Baddow Hospital

Quality Report

Baddow Hospital,
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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?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Baddow Hospital is operated by Baddow Hospital Company Limited. The hospital comprises one ward with eight day case beds, five outpatient consultation rooms, two en-suite bedrooms for day case or overnight patients, two theatres, one pain management room, two treatment rooms and one ultrasound room.

The hospital provides surgery, and outpatients and diagnostic imaging services, both for patients over 18 years of age. We inspected both of these services. We carried out an announced inspection on 3 April 2017.

We last inspected Baddow Hospital in September 2016 where it was rated inadequate. This was based on findings including (but not limited to) a lack of formalised sharing learning from incidents; lack of a risk register and suitable governance processes; lack of a performance dashboard to monitor safety and quality; and a failure to meet national standards for safeguarding. Following this inspection, we issued a warning notice because the service was not meeting its legal requirements under Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also issued a requirement notice under Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The primary focus of this comprehensive re-inspection was to check whether the service was now compliant with these Regulations, although we covered all domains as outlined in the report, using our comprehensive inspection methodology.

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.

Services we rate

We rated this hospital as good overall.

We rated surgery as good because:

- Staff were familiar with the incident reporting system, and actions and learning from incidents were documented and discussed at the relevant meeting such as clinical governance meetings and then shared with staff.
- The service had implemented a performance dashboard following our previous inspection to give an overview of safety, quality and risk. This included, for example, confirmation of the daily trolley checks, and the patient to staff ratio.
- All equipment we checked was properly stored and in date, including within servicing date for electrical equipment.
- Safeguarding training and procedures were in line with national guidance.
- The admission criteria had been updated since our last inspection, primarily to exclude patients under the age of 18, to ensure the service was only admitting patients for whom it could provide safe care.
- Nursing and medical staffing levels were both sufficient to safely meet the needs of patients.
- Policies were up-to-date, based on national guidance and best practice and legislation, for example the safeguarding policy. Staff were updated on any policy changes and knew how to access policies.

Summary of findings

- Following our previous inspection, the service had implemented a comprehensive local audit programme and started participating in national audits, namely the Patient Reported Outcome Measures (PROMS) and the Breast Implant Registry, in order to benchmark and monitor performance.
- There were opportunities for staff to undertake additional training or courses to develop their competencies.
- Since our previous inspection, the service had updated their training programme to include comprehensive training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff showed good awareness of MCA and DoLS.
- Staff displayed a caring approach and maintained patients' privacy and dignity, for example by using retractable screens to section off patient areas.
- Services were planned and delivered to meet patients' needs. For example, there was a daily briefing where staff went through the plan for the day to ensure they could deliver services in a timely manner.
- Translation services were available for staff to access for patients whose first language was not English.
- The service had made significant improvements since our previous inspection (for example around governance processes, audits and safeguarding) and was now focusing on embedding these changes.
- The service had implemented an appropriate risk register since our previous inspection. There was a nominated lead who had overall responsibility for monitoring risks on the register. All staff had access to the register and were encouraged to record any risks or incidents of any type.
- Service leads had identified an area for improvement around information governance, as this was a recurring issue on the risk/incident register. The service had implemented additional training for staff to address their information governance concerns and senior staff told us they were beginning to see a culture change around better information governance.
- Service leads had focused on implementing and encouraging a positive change in culture around the areas of concern we had identified from our last inspection. For example, staff were encouraged in team meetings to take an active role in the new combined risk and incident register.

However, we also found the following areas for improvement:

- There was no clear, structured strategy to achieve corporate objectives within a set timeframe, although we understood that the hospital's main focus had been addressing the areas of concern we had found on our previous inspection. This was detailed in their hospital improvement plan.
- When we inspected, records for appointments on the same day were not locked within the reception area, although they were out of sight and out of general thoroughfares so only staff would have been able to see and access them.
- Theatre team meeting minutes from March 2017 noted that morale was low and this was in part owing to recent redundancies. There was nothing in these minutes to say what managers were doing to boost morale.

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

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
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. We rated surgery as good because: • Staff were familiar with the incident reporting system, and actions and learning from incidents were documented and discussed at the relevant meeting such as clinical governance meetings and then shared with staff. • The service had implemented a performance dashboard following our previous inspection to give an overview of safety, quality and risk. This included, for example, confirmation of the daily trolley checks, and the patient to staff ratio. • All equipment we checked was properly stored and in date. • Safeguarding training and procedures were in line with national guidance. • The admission criteria had been updated since our last inspection, primarily to exclude patients under the age of 18, to ensure the service was only admitting patients for whom it could provide safe care. • Nursing and medical staffing levels were both sufficient to safely meet patients' needs. • Policies were up-to-date, based on national guidance and best practice and legislation, for example the safeguarding policy. Staff were updated on any policy changes and knew how to access policies. • The service had implemented a comprehensive local audit programme and started participating in national audits, namely the Patient Reported Outcome Measures (PROMS) and the Breast Implant Registry, in order to benchmark and monitor performance. • There were opportunities for staff to undertake additional training or courses to develop their competencies.

Summary of findings

- Since our previous inspection, the service had updated their training programme to include comprehensive training on the Mental Capacity Act 2005, (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff showed good awareness of MCA and DoLS.
- Staff displayed a caring approach and maintained patients' privacy and dignity, for example by using retractable screens to section off patient areas.
- Services were planned and delivered to meet patients' needs. For example there was a daily '10 at 10' meeting where staff went through the plan for the day to ensure they could deliver services in a timely manner.
- Translation services were available for staff to access for patients whose first language was not English.
- The service had made significant improvements since our previous inspection (for example around governance processes, audits and safeguarding) and was now focusing on embedding these changes.
- The service had implemented an appropriate risk register since our previous inspection. There was a nominated lead who had overall responsibility for monitoring risks on the register. All staff had access to the register and were encouraged to record any risks or incidents of any type.
- Service leads had identified an area for improvement around information governance, as this was a recurring issue on the risk/incident register. The service had implemented additional training for staff to address their information governance concerns and we were told they were beginning to see a culture change around better information governance.
- Service leads had focused on implementing and encouraging a positive change in culture around the areas of concern we had identified from our last inspection. For example, staff were encouraged in team meetings to take an active role in the new combined risk and incident register.

Summary of findings

Outpatients and diagnostic imaging

Good

Surgery was the main activity of the hospital. Please see above for full summary.
We rated outpatients and diagnostic imaging as good.

- Outpatient consultation rooms were visibly clean and we saw staff compliance with infection prevention and control in outpatient areas..
- There was emergency equipment for outpatients including a defibrillator stored behind the main reception desk.
- Appointments were arranged at the convenience of the patient and ran in a timely manner.
- The service used a disability audit form which aimed to ensure the department was accessible to all. This included, but was not restricted to, factors such as appropriate seating in waiting areas, a lowered section of the reception desk and information tailored to specific needs.

Summary of findings

Contents

Good

Baddow Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Baddow Hospital

Baddow Hospital is operated by Baddow Hospital Company Limited. The hospital opened in 2013. It is a private hospital in Great Baddow, Essex. The hospital primarily serves the communities of the Chelmsford area.

Baddow Hospital treats patients funded by private medical insurance cover, self-funding or NHS outsourced patients. The specialities covered are general surgery, gynaecology, urology, dermatology, rheumatology, ENT (ear, nose and throat), pain management, maxillofacial, podiatry and foot and ankle surgery. The hospital also provides cosmetic surgery services; however, we do not currently have a legal duty to rate cosmetic surgery services.

The hospital has had a registered manager in post since October 2014.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two CQC inspection managers. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Baddow Hospital

The hospital comprises one ward with eight day case beds, five outpatient consultation rooms, two en-suite bedrooms for day case or overnight patients, two theatres, one pain management room, two treatment rooms and one ultrasound room.

It is registered to provide the following regulated activities:

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

During the inspection, we visited all areas of the hospital and spoke with eight members of staff including the ward lead, operating department practitioner (OPD), cleaning staff, administrative staff and the senior management team. We also reviewed data provided by the hospital before, during and after our inspection and reviewed three sets of patient records.

We were unable to speak with patients or observe care and treatment on the day of our inspection; however we reviewed patient feedback and had spoken to patients and observed care and treatment at the previous inspection in September 2016.

Activity (March 2016 to March 2017):

- There were 2,120 day case episodes of surgery in total from March 2016 to March 2017 and 77 overnight cases within the same period, equating to 3.6% of all surgery. From September 2016 to March 2017, surgeries were 70.5% NHS funded and 29.5% privately funded.
- There were 10,187 outpatient total attendances between March 2016 and March 2017. Of these, 49.8% were NHS funded and 50.2% were privately funded.

As of April 2017, there were 27 anaesthetists, 38 consultants and six resident medical officers (RMOs) working at the hospital under practising privileges.

The accountable officer for controlled drugs (CDs) had been in post since September 2014.

Track record on safety (April 2016 to March 2017):

Summary of this inspection

- No never events
- No clinical incidents resulting in severe harm or death
- 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 patient complaints

Services accredited by a national body:

- None

Services provided at the hospital under service level agreement:

- Diagnostic services
- Pharmacy services

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 had been a drive towards encouraging staff to report incidents since our previous inspection. There was an incident reporting system, incorporated as part of an overall document for the service which monitored risks, incidents and complaints of all types and severity. All staff had access to this and were familiar with using it.
- Actions and learning from incidents were documented in the combined risk and incident register and discussed at the relevant meeting such as clinical governance meetings. There was an improvement in sharing learning among all staff since our last inspection.
- The service had implemented a performance dashboard following our previous inspection to give an overview of safety, quality and risk, for example by documenting that the daily trolley checks had been completed, and the patient to staff ratio.
- All equipment we checked was properly stored and in date.
- Safeguarding was a main focus of the hospital improvement plan that had been developed since the previous CQC inspection in September 2016. This included appointing two new safeguarding leads in line with national guidance, who were both trained to level four safeguarding adults; and improving training so that all clinical staff and service leads were trained to level three in safeguarding adults and non-clinical staff were trained to a minimum of level two. Staff had also completed level two training in safeguarding children, although the service was no longer treating children.
- The admission criteria had been updated since our last inspection, primarily to exclude patients under the age of 18 from being treated at the hospital. This meant the service was only admitting patients for whom it could provide safe care.
- Nursing and medical staffing levels were both sufficient to safely meet patient acuity and was planned in advance and then discussed at daily morning meetings.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Policies were up-to-date, based on national guidance and best practice and legislation, for example the safeguarding policy. Staff were updated on any policy changes and knew how to access policies.
- Following our previous inspection, the service had implemented a comprehensive local audit programme and started participating in national audits, namely the Patient Reported Outcome Measures (PROMS) and the Breast Implant Registry, in order to benchmark and monitor performance.
- There were opportunities for staff to undertake additional training or courses to develop their competencies. For example, the theatre scrub nurse had been booked onto a surgical first assistant course.
- Since our previous inspection, the service had updated their training programme to include comprehensive training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The content of this was appropriate for the roles staff would be carrying out and staff showed good awareness of MCA and DoLS.

Are services caring?

Good

We rated caring as good because:

- The service had started collecting friends and family test (FFT) data since our previous inspection. From January to March 2017 FFT results showed that, out of 177 submissions, 176 said they were likely to recommend the service. This was above the target of 90%.
- Staff displayed a caring approach and maintained patients' privacy and dignity, for example by using retractable screens to section off patient areas.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered to meet patients' needs. For example there was a daily morning briefing where staff went through the plan for the day to ensure they could deliver services in a timely manner.
- Procedures and appointments were arranged between consultant and patient, at the patient's convenience.
- Discharge planning happened as early as possible, usually at the pre-assessment phase. Following discharge the patient's consultant completed a discharge summary and sent a copy to the patient's GP.

Summary of this inspection

- Training had been updated since our previous inspection to include dementia awareness and the needs of patients with learning disabilities. All staff had completed this training at the time of our inspection.
- Translation services were available for staff to access for patients whose first language was not English.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Although the service had made significant improvements since our previous inspection (for example around governance processes, audits and safeguarding), many of the governance and cultural improvements were still in their infancy and therefore not embedded into the service and was now focusing on embedding these changes.
- There was no clear, structured strategy to set out specific targets and actions to achieve these. Although we understood that the hospital's main focus had been addressing the areas of concern we had found on our previous inspection, it was not clear how the service was going to develop following this.
- The leadership team were still familiarising themselves with the new approaches they had implemented, although they showed commitment to this.
- The service had implemented an appropriate risk register since our previous inspection. There was a nominated lead who had overall responsibility for monitoring risks on the register. All staff had access to the register and were encouraged to record any risks or incidents of any type.
- Service leads had identified an area for improvement around information governance as this was a recurring issue on the risk/incident register. The service had implemented additional training for staff to address their information governance concerns and we were told they were beginning to see a gradual culture change around better information governance, although this was still at an early stage.

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	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Surgery

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

Are surgery services safe?

Good

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 section.

We rated safe as good.

Incidents

- There had been a drive towards encouraging staff to report incidents since our previous inspection and this was clear from minutes of meetings including the extraordinary Medical Advisory Committee (MAC) meeting in January 2017 and theatre, ward and outpatient team meetings in February 2017, which included reminders to staff about incident reporting and how to report.
- There was an incident reporting system in place and all staff knew how to use it. This was incorporated as part of an overall document for the service that monitored risks, incidents and complaints of all types and severity. All staff had access to this. Risks and incidents were graded as low, medium, high or extreme risk, or not assessed. They were also rated according to the level of action required to address the risk or incident, on a scale of A-D (with A being the most urgent level of action).
- We reviewed this document and saw that incidents had been documented, graded and reviewed appropriately. There were actions documented to reduce the risk of similar incidents reoccurring; for example, a near-miss relating to a patient being consented for a different procedure (which had been graded as high seriousness) had a corresponding action to ensure consultants always reviewed patients before starting their theatre lists. This incident was also put on the agenda for the next MAC meeting (held quarterly).
- There were 12 entries on this incident/risk register that were graded as high seriousness as of March 2017. However, this was a local service categorisation and the performance dashboard showed there had been no serious incidents from January to March 2017. As the register was a live working document, this was a combination of entries added in March 2017 and entries that had been added previously but had been reviewed as ongoing. The incidents rated as 'high seriousness' included a mixture of clinical, corporate and health and safety risks across the service. For example, one was in relation to a patient who arrived for their procedure by taxi with no one to travel with them post procedure, the risk being that the patient would be travelling back alone after the procedure with no one to assist in the event of side effects such as fainting or dizziness. This had been mitigated by taking the patient back to the ward to phone a relative to collect them after the procedure, before the procedure could commence.
- There had been no never events in surgery between April 2016 and March 2017. 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.
- There had been no mortalities within the service between April 2016 and March 2017.

- Discussion of morbidity and mortality was included in the agenda for MAC meetings. These were held quarterly which was an increase in frequency from our previous inspection (where they were being held twice-yearly).
- Actions and learning from incidents were documented in the combined risk and incident register and discussed at the relevant meeting such as clinical governance meetings. There was evidence of an improvement in sharing learning among all staff since our last inspection. For example, an entry from March 2017 related to an incident where the side for a patient procedure had not been specified in the procedure list, although the entry did not specify the procedure or exact site for the procedure. Actions taken included a discussion between the consultant and secretary to ensure that all relevant information is available before the patients are put on to a list; and to include both the pre-assessment nurse and secretary in the team debrief following the incident with changes of practice to be made. This was due to be reviewed at the next MAC meeting, however as the incident was very recent this had not yet taken place.
- Staff were aware of the principles of duty of candour. The duty of candour is a legal duty 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. Duty of candour was included in mandatory training for all staff. There had been three incidents from September 2016 to March 2016 where showed duty of candour had been carried out, which was recorded in the combined incident/risk register.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service had implemented a performance dashboard following our previous inspection. The performance dashboard was displayed clearly in reception to give an overview of safety, quality and risk, for example by documenting that the daily trolley checks had been completed, and the patient to staff ratio. The dashboard also showed the number of surgeries for the day. For each criterion there was a named member of staff responsible for ensuring compliance. However, surgical site infections (SSI) were not recorded on this dashboard.
- Venous thromboembolism (VTE) checklists had been completed 100% of the time in January and February 2017 and 99% in March 2017. There were no cases of hospital-acquired VTE from April 2016 to March 2017.

Cleanliness, infection control and hygiene

- All areas of the hospital were visibly clean. There were cleaning schedules throughout the hospital and cleaning was carried out by cleaning staff employed by the hospital.
- Infection prevention and control (IPC) training was part of induction training for all staff and records showed that 100% of staff had completed this training.
- Staff were compliant with hand hygiene and the hospital's infection prevention control policy; for example, we saw regular hand washing and compliance with the 'bare below the elbows' policy. Personal protective equipment (PPE) such as disposable gloves and aprons was available in all areas. Service leads confirmed they had recently increased the number of hand sanitising dispensers.
- The service was carrying out monthly audits of hand hygiene, which included an observational audit documenting any missed hand hygiene opportunities on ward entry. The audit for January 2017 showed one missed hand hygiene opportunity and for both the February and March 2017audits there were no recorded missed opportunities.
- Clinical waste was disposed of appropriately and in line with the hospital's clinical waste procedures using yellow clinical waste bags.
- The service used "I am clean" stickers to show when equipment was last cleaned.
- Sharps bins were signed and dated and filled to a safe level. However, there was an entry on the hospital's combined incident/risk register dated March 2017 that sharps bins had not been assembled correctly resulting in the lid falling off when the bins were being taken out and sharps falling onto the floor. This had been actioned appropriately by emailing all staff regarding correct assembly of sharps bins with documentation. This had also been discussed at the following clinical governance meeting in March 2017.
- There were up-to-date policies and procedures in place for infection prevention and control (IPC). Staff confirmed they could access these via the intranet.

- The hospital also employed a specialist infection prevention and control doctor in an advisory capacity who provided quarterly infection control reports for the hospital.
- We reviewed the annual IPC report, ratified in March 2017, which assessed IPC according to ten recognised criteria and found the service to have sufficient measures in place to ensure effective IPC as well as setting IPC objectives for the following year.
- There had been no incidences of hospital-acquired MRSA from April 2016 to March 2017.
- The service had reviewed its MRSA policy since our previous inspection (where we had concerns that not all patients were being screened and the policy did not require swabs to be taken). Under the newly adopted policy since January 2017 100% of appropriate patients had been screened for MRSA. This equated to all patients who had a face-to-face assessment, plus patients who had a telephone assessment and had 'triggered' as a potential MRSA risk. This selection process for MRSA screening had been approved by the specialist IPC doctor.

Environment and equipment

- There were two operating theatres, one of which had laminar flow. Laminar flow is a system of circulating filtered air to reduce the risk of airborne contamination and exposure to chemical pollutants in theatres. There was also a pain management room, a recovery area with four bays, a recovery ward area consisting of eight day stay beds, known as "pods" with retractable screens for privacy, and an additional two bedrooms with en-suite facilities for day case and overnight stays, should a patient require overnight care.
- There was one trolley with resuscitation equipment for the whole hospital. This was fully stocked and records showed daily checks had been carried out and signed off by the operating department practitioner.
- We checked single use equipment throughout the hospital and found that this equipment was properly stored, in date and packaging was intact. Electrical equipment was within servicing dates.
- We looked at records for the difficult airway trolley and saw they had been checked and signed off daily by the operating department practitioner (ODP) and reviewed by the theatre lead. This was an improvement from our previous inspection where we were concerned that there were no records kept for the checking history of the trolley.
- There were fire extinguishers stored safely in theatres and on the ward which had been serviced and were in date. However, there was a large volume of dust on the fire extinguisher handle next to the theatre store room.
- The service was not carrying out patient-led assessments of the environment (PLACE) in line with national guidance. These assessments are designed by the Department of Health to allow services providing NHS funded care to benchmark and compare environmental standards nationally.

Medicines

- Controlled drugs (CDs) were stored securely. We checked CDs in theatres and they were all in date. Daily checks had been done with no gaps in the checking records from January to March 2017. Medicines for resuscitation were checked daily along with the emergency equipment.
- We checked the blood fridge which was within the appropriate temperature range and daily temperature checks had been carried out and signed off.
- There was a service level agreement (SLA) in place with a nearby NHS trust for pharmacy support.

Records

- Records were stored in the reception area of the hospital for the day ahead and would be picked up by individual consultants and stored in metal lockable cabinets within inpatient areas for those patients being treated at that time. During our recent inspection, the records for the following day were not locked within the reception area, however, they were out of sight and out of general thoroughfares so only staff would have been able to see and access them.
- Records that were not required on that day or the next day were stored in a locked filing cabinet behind closed doors within the hospital's internal medical records department.
- We reviewed three sets of patient pre-operative records on the day of our inspection. We found that an appropriate pre-operative assessment had been carried out and recorded in all of the records.

- There were registers kept for implants such as breast implants and these were fully completed with relevant traceability stickers attached, in line with NICE guidance and recall requirements.
- The local records audit in January 2017 found that there were gaps in documentation, although it did not say what proportion of records were incomplete. The audit highlighted that staff needed to be more vigilant in completing all pieces of documentation and included as an action to improve staff awareness through discussion in team meetings. The records audit from February 2017 stated there had been improvement in documentation, but again there was no proportion of records included in this so it was impossible for us to quantify this.
- In the Heads of Department (HODS) meeting of January 2017 a concern was raised that charge sheets were sometimes omitted from patient files, although there was no action highlighted in these meeting minutes to address this. We did not come across this when reviewing records on the day of our inspection.

Safeguarding

- During our previous inspection in September 2016, we highlighted concerns regarding the level of safeguarding training and awareness at all levels. At this inspection, we saw evidence that the hospital had increased training and awareness and was compliant with Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as outlined in this section.
- Safeguarding was included as a main focus of the hospital improvement plan that had been developed since the previous CQC inspection in September 2016. This included appointing two new safeguarding leads who were registered professionals, in line with guidance issued by the Royal College of Paediatrics and Child Health (Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, intercollegiate document, 2014).
- The two safeguarding leads were both trained to level four safeguarding adults. All clinical staff and service leads were trained to level three in safeguarding adults and non-clinical staff were trained to a minimum of level two. We reviewed the mandatory training data for the service which showed that 100% of staff had completed this as planned. Staff had also completed level two training in safeguarding children, although the service was no longer treating children.
- A new safeguarding awareness board was on display in the corridor area. This included reminders about Gillick competence and the Fraser guidelines. (Gillick competence is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. The Fraser guidelines apply specifically to contraception and are used to decide whether a girl of 16 or under can be given advice or treatment without the consent or knowledge of her parents.) Although the service was no longer treating any patients under 18, service leads told us they wanted to improve staff knowledge and culture around all aspects of safeguarding.
- The safeguarding policy had been updated since our previous inspection (where it was found to be out of line with national guidance). This included establishing a Safeguarding Adults Governance Group, the purpose of which was to 'investigate any clinical or associated activity that impacts on adults in our care and to develop, comply and monitor systems and processes to ensure the issues of safeguarding of adults are adopted and embedded within the hospital.
- All staff we spoke with knew how to recognise and report potential safeguarding concerns.
- Safeguarding was included on the agenda for both the extraordinary MAC meeting and the HODS meeting from January 2017. Minutes of this meeting showed discussion of the concerns around safeguarding that were found on our previous inspection and shared with HODS the proposed improvements including updating the safeguarding policy and changing the safeguarding leads.

Mandatory training

- Records showed that, as of April 2017, 93% of all staff were up to date with mandatory training. For the three members of staff who had not completed it, they had commenced employment after the last mandatory training day, which had been in October 2016. All staff had completed the online mandatory training induction course pending the next mandatory training day, although a scheduled date for this was not indicated.

- Mandatory training was provided on an annual basis to all staff and was delivered either in the hospital by a suitable and outsourced training company, or via online modules. Subjects covered during training included fire safety awareness, health and safety, manual handling, basic life support, sepsis management and infection control.

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

- There was a resuscitation trolley that had been checked daily for the previous eight weeks, and an emergency grab bag in reception.
- The hospital had an admission policy setting out safe and agreed criteria for selection and admission of people using the service. The admission criteria had been updated since our last inspection, primarily to exclude patients under the age of 18 from being treated at the hospital. The criteria also specified other restrictions; for example, those with a body mass index (BMI) of over 40 could not be treated as the service did not have the facilities available to care for such patients safely.
- The service was monitoring its own breaches for monitoring outpatient bookings to ensure no consultations were booked for patients under 18. This was a recent patient safety control as the service had voluntarily suspended its services for patients under the age of 18 following our last inspection. There were two breaches in January 2017 and none in February or March 2017. The service's target was zero breaches. However, there was no action for improvement identified within this document.
- The hospital used the National Early Warning Scoring System (NEWS). When completed, early warning systems generate a score through the combination of a selection of routine patient observations, such as heart rate. These tools were developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation.
- There was a service level agreement (SLA) in place with a local NHS trust in the event of a patient's condition deteriorating. Any patient requiring additional clinical support would be transferred to the acute NHS trust.
- The hospital stored one unit of blood in case of emergency which was then 'recycled' back to the local NHS trust if it had not been used, so that the NHS trust could use it, and replaced with a new one.
- There was an up-to-date deteriorating patient policy with a review date of July 2018. Staff were aware of this policy and could access it via the intranet.
- The service used the World Health Organization (WHO) Surgical Safety Checklist and five steps to safer surgery for admitted patients. It was embedded into the provider's patient admission paperwork for those undergoing surgical procedures.
- Audits to assess compliance with the WHO checklist were carried out monthly. This was an improvement from the previous inspection of the service which had found these audits were infrequent. This was now included on the performance dashboard, which showed that between October 2016 and March 2017 there were two breaches of the WHO checklist completion in 1074 surgical interventions which equated to a 99.8% compliance rate. These breaches were because of missing signatures.
- Ward staff told us that doctors were always accessible and responded in a timely way to their concerns about patients, and that when a patient stayed overnight there was always a Resident Medical Officer (RMO) on site between 8pm and 7am.
- The surgeon and anaesthetist were required to remain within a 30 minute return to the hospital for emergencies overnight. In addition, there was an on call theatre team for overnight admission.
- Following discharge, patients were given suitable information about what to do if they were worried about their condition and if they required emergency advice or treatment.

Nursing and support staffing

- At the time of inspection the service employed four registered nurses and two health care assistants (HCAs) in total on the ward; and five registered nurses, three operating department practitioners (ODPs) and three HCAs in theatres. The service's performance dashboard showed that theatre staffing levels were consistently compliant with National Institute for Health and Care Excellence (NICE) safer staffing guidelines between January 2017 and March 2017. Staff rotas also confirmed this.
- There was always a senior member of staff on duty per shift and for each area and we saw staffing levels and skill mix were safe and appropriate to meet patient needs.

Good

Surgery

- The hospital did not use an acuity tool to determine staffing numbers. However, staffing was assessed by the nurse lead weeks prior to planned admissions, and then reviewed days ahead of admission and daily, and staffing numbers adjusted accordingly to ensure safe staffing levels.
- Nurse staffing numbers were also assessed at the daily '10 at 10' morning meetings (which were held to run through the activity for the day ahead and led by the hospital manager).
- There was an up-to-date staff policy and procedure, which outlined minimum staffing levels. For example, when theatre operated there were always two nurses present in theatres.
- There were no staff vacancies at the time of our inspection.
- The service was not using bank or agency staff at the time of our inspection and had not done so for February and March 2017. However, data provided by the service showed that between September 2016 and March 2017 there were two full time equivalent (FTE) days covered by agency nurses on the ward and 91 FTE days in theatres. For the same period there were 76 FTE days covered by bank nurses on the ward and 58 in theatres.
- In January and February 2017 overall across the service there had been 263 recorded sick leave hours, out of a total 11,995 hours worked in the same timeframe, a proportion of 2.2%. The data for March was not yet available at the time of our inspection but the service was monitoring this on a monthly basis.

Medical staffing

- There were 27 anaesthetists, 38 consultants and six resident medical officers (RMOs) working at the hospital under practising privileges.
- RMOs were employed on a locum basis in the event that a patient required an overnight stay. RMOs worked entirely night shifts between 8pm to 7am.
- Consultant surgeons and anaesthetists were available at all times throughout the duration of their patients' stay.
- The hospital had a Medical Advisory Committee (MAC) which was chaired by a consultant plastic surgeon, and all specialities practised at the hospital were represented within the committee.
- Medical staffing was discussed and planned at the daily '10 at 10' meeting.

Emergency awareness and training

- The hospital was not a major incident receiving centre and therefore there was no major incident training or policy in relation to this.
- However, there was an up-to-date business continuity plan, which outlined protocol and procedure in the event of an emergency or unexpected disruption to service provision. Staff were aware of this document and how to access it.
- Fire escape routes were clearly signposted in all areas.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Policies were based on national guidance, best practice and legislation, for example the staffing policy made reference to professional registration councils and relevant expert and professional bodies such as the Nursing and Midwifery Council (NMC). The consent policy made reference to the most up-to-date legislation.
- The Medical Advisory Committee (MAC) were responsible for developing, ratifying and reviewing of clinical policies and procedures.
- Staff could access policies and procedures via the hospital intranet and were updated on any important changes via the heads of department. This was an improvement from our previous inspection where updates were not documented formally and staff had not shown awareness of recent changes.

Pain relief

- There were processes in place to assess, monitor and manage patients' individual pain levels. This included through routine patient observations and local audits to identify areas for improvement.
- A documentation audit carried out by the service in January 2017 found that pain and sickness were not always properly documented in patient notes. This was shared with staff in the ward team meeting in January 2017 and staff were reminded about documenting this correctly.

- There was a monthly pain and nausea audit. Actions from this included reminders to staff about escalating any unusual pain, and informing consultants.
- There was always a doctor on site, including during the night for overnight stays when required. This meant that there was always access to further pain relief as necessary and at short notice.
- Staff assessed patients' pain as part of the routine observations and also reassessed it following the administration of pain relief.

Nutrition and hydration

- There was a range of food and drinks available for a range of dietary needs for admitted patients.
- For day case patients, who formed the vast majority of the service's work, light meals were available. Patients requiring an overnight stay were offered a choice of hot meals.
- Within the theatres department the standard starve time of six hours was used. This information was given verbally to patients at pre-assessment and as part of the information they were sent prior to surgery.

Patient outcomes

- The Medical Advisory Committee (MAC) monitored clinical outcomes in quarterly meetings for patients such as rates of surgical site infections, adverse incidents, serious incidents, unplanned return to theatre cases and complaints. This was an improvement in oversight and monitoring from our previous inspection where they had only taken place twice-yearly.
- The service had recently started participating in national audits, namely Patient Reported Outcome Measures (PROMS) and the Breast Implant Registry. This was an improvement from our previous inspection (where it was found that no national audit participation was taking place) as over a longer term it would allow the service to benchmark its performance against other similar providers. As this was a recent improvement, there was no reportable PROMS or Breast Implant Registry data available for the service at the time of our inspection. PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre-operative and post-operative surveys.
- Since our previous inspection, the hospital had also started submitting data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- As part of its participation in national audit, the hospital was now a member of The National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- There was a comprehensive local audit schedule in place since our previous inspection, including but not limited to data protection, equipment and World Health Organization checklist audits. Team meetings included reminders about the importance of thorough and regular auditing to assess quality and performance. For example, the ward team meeting minutes from January 2017 highlighted to staff the new documentation audit and the finding that pain and sickness were not consistently being recorded properly in patient records with a reminder to record this information appropriately.
- Audits included actions required for improvement. For example, the monthly audit of the performance dashboard for March 2017 noted that there was no record on one day of fridge temperature checks in the minor operations room. The service lead had been emailed a reminder about this and the service provided assurance that this had no impact owing to no procedures taking place in the minor operations room that day.
- The hospital's local audit programme was implemented in January 2017 so there were limited results available; however, this showed commitment to monitoring performance and outcomes and identifying areas for improvement, which was an improvement from our previous inspection.
- There were care bundles in place for prevention of surgical site infection and cannulation.

Competent staff

- There was a system in place for the granting and monitoring of practising privileges for consultants working at the hospital. Privileges were reviewed yearly by the Medical Advisory Committee (MAC) as standard and also more frequently if a need was identified. All consultants were up to date with revalidation.
- All staff were up-to-date with appraisals except three members of staff where there were reasons given such as long-term sickness.

Good

Surgery

- All new staff underwent a comprehensive induction programme when they commenced employment at the hospital. Records showed that 100% of staff had completed this.
- There were opportunities for staff to undertake additional training or courses to develop their competencies. For example, the theatre scrub nurse had been booked onto a surgical first assistant course.
- We reviewed supervision logs for clinical staff from January 2017 and saw they included discussion around the support required by the individual members of staff, areas of professional development and actions to improve skills and competencies.

Multidisciplinary working

- We observed effective multidisciplinary team (MDT) working between staff and staff confirmed they had good communication with and access to other staff groups across the hospital.
- Service leads also told us their external MDT working relationship with the local NHS trust under a service level agreement (SLA) was good, for example for pharmacy support and in the event of a deteriorating patient requiring transfer.

Seven-day services

- The hospital was predominantly a day case hospital; however, patients could stay overnight if there was a clinical need. In this case, there would be a resident medical officer on site and the relevant consultant and anaesthetist were required to stay within 30 minutes of the hospital.
- The hospital offered advice services from an out-of-hours nurse advisor via telephone between 8pm and 8am.
- Pharmacy services were provided under a SLA with the local acute trust.

Access to information

- Healthcare records were stored securely on site so staff could access them as needed, and staff confirmed they could access all the patient information they required.
- Discharge summaries were sent to the patient's GP following patient discharge, and staff told us that GPs could contact the hospital for further information and advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Initial consent had been documented in the three pre-assessment records we reviewed.
- Since our previous inspection, the service had updated their training programme to include comprehensive training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We reviewed this training which was appropriate for the roles and responsibilities staff would be carrying out.
- The hospital had an up-to-date policy in place for consent to care and treatment, which staff could access via the intranet. These policies made reference to obtaining valid consent, MCA and DoLS and had been updated since our last inspection to include national guidance, best practice and more specific advice on MCA and DoLS.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- There were no patients available for us to speak to on the day of inspection; however, staff we spoke with displayed a caring and patient-centred approach.
- The service had recently started collecting friends and family test (FFT) data which was an improvement from our previous inspection. From January 2017 to March 2017 FFT results showed that, out of 177 submissions, 176 said they were likely to recommend the service. This was above the target of 90%.
- There were signs throughout the hospital informing people about chaperoning and that they could request a chaperone as required.
- Efforts were made to ensure privacy and dignity was maintained, for example, there were retractable screens to section off patient areas.

Understanding and involvement of patients and those close to them

- We were not able to speak to any patients on the day of our inspection; however, from our previous inspection in

September 2016 there was evidence from patients, feedback and records, that patients were involved in their own care such as being kept up to date with discharge arrangements.

Emotional support

- At the pre-assessment stage of care and treatment, patient needs were assessed holistically including assessment of emotional wellbeing, and then inpatient care could be tailored accordingly.
- There were no dedicated leads for emotional or psychological support for patients within the service; however, staff had access to external organisations for specialist support for patients if required.
- Out of hours there was a dedicated nurse advisor employed by the hospital who was available via telephone.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet patients' needs. For example, there was a daily '10 at 10' meeting where staff went through the plan for the day to ensure they could deliver services in a timely manner. This was led by the hospital manager.
- All areas were on the ground floor only so were easily accessible.
- Operating sessions took place Monday to Saturday from 8am to 12.30pm, and from 1.30pm to 5.30pm. All specialities covered at the hospital were able to use the theatres.
- Patients received sufficient information before appointments. This included a pre-operative assessment face to face or via the telephone, hospital contact details, hospital directions, their consultant's name and relevant information about the appointment or procedure including pre-procedure requirements. This information was also on the hospital's website.

Access and flow

- Appointments were arranged between consultant and patient at the convenience of the patient.
- Staff told us theatre lists ran promptly and patients were regularly updated about the time of their procedure.
- The service had not undertaken any contract work which required them to submit and comply with NHS referral to treatment times in the past 12 months so this data was not available.
- Discharge planning happened as early as possible, usually at the pre-assessment phase. Following discharge the patient's consultant completed a discharge summary and sent a copy to the patient's GP.
- The service had amended its admission and discharge criteria since our previous inspection in order to restrict it to patients over 18 only. The criteria also specified other exclusions that were appropriate for the services being carried out, for example, patients had to be able to mobilise from bed to chair weight bearing.
- As part of their performance dashboard, the service was monitoring the number of referrals returned to the local NHS trust because of the patient not meeting the service's eligibility criteria. From January 2017 to March 2017 there had been 27 referrals returned for this reason, out of a total 298 referrals received under the NHS contract. This was monitored by the NHS outsourcing lead for the service.
- From March 2016 to March 2017, there had been two patient transfers to the local NHS trust because of these patients requiring additional acute care.
- From March 2016 to March 2017, there had been no unplanned readmissions to the service.
- From January 2017 to March 2017, there had been three surgeries cancelled on the day, out of a total 353 surgeries carried out during this period. The operations manager confirmed those cancellations were for patients who had decided to cancel on the day of scheduled procedure.
- From March 2016 to March 2017, there were 321 surgeries cancelled equating to 13.1% of total scheduled surgeries. Of these, 78 (24.5%) were for clinical reasons (such as being ill on the day of scheduled surgery). The operations manager was able to explain the reasons for these such as the patient deciding to cancel on the day of scheduled procedure, and reasons for cancellation were documented on the service's key performance indicator tracking document.

Good

Surgery

- During the same period there were 11 same day patients who did not attend (DNAs) for surgery. However, we did not see any indication of actions to improve DNAs.

Meeting people's individual needs

- During our previous inspection in September 2016, we found that staff had minimal awareness relating to the need of patients living with dementia or a learning disability. During this inspection staff showed improved awareness about meeting the specific needs of such patients. The service had updated their training programme to include dementia awareness and caring for patients with a learning disability. At the time of our inspection, all staff had completed this training. We reviewed the training, which included explanations of recognising the symptoms of dementia and the causes, and the 'principles of dignity' to be followed.
- Every department was clearly signposted, on the ground level, and all areas were accessible to people who were wheelchair users.
- Translation services were available to staff for patients whose first language was not English.
- In reception, there was a water dispenser and a hot beverage machine, where patients and visitors could help themselves.
- There was a variety of information available to people who used the service. This included via the hospital's website, patient information leaflets, the hospital 'Health Matters' quarterly newsletter, and notices displayed throughout the hospital.

Learning from complaints and concerns

- There was an appropriate and up-to-date complaints policy and staff were aware of how to handle a complaint in line with this policy.
- Complaints were recorded in the service's overall risk and incident register as part of their means of monitoring potential areas of concern generally. There were five complaints recorded on this document from September 2016 to March 2017. However these were not all direct complaints about the service; for example, one was from a patient complaining that their GP surgery was refusing to see them post-operatively. This had been because of a change of email address meaning that the GP did not have all the patient's discharge information. As a learning action, it was documented in the register to contact the GP to verify the email address or contact details in the event of a similar issue.
- The register also recorded the action taken in response to complaints and the meeting where the complaint was discussed, which corresponded with the meeting minutes we reviewed.
- We saw within MAC meeting minutes, for example those from March 2017, that there was discussion of complaints and learning shared from complaints to try and improve the service.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership / culture of service related to this core service

- The surgery leadership team locally were the theatre manager and ward lead. They were supported by the senior management team.
- Staff reported that the culture in the service was inclusive and "like family".
- Service leads had focused on implementing and encouraging a positive change in culture around the areas of concern we had identified from our last inspection. For example, staff team meeting minutes showed evidence of encouraging staff to take an active role in the new combined risk and incident register, and improving awareness around safeguarding and the Mental Capacity Act 2005 (MCA).
- However, this work was still at an early stage and not yet fully embedded into the service, so it was not possible to fully assess the extent of the changes in leadership and culture.
- HODS meetings were monthly. Learning and updates from these, for example from incidents or changes in national guidance, were then shared with staff within the department. This was a recent initiative to ensure all staff received the relevant information, so we were not able to fully assess its effectiveness. However, it represented an improvement from our previous inspection in terms of sharing information and learning with staff.

- A lead had been recently appointed to provide emotional and psychological support for staff as needed.
- However, theatre team meeting minutes from March 2017 noted that morale was low and this was in part owing to recent redundancies. There was nothing in these minutes to say what managers were doing to boost morale and it was not included in the service's risk register. The senior team also raised this to us during inspection, although staff we spoke with did not raise this as a concern.

Vision and strategy for this this core service

- The service had made significant improvements since our previous inspection (for example around governance processes, audits and safeguarding) and was now focusing on embedding these changes. However, the improvements were still at an early stage
- Managers told us they were focusing on building up their self-pay work following a recent reduction in work outsourced by the NHS and redundancies of 25% of staff (equating to 12 members of staff) since September 2016. This was noted in the MAC meeting minutes from March 2017.
- However there was no clear, structured strategy to set out specific targets and actions to achieve these. Although we understood that the hospital's main focus had been addressing the areas of concern we had found on our previous inspection, it was not clear how the service was going to develop following this. It was not clear, for example, how they were planning to build up their self-pay work.

Governance, risk management and quality measurement

- We saw evidence that the hospital was now compliant with Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as outlined in this section.
- The service had a risk register in place, which had been developed since our previous inspection, where we had concerns about a lack risk register or any other formal documented means of monitoring risk. This was a centralised log of all incidents and risks in the service. Although the risk register was still in its infancy, it showed appropriate oversight and management of the risks in the service. There was a nominated lead who had overall responsibility for monitoring risks on the register, but all staff had access to the register and were encouraged to record any risks or incidents of any type. Staff confirmed this and the risk register showed that entries had been included by a range of staff.
- However, there was still some confusion around how risks and incidents were being graded on the register. The service was grading some risks and incidents as 'high seriousness', although there had been no actual serious incidents, in line with the Serious Incident Framework (for patients receiving NHS funded care), in the same timeframe. It was unclear how the service was reaching a decision about the severity of risks or incidents. Senior managers acknowledged on the day of our inspection that the register was still a work in progress and was being monitored and adapted as required.
- Items on the risk register were discussed at monthly clinical governance meetings and heads of department (HODS) meetings and this information was shared with departmental staff by HODS. We saw evidence of this in the meeting minutes from February and March 2017. This was a significant improvement from our previous inspection in terms of risk management and sharing information with staff.
- MAC meetings were held quarterly which was an improvement from our previous inspection where they were taking place twice a year. This increased frequency meant there was better oversight about the quality and performance of the service.
- The MAC comprised a chairman and representatives from all specialities covered by the service. The senior management team, information governance lead, NHS lead and theatre sister were also included as non-voting members.
- We reviewed the MAC meeting minutes from September 2016, February 2017 and March 2017 and saw they included discussion of, for example, clinical complaints, staffing, and review of safety measures such as post-operative infection rates. The minutes also included actions for any issues raised and these were highlighted in red.
- The MAC had also held an extra-ordinary meeting following the publication of the last CQC report in January 2017. We reviewed the minutes from this, which included sharing of all the concerns found at our inspection in September 2016 and the actions the

service was taking both immediately and in the long term to address these (such as putting up a new safeguarding awareness board and encouraging a safeguarding-focused culture).

- The hospital had also implemented monthly clinical governance meetings since January 2017 in response to our concerns from our previous inspection that there was no appropriate oversight of clinical governance in the service. This improvement was still in its infancy at the time of our inspection; however, service leads showed commitment to monitoring and improving clinical governance issues in the service.
- Service leads had identified an area for improvement around information governance. For example, the performance dashboard identified four instances of patient confidentiality breaches in January 2017, two in February and three in March, against a target of zero breaches. Specific incidents had also been identified in the combined risk/incident register. The service had implemented additional training for staff to address their information governance concerns and we were told they were beginning to see a culture change around better information governance although this would take time to implement fully. This was also supported by administrative meeting minutes from March 2017 where staff had been updated on data protection (for example a reminder about the most appropriate way to verify patient details). There was a compliance lead allocated with responsibility for this risk.
- Meeting minutes such as the HODS meeting in January 2017 included discussion around the hospital improvement plan following the publication of the last CQC report in January 2017. For example, it was shared that a risk register would be implemented with immediate effect and all staff would be encouraged to use it. This showed a commitment to improving safety, quality and risk management within the service.
- We reviewed the hospital improvement plan, dated January 2017, which contained comprehensive evidence of how the service was addressing the issues we had found on our previous inspection, including but not limited to participation in national audits, training in dementia awareness and updating safeguarding training to ensure it was in line with national guidance. When we spoke with the leadership team they explained clearly the work that had been done to improve services such as improving and increasing training, implementing a local audit programme and contributing to national audits, which have been detailed under the relevant subheadings in this report. However, it was acknowledged that the changes were recent and it would require long-term focus and oversight in order to embed the improvements into the culture of the service.

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

- There were regular patient information events held at the hospital, such as the 'Body Beautiful Evenings', which were hosted by a cosmetic and aesthetic surgeon.
- Staff told us that they felt engaged and in the service and enjoyed their work. Team meeting minutes and the '10 at 10' showed evidence of staff feeling confident to raise any questions or concerns.
- A staff quiz was introduced since our previous inspection to help the hospital management involve staff in identifying areas for improvement.
- However, there was no staff satisfaction survey or other formalised means of gaining feedback from staff about management and their experiences of working for the service.

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

- The service had recently developed an additional theatre to increase day surgery sustainability options.
- The service had recently started using a newly-developed liquid nitrogen capsule based pen within dermatology which eliminated the need for conventional liquid nitrogen decanting and had been found to have surgical benefits and lesser health risk than the traditional Cryogun because it was more narrowly focussed.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- There was no local outpatients incident log but all incidents were logged on the hospital-wide incident and risk register. This worked for the hospital because of its small size, to improve oversight of incidents in all areas.
- This risk/incident register documented an incident of a 17-year-old patient attending an outpatient appointment which was not compliant with the service's new admission criteria and policy, following our previous inspection in September 2016, that only patients over 18 would be seen and treated in the service. This had occurred because of an administrative oversight when booking the appointment. The error was realised at the time of the appointment, the patient was informed and the service did not carry out care or treatment on this patient.
- For our full findings please refer to the surgery core service report.

Cleanliness, infection control and hygiene

- Outpatient consultation rooms were visibly clean and we saw staff compliance with infection prevention and control in outpatient areas.
- For our findings please refer to the surgery core service report.

Environment and equipment

- All outpatient areas were well laid out, visibly clean and free from clutter, on the ground floor.
- There was emergency equipment for outpatients including a defibrillator stored behind the main reception desk.
- For our full findings please refer to the surgery core service report.

Medicines

- No controlled drugs (CDs) were stored in the outpatient areas. They were stored in theatres and oversight of CDs was managed by the lead operating department practitioner (ODP).
- For our findings on medicines please refer to the surgery core service report.

Records

- Outpatients staff would obtain the records from reception for the pre-assessments scheduled for that day in the morning and stored them in a locked cabinet in the treatment room where appointments took place until the time of each appointment.
- For our full findings please refer to the surgery core service report.

Safeguarding

- For our full findings please refer to the surgery core service report.

Mandatory training

- For our full findings please refer to the surgery core service report.

Assessing and responding to patient risk

Good

Outpatients and diagnostic imaging

- Staff working on reception, which was next to the waiting area for outpatients appointments, had training in basic life support.
- For our full findings please refer to the surgery core service report.

Nursing staffing

- At the time of inspection, the service employed two registered nurses and one HCA in outpatients.
- For our full findings please refer to the surgery core service report.

Medical staffing

- For our full findings please refer to the surgery core service report.

Emergency awareness and training

- For our full findings please refer to the surgery core service report.

Are outpatients and diagnostic imaging services effective?

We did not rate the outpatients and diagnostic imaging service for the effective domain.

Evidence-based care and treatment

- For our full findings please refer to the surgery core service report.

Pain relief

- Staff told us that patients attending outpatient appointments rarely required or requested pain relief owing to the type of services offered; however, patients were told that they could call after their appointment or treatment if they were experiencing pain and the nurse would offer appropriate advice or ask the patient to come in if it was necessary or if the patient was particularly concerned. This was also included on the discharge leaflet patients received.
- For our full findings please refer to the surgery core service report.

Patient outcomes

- Follow-up appointment arrangements depended on the type of treatment the patient was receiving and the consultant's preference. For instance, it was routine for cosmetic surgery patients to have an appointment with one of the outpatients nurses one week after their procedure, although some consultants made arrangements themselves to see patients for a follow-up. For NHS-funded patients, follow-up arrangements would depend on the arrangements with the NHS trust.
- For our full findings on patient outcomes including local and national audit please refer to the surgery core service report.

Competent staff

- For our full findings please refer to the surgery core service report.

Multidisciplinary working

- The service worked alongside another private hospital in Chelmsford to undertake diagnostic imaging. This was overseen by the outsourcing department and the outsourcing manager reported that links with the service were effective so patient care and transfer ran smoothly.
- For our full findings please refer to the surgery core service report.

Access to information

- Information governance was an area the service was actively trying to improve as there had been a pattern of data protection concerns recorded on the combined risk/incident register between January and March 2017. The service was implementing new training and sharing learning with staff about data protection and confidentiality to address this.
- For our full findings please refer to the surgery core service report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- For our full findings please refer to the surgery core service report.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Good

Outpatients and diagnostic imaging

Compassionate care

- For our full findings please refer to the surgery core service report.

Understanding and involvement of patients and those close to them

- For our full findings please refer to the surgery core service report.

Emotional support

- For our full findings please refer to the surgery core service report.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The service used a disability audit form which aimed to ensure the department was accessible to all. This included, but was not restricted to, factors such as appropriate seating in waiting areas, a lowered section of the reception desk and information tailored to specific needs.
- Staff told us services were flexible to accommodate patients' needs and preferences, for example by adding a patient onto their evening clinic list.
- Pre-assessment outpatient appointments were scheduled as soon as the service received the booking form.
- For our full findings please refer to the surgery core service report.

Access and flow

- The service was monitoring the rate of patients who did not attend (DNA) outpatient appointments through their performance dashboard. From January 2017 to March 2017, there were 81 instances of DNA, out of a total 1,709 outpatient consultations in this time. However, there was no indication of any specific actions to reduce DNAs.
- The service had a process in place to inform patients of delays in waiting times; staff told us that this did not happen often. We saw that access and flow through outpatients was planned in advance to minimise the risk of delays for scheduled appointments.
- The service had not undertaken any contract work which required them to comply with referral to treatment times in the past 12 months. They did not do Choose and Book under their contract (whereby NHS patients can choose a hospital or clinic and book the date and time of their appointment).
- For our full findings please refer to the surgery core service report.

Meeting people's individual needs

- For our full findings please refer to the surgery core service report.

Learning from complaints and concerns

- Complaints were documented and actioned in the hospital-wide register for incidents, risks and complaints with no separate departmental log held. For our full findings please refer to the surgery core service report.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership and culture of service

- There was a dedicated outpatients lead who was supported by the hospital management team.
- For our full findings please refer to the surgery core service report.

Vision and strategy for this this core service

- There was no department-specific vision for outpatients as this was overseen at a service-wide level. For our full findings please refer to the surgery core service report.

Governance, risk management and quality measurement

Good

Outpatients and diagnostic imaging

- Governance, risk management and quality measurement were overseen at a hospital-wide level. For our full findings please refer to the surgery core service report.

Public and staff engagement

- For our full findings please refer to the surgery core service report.

Innovation, improvement and sustainability

- There were no specific examples of innovation within outpatients at a local level.
- For our full findings please refer to the surgery core service report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure admission processes are clear and that there is vigilance when booking patients to ensure all patients meet the admission criteria (for example confirming that they are 18 or over).
- The service should work towards a clear vision and strategy for the future and development of the service.
- The service should continue to embed the risk management and governance processes that have been implemented so far and use these to improve services.
- Continue to embed the clinical audit programme to monitor patient outcomes and explore ways of capturing this information to continuously improve.
- The service should implement means of obtaining staff feedback to monitor and promote staff satisfaction.