults. Safeguarding policies should be separated out with clear references to legislation and statutory guidance, including the statutory guidance to the Care Act 2014. Separate policies demonstrate the importance placed upon child safeguarding and children's rights. Staff told us they were able to access the safeguarding policy via the hospitals intranet.
- The hospital reported there were no safeguarding incidents in the reporting period January 2016 to December 2016. However, information received from the hospital regarding a significant event for a young person under the age of 18 years was not recognised as a safeguarding concern or reported to the appropriate authorities.
- The hospital provided outpatient appointments to children under the age of 17 years. During the reporting period January 2016 to December 2016 there were 1297 outpatient attendances. The hospital employed a registered children's nurse (RCN) five hours per week trained to safeguarding level 3 who would accompany children and their parents when on the hospital site when attending consultant appointments.
- The hospital had an up to date chaperone policy. Staff were available for any patient requiring chaperoning. Notices were on display offering chaperones to patients in waiting areas in the hospital, consultation rooms, and the diagnostic imaging department.

Mandatory training

- Mandatory training included basic life support, fire training, health and safety, infection control, hand hygiene, data protection, manual handling, safeguarding adults and children.
- Staff told us that the training was provided as face to face and also online.
- Data provided by the hospital for 2016 showed mandatory training completed by nursing and administrative staff was 92% (14) and 56% (5) for GP's. Staff were sent reminders by the management team concerning outstanding mandatory training. We noted the provider booked staff to attend remaining training sessions.
- Manual handling formed part of the mandatory training programme for staff. Data provided by the hospital showed 83% (12) of all nursing and administrative staff and 56% (5) of the GP's had completed their mandatory training.

Assessing and responding to patient risk

- The hospital did not have a radiation protection supervisor (RPS) within its service. The Hospital was not following its own Radiation Safety policy which stated 'A

competent trained Radiation Protection Supervisor must be appointed for each area of work within the department where radiation is used.' and was also the requirements of Regulation 17 of the Ionising Radiations Regulation 1999 (IRR99) which specifies the requirement of a RPS. Staff told us the previous RPS left and the post had been vacant for a year.

- If patients became unwell whilst in the hospital staff could escalate concerns about patients to their doctor or duty doctor.
- Chase Lodge Hospital did not provide high dependency, intensive or overnight care. In an emergency situation the standard 999 system was used to facilitate the transfer of the patient to an NHS hospital. There was a written procedure which guided staff through their actions in the event of emergency.
- The hospital had an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Basic life support training formed part of the mandatory training programme for staff. Data provided by the hospital showed 44% of administrative staff and 100% of the GP's and nursing staff had completed their mandatory training.Staff were not required to complete specialist pediatric life support training, however, children were seen at the hospital.
- There was standard emergency equipment for adults and children which included defibrillator. Staff checked it every 2 weeks to ensure it was ready to use at all times.

Nursing and supporting staff

- The hospital employed a 0.75 whole time equivalent (WTE) registered nurse and 0.75 WTE healthcare assistant. The hospital also contracted with a registered children's nurse (RCN) 5 hours per week. There was no nursing cover at weekends.
- The hospital did not use bank and agency nursing staff in the reporting period January 2016 to December 2016. Nursing staff told us they would cover each other for unplanned absences.
- The hospital employed a radiologist eight hours per week to work in diagnostic imaging.
- The hospital employed 11 administrative staff such as a business manager, medical secretaries, receptionists and account manager.
- We reviewed four staff nursing and administrative personnel files and found employment records were not complete. For example, not all the records had proof of identification, references, evidence of full employment history including reasons for ending their previous employment and the appropriate checks through the Disclosure and Barring Service (DBS).

Medical staffing

- There were nine doctors recorded as having practising privileges at the hospital. Of this number, 56% (5) worked regularly at the hospital undertaking 100 or more consultations from January 2016 to December 2016. A further 33% (3) doctors undertook between 10 and 99 consultations in the same time period.
- We reviewed five GP and GP associate personnel files that practice under practising privileges and found staff records were not complete. For example, not all the records had references, evidence of full employment history and the appropriate checks through the Disclosure and Barring Service (DBS).
- The hospital had a process in place for clinical staff, including consultants, to apply to work under practising privileges. The provider told us applications were considered by the medical advisory committee (MAC). However, we found little evidence of medical staff working under practising privileges who had been considered by the MAC. MAC was not involved with appointing doctors or in reviewing their right to practice at the hospital. It was not clear how decisions related to granting practicing privileges were made and which criteria were considered when appointing doctors.
- Consultants who held clinics in the hospital were responsible for the care of their patients. Secretaries organised the clinic lists around consultant and patient availability.
- Out of hours GP consultations and emergency doctor appointments were provided by another organisation, via service level agreement, who offered emergency doctor appointments.

Major incident awareness and training

Outpatients and diagnostic imaging

- The hospital had a comprehensive business continuity plan in place for major incidents such as power failure or building damage available on the hospital intranet page. The plan included emergency contact numbers for staff.
- Staff told us the business continuity plan had been tested when the telephone system had gone down.
- The hospital carried out regular fire drills. The last recorded fire drill was November 2016.
- Fire training formed part of the mandatory training programme for staff. Data provided by the hospital showed 100% (15) of all nursing and administrative staff and 56% (5) of the GP's had completed their mandatory training.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- The hospital's policies and procedures referred to professional guidance produced by the National Institute for Health and Care Excellence (NICE), and the Royal College of Radiology.
- The hospital advised NICE guidance was reviewed and disseminated to all the clinicians if relevant. We saw the hospital also had a system in place for doctors to sign to confirm they had read NICE alerts.
- There was no clinical audit programme in place which would ensure compliance with NICE guidelines.
- Clinical policies and procedures were available on the hospital's intranet and staff were aware of how to access them. We saw that not all policies were dated, reviewed by their review date, or had a date for review. This meant that staff could be working with policies and procedures that did not reflect the latest professional guidance.
- In the imaging department we saw local rules were in place. This meant there was a record of all the working practices which must be followed to ensure staff are safe when working with radiation and they comply with the Ionising Radiations Regulations 1999 (IRR99).
- The hospital received alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) which was over seen by the pharmacy. We saw there was a spreadsheet in place which detailed when the alerts had been actioned. The MHRA regulates medicines, medical devices and blood components for transfusion in the UK.

Pain relief

- Pain relief medication was available on prescription from a doctor or consultant.
- Doctors told us they discussed pain management in the consultation process for patients if required.
- The provider did not use standarised pain score system to support children with measuring levels of pain. To establish it doctors were guided by observations and by talking with children and their carers.

Patient outcomes

- The hospital did not participate in the Quality Outcomes Framework (QOF is a system intended to improve the quality of general practice and reward good practice).
- The hospital was not required to participate in national clinical audits for 2016. The hospital undertook quarterly cervical smear test audits for the period. Of the audited 33 results it was not clear what actions were taken in four cases where the result had not been conclusive.
- The imaging department did not undertake local audits to ensure they operated in line with published guidelines. The hospital advised there was not enough data to ensure comparability. They were not required to participate in national clinical audits.
- The imaging department did not undertake audits of images carried out on site.
- The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 is legislation which provides a framework intended to protect patients from the hazards associated with ionising radiation. The imaging department used a NHS hospital to undertake an IR(ME)R audit in February 2017 which rated the department as 'Nearly fully compliant with a few minor improvements necessary'.
- The imaging department did not audit diagnostic reference levels (DRLs).
- The hospital did not participate in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focused

assessment and accreditation programme designed to "help diagnostic imaging services to ensure their patients consistently receive high quality services, delivered by competent staff working in safe environments".

Competent staff

- Not all the staff had annual appraisals. Data provided by the hospital showed three staff had an appraisal, with two of the three appraisals within the last 12 months. The hospital had an appraisal policy and procedure in place which covered all employees which meant the hospital's appraisal policy and procedure was not being followed. One member of clinical staff had been employed for over a year, staff told us they did not know who their appraiser should be.
- Staff surveys in December 2015 and January 2017 were used to gauge staff knowledge of current procedures. When the hospital had judged that staff knowledge was not acceptable suitable training had been scheduled in; for example training related to needle stick injuries.
- The hospital had an induction process for new staff and also provided staff handbooks as part of the induction process.
- The hospital had terms and conditions for practising privileges which required NHS post holders to provide a copy of their appraisal. There was no evidence of appraisals being in place for doctors working under practising privileges.

Multidisciplinary working

- The hospital did not have an effective process in place to communicate with NHS GP's about the management of patients with long term conditions. Staff told us they would advise patients to contact their NHS doctors about their results, medicines or treatments.
- Staff described how they worked together with multi-disciplinary input from nursing, GP's and diagnostic staff. Staff told us consultants were approachable and always willing to give help and advice.
- We heard positive feedback from staff about good teamwork. Nursing staff described how they worked closely with the pharmacist.
- GP's were able to refer patients to the consultants working under practising privileges to a range of services such as paediatricians and psychologists.

Seven-day services

- The GP services were available at Chase Lodge Hospital Monday to Thursday from 8am to 7pm, on a Friday from 8am to 6pm, on a Saturday from 9am until 12pm and on a Sunday from 10am to 2pm.
- Nursing staff worked Monday to Friday.
- The pharmacy was open Monday to Friday from 8.30am to 6.30pm.

Access to information

- The terms and conditions for practising privileges required consultants and GP's to maintain a set of medical records within Chase Lodge Hospital for each patient so the hospital could have access. However, not all consultants were complying with this.
- Staff we spoke with told us they had access to hospital's policies and procedures on the intranet.
- Access to blood test results was provided electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. The hospital did not have a policy for Deprivation of Liberty Safeguards.
- The hospital had a consent policy and a consent protocol, neither documents had protocols for gaining parental consent or when Frazer guidelines or Gillick competence should be applied. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.
- Patients told us staff asked their permission before treatment was given.
- Staff told us they would seek verbal consent; however we did not see this had been recorded in patients records.

Outpatients and diagnostic imaging

- Staff told us they would seek consent from parents before administered immunisation to their child, and if a child's parent was not present then they would require written consent form the child's parent before administering immunisations.
- In the imaging department we saw verbal and/or written consent was documented for imaging intervention.
- We saw evidence of consent forms being in place for patients undergoing a minor operative procedure. The form had details of the procedure and associated risks.
- The hospital audited consent forms in January 2016 and May 2016. On both occasions 10 consent forms were audited and demonstrated in 100% of forms patients signed the consent form agreeing to the procedure and the form had been signed by a doctor or healthcare professional.
- The imaging department was not required to participate in national clinical audits or benchmarking.

Are outpatients and diagnostic imaging services caring?

Compassionate care

- We observed staff interactions with patients were courteous and professional. Patients told us staff were approachable and had time to explain things. One patient told us the doctor was "really good, really pleased to have seen (doctor) now feel much happier".
- We spoke with nine patients who all expressed positive views about their experiences at the hospital. We also received one comment card which stated 'the staff were friendly, the doctors very helpful' and they received 'a personalised service'.
- Patients told us they were happy with the care provided and they were treated with dignity and respect. We observed staff being respectful at all times and with particular regard to patients' privacy and dignity.
- The hospital undertook its own patient satisfaction survey, which was similar to the NHS Friends and Family test used to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The results from the period January 2016 to December 2016 showed 90% (27) patients were extremely likely or likely to recommend the service to others. However, the response rate was low with 30 patients completing the survey.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt well informed about their care including any investigations that were planned. Patients said doctors were thorough, took time to explain procedures to them and they felt comfortable and reassured. One patient told us they "never feel there is a time limit".
- Patients felt they were given adequate information. One patient who told us they were a regular patient received advice on managing their long term medical condition and life style.
- A parent we spoke with was happy with the service their child received. The parent told us the doctor had kept them informed as the diagnostic process had progressed.
- We spent time in the main outpatient reception area and observed patients being greeted and booked into the clinics. There were clear instructions for any paperwork needed completing and patients were able to ask any questions.
- When patients were taken to the clinical rooms we observed staff addressed each patient by name and escorted them to the appropriate place.
- The hospitals website provided information on the cost of treatment for various procedures. Patients were able to pay for themselves and were required to pay a one off registration fee. Treatment could also be funded through private medical insurance.

Emotional support

- Notices were on display in and around consulting rooms and in the reception area which advised patients chaperones were available if required. One patient told us they had used a chaperone (receptionist) during the evening for a consultant's appointment. The hospital had a chaperone policy. The policy stated 'A chaperone will always be a member of the Chase Lodge Hospital team who has undergone chaperone training. This will usually be a clinical member of staff'.

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- Patients were able to be referred to access psychiatry and psychology services which also operated on site.
- We saw relatives were able to accompany patients during consultations.

Are outpatients and diagnostic imaging services responsive?

Service planning and delivery to meet the needs of local people

- The hospital offered GP appointments, access to consultants and diagnostic imaging services to children and adults. Only procedures which did not require general anaesthesia were performed at the hospital.
- Appointments were offered at times to suit the patients.
- When children attended consultations with consultants the hospital brought in a dedicated registered children's nurse (RCN) to support children under the age of 17 years. The RCN worked five hours per week and supported children with minor interventions such as children's immunisations or phlebotomy.

Access and flow

- There were 5,547 outpatient total attendances in the reporting period January 2016 to December 2016 of these 100% were funded by other means, none were NHS funded. Of these 1297 attendances were attributed to children under the age of 17 years.
- Between March 2016 and March 2017 patients did not attend 258 GP appointments. It was not clear what steps the hospital took to address this.
- The hospital did not operate a waiting list as patients were offered the most convenient appointment with their preferred GP or consultant. They did not audit patients waiting times from their initial contact to first appointment and/or treatment.
- Patients we spoke with told us they had no problem arranging a suitable appointment with a doctor of their choice. We observed patients were seen promptly after arriving in the clinic.
- The hospital audited patient waiting time from their arrival. Data provided covered three audits from May 2015, June 2016 and January 2017. This demonstrated the number of patients waiting more than 15 minutes had reduced from June 2016 to none in January 2017 with the majority (about 61%) of patients being seen within 5 minutes.

Meeting people's individual needs

- The hospital did not have separate waiting areas for children. The waiting area was also shared with a dental surgery that was located on site.
- Most treatment rooms did not have curtains or a privacy screen and windows in some rooms did not have blinds or screening.
- We found there was a lack of sound proofing between rooms which meant the patient conversation could be overheard.
- The hospital had one staff member trained as a 'dementia friend'. However, there was no formal routinely provided dementia awareness training to hospital staff. A 'dementia friend' is someone who has an understanding of what it's like to live with dementia.
- The hospital had a process to note that a patient was living with a learning disability or with dementia. It was noted within the electronic records system. Staff told us if they had concerns about a patient they would highlight this to the GP's. However, not all the staff were aware the coding system was used to flag patients
- Disabled patients could access and use the hospital. A lift was available to access the first floor. However some of the rooms were inaccessible by wheelchair. There was also a chair lift for four steps to take patients from the reception area to a consultation room.
- The hospital did not have facilities for patients with bariatric needs.
- In the waiting area we saw signs were written in 12 languages. Staff told us they could access a dedicated language line service for interpreting services.
- A water dispenser and a tea and coffee machine were available for patients to use in the pharmacy.
- Patients were able to access free Wi-Fi whilst in the hospital.
- In the waiting room hearing loop facility was available.
- The hospital provided baby changing facilities.

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Learning from complaints and concerns

- The hospital had a complaints policy and complaints procedure in place. The complaints procedure gave details of the independent sector complaints adjudication service (ISCAS).
- There was a system for capturing and learning from complaints. The hospital provided details of six complaints received between January and April 2017. The hospital aimed to acknowledge all complaints within three working days with a target of 28 working days for a full response. Four of the complaints were upheld and resolved within the hospital target of 28 days. We did not identify and particular patterns or trends in these complaints.
- We saw complaints were discussed at clinical meetings minutes in January and April 2017. The minutes detailed if the complaint was upheld and action taken by the hospital to prevent a reoccurrence.
- Staff told us they would refer any complaints to the hospitals business manager.
- Information leaflets were available in the hospitals reception area which provided details about the complaints process. The leaflets also had details of the independent sector complaints adjudication service. This information was also available on the hospitals website. However, this information was not easily accessible for patients.

Are outpatients and diagnostic imaging services well-led?

Leadership of the service

- There was a clear leadership structure; the senior leadership team was made up the chief executive officer (CEO) and founder and clinical partner and business manager. The senior leadership team had identified the need to split the clinical and operation management function of the hospital and had been trying to recruit a hospital manager. Staff told us the managers were supportive and approachable. Staff told us they felt respected and valued.
- There was a lack of understanding of regulatory requirements amongst the senior team with regard to reporting and notifications. The role of the registered manager was not clearly developed. There was confusion over the role of the nominated individual with the owner who was also a practicing doctor at the location being registered as both registered manager and one of the nominated individuals. The hospital manger post was vacant for many months and the provider told us they had difficulties with finding a suitable candidate to fill the post. The hospital advised us that the person identified as the second nominated individual was not supposed to have been registered as such but no notification had been received to make this variation.
- The hospital provided details of monthly management, interim operational meetings and clinical meetings that involved managers and some of the GPs working at the hospital. However, the hospital did not have a regular all staff team meeting which would aim to share good practice, focus on quality improvements, and staff engagement.

Vision and strategy for this service

- The senior leadership team described the vision for the service as a GP run hospital that provided easy and convenient access to specialist investigations, consultant out-patient clinics and a wide range of complementary and aesthetic services, with a view to offering "high quality holistic care under one roof".
- The ethos of the service was ‘Safe, Professional, Effective, Caring’.
- An example was shared by the leadership team of GPs that worked at the hospital being able to directly refer patients to specialist consultants without the delay of referral to another service.
- Staff we spoke with were aware of the hospital’s vision and ethos; staff believed everyone was doing their best to deliver the hospitals vision and ethos to patients.

Governance, risk management and quality measurement

- Chase Lodge Hospital did not have a clear and robust governance structure in place with limited involvement from the medical advisory committee. There was a lack of governance oversight; we are aware the hospital has previously undertaken a procedure it was not registered or regulated to perform (September 2015). We requested details for root cause analysis undertaken by

the hospital, two were provided neither of which related to the procedure. There were few processes in place to improve patient safety, to learn from patients' experience, improve clinical effectiveness and the patient experience. Root cause analysis (RCA) identifies what, how, and why patient safety incidents happen. It is used to identify areas for change and to develop recommendations which deliver safer care for patients.

- The hospital had employed the services of a clinical governance consultant on a day a week basis to help provide governance advice during the process of recruitment for a substantive hospital manager.
- We saw evidence of Medical Advisory Committee (MAC) meetings in November 2014, June 2016 and April 2017. The hospital appointed a new MAC chair earlier this year who had reviewed its structure. The previous MAC chair left in 2016. The MAC did not have terms of reference and was not effective. For example MAC did not review doctors practising privileges and was not responsible for reviewing clinical guidance. It is usual practice for the MAC to advise the registered person on matters relating to the granting of practising privileges, clinical standards, new and emerging professional guidance, the introduction of new treatments and capital investments.
- The hospital had a risk register in place. There were 14 risks identified between January 2016 to April 2017. These related to complaints/claims (1), financial (2), injury to patient, visitor or staff (8) and nine of the risks were still ongoing or in progress. Radiator covers on the ground floor had been identified as a risk and was due to be resolved by July 2017. The risk register did not reflect the risks found during the inspection such as: vacant hospital manger's post; lack of understanding of regulatory requirements among senior management team; or environmental risks such as the radiator in the paediatric consulting room. Staff told us informal conversations are encouraged but where issues existed and need to be escalated these would be escalated to a formal meeting.
- Information governance was not being over seen appropriately. Consultants were taking patient information off site, however it was not clear whether consultants complied with data protection regulations or were registered as information protection officers. There was also evidence that prescription were not being issued under the name of the prescribing doctor. Electronic prescription defaulted to one doctor who was identified as the main authoriser.
- The provider did not undertake audits to determine to check if quality of records was of satisfactory standard or if records were stored securely. They did not routinely audit if patients confidentiality was maintained at all times.
- Chase Lodge Hospital did not have effective systems in place for recruitment and selection of staff which ensured appropriate recruitment checks had been undertaken prior to employment. Not all the records had proof of identification, references, evidence of full employment history including reasons for ending their previous employment and the appropriate checks through the Disclosure and Barring Service (DBS).

Culture within the service

- Staff described the culture as open and transparent where staff supported each other.
- Staff enjoyed working at Chase Lodge Hospital; they were enthusiastic about the care and services they provided for patients. They described the hospital as a good place to work. Some of the staff we spoke with had worked for the provider for several years and were enthusiastic about the services the hospital offered and the care provided.

Public engagement

- Staff told us the patients participation group had not met in the last three or four years. The hospital provided details of issues raised by the patients and actions they had taken to address concerns. For example, patients raised concerns the phones were sometimes engaged and not always answered properly; the outcome was to send more texts where possible for example when patients prescriptions were ready to be picked up.
- The hospital provided data from their patients satisfaction survey which they undertook in 2015 and 2016. The results from the period January 2016 to December 2016 showed 90% (27of 30) patients were extremely likely or likely to recommend the service to others. The results the period from January 2015 to

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December 2015 88% (22 of 25) were extremely likely or likely to recommend the service to others. The response rate was low with 30 patients and 25 patients completing the survey.

Staff engagement

- The staff survey undertaken in August 2016 asked staff if they felt supported by colleagues. Eight out of ten surveys were returned with acceptable answers. However, staff also commented time and priorities sometimes prevented them for asking for support. No further action was considered necessary.

Innovation, improvement and sustainability

- A day surgery unit was under construction at the hospital and it was due to open in 2017. This was to enhance the services the hospital provided on site.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure there is a robust governance structure in place to improve patient safety, learn from patients' experience, and improve clinical effectiveness.
- Ensure appropriate management of medicines including controlled drugs and administration of travel vaccinations.
- Ensure that appropriated recruitment checks are completed for all staff including appropriate checks through the Disclosure and Barring Service (DBS).
- Ensure there is a radiation protection supervisor (RPS) which is a requirement of Regulation 17 of the Ionising Radiations Regulation 1999 (IRR99).
- Ensure ionizing radiation is measured and monitoring instruments are fit for purpose.
- Ensure medical records for all patients are maintained within the hospital.
- Ensure staff receives appropriate level of safeguarding training as required by current guidance.

Action the provider SHOULD take to improve

- Ensure that policies are reviewed regularly and version control system is implemented.
- Ensure that clinical waste is managed safely.
- Ensure the environment, including the radiators, is assessed to prevent risk of harm to children.
- Ensure that GP's undertake mandatory training and that record of staff training is maintained.
- Ensure all staff, including medical staff working under practicing privileges, are appraised and record of it is maintained.
- Ensure there is an effective system to communicate with NHS GP's about the management of patients with long term conditions.
- Ensure there is an up to date policy for Deprivation of Liberty Safeguards and that staff receive training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.
- Endeavour to improve the patient satisfaction survey response rate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; e. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; g. the proper and safe management of medicines; We noted: • There was no radiation protection supervisor (RPS) which is a requirement of Regulation 17 of the Ionising Radiations Regulation 1999 (IRR99). • Ionizing radiation was not measured as monitoring instruments were not fit for purpose. • Medicines were not managed appropriately. • Not all staff received appropriate level of safeguarding training as required by current guidance.

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Requirement notices

- Clinical waste was not managed safely.
- Environment was not assessed to prevent risk of harm to children.
- Not all GP's undertook mandatory training and record of staff training is maintained.
- There was no up to date policy for Deprivation of Liberty Safeguards and that staff receive training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.
- Incidents were not formally investigated to ensure lessons were learnt and actions were taken to prevent future occurrence.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed 1. Persons employed for the purposes of carrying on a regulated activity must— a. be of good character, b. have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and c. be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. 2. Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in— a. paragraph (1), or b. in a case to which regulation 5 applies, paragraph (3) of that regulation. 3. The following information must be available in relation to each such person employed— a. the information specified in Schedule 3, and

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Requirement notices

b. such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

We noted:

- The provider did not undertake appropriate recruitment checks for all staff.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; c. maintain securely such other records as are necessary to be kept in relation to— i. persons employed in the carrying on of the regulated activity, and ii. the management of the regulated activity; e. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

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Requirement notices

We noted:

- There was lack of robust governance structure to improve patient safety, learn from patients' experience, and improve clinical effectiveness.
- There was lack of oversight to ensure that policies were reviewed and there was no version control system.
- Not all risks were adequately assessed.
- Not all patients records were maintained within the hospital.
- Not all staff, including medical staff working under practicing privileges, were appraised and record of staff competencies, training and appraisal was not always maintained.