Baddow Hospital Company Limited

Baddow Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Baddow Hospital is a privately run hospital on the South Eastern Healthcare Park two miles south west of Chelmsford City in Essex. The South Eastern Healthcare Park has planning permission for a total of four healthcare related service buildings, including Baddow Hospital which opened in June 2013 for private healthcare treatment after two years of extensive construction and remodelling.

The Care Quality Commission (CQC) carried out a comprehensive inspection on 04 November 2014. The reason for undertaking this scheduled inspection was to assess this private hospital to determine if all essential standards are being met. The hospital opened in June 2013. There were two identified risk areas which required follow up, these were the number of changes to the registered manager and a lack of a controlled drugs accounting officer.

For the purpose of the comprehensive inspection we undertook an on-site review of surgery and outpatient services. The on-site element of the inspection involved a team of experts by experience (service users), clinical associates (experienced healthcare professionals) and CQC inspectors. The team is divided into subteams, each of which looked at one the service lines described above. The subteams were led by an experienced inspector, supported by clinical experts.

Prior to the CQC on-site inspection, the CQC considered a range of information including information held within CQC and that provided by the provider.

The inspection team make an evidenced judgment on five domains to ascertain if services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

Our key findings were as follows:

- Caring and compassionate care was evident in all areas.
- Those patients who we received feedback from were very complimentary about the service they received.
- There was a registered manager and accountable officer in place.
- Staffing levels exceeded the safe staff level guidelines with the support of bank and agency staff.
- The service had a robust process for appointing medical staff to the service with practicing privileges.
- The hospital was visibly clean and good systems and processes for infection prevention and control were in place.
- The service benefited from a very committed and loyal workforce.
- The governance and management arrangements were in their infancy and were not robust.
- We found that the facilities and equipment provided for this service were outstanding in relation because they were state of the art, modern and met patient's needs.

We also found that there were areas where the provider needs to make improvements:

- The provider should provide induction to all medical, bank and agency staff.
- The provider should ensure that all staff training competencies on equipment and clinical observations are checked, monitored and up to date.
- The provider should provide all staff with meetings to discuss the clinical services. These minutes should be recorded.
- The provider should ensure that management support and oversight of theatres is provided by the registered manager.
- The provider should develop and embed the governance systems further to ensure that they are robust.

Summary of findings

- The provider should ensure the accurate recording and reconciliation of controlled drugs be maintained.
- The provider should ensure that risk assessments are undertaken as appropriate.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery		We found that the surgical service protected people form avoidable harm, was effective, caring, responsive and well led to meet the needs of patients having surgery at the hospital. The management at surgery level were clear about their roles and vision for the unit. We found that staff morale was high and that they worked in an environment that was open and transparent. Consultants were described as approachable and responsive by staff. There was a vision and strategy for the service with a clear trajectory for the business. Financial management was maintained to ensure quality and safety was sustained. Many of the governance processes in place were in their infancy and required embedding.
Outpatients and diagnostic imaging		Outpatient services were safe, effective, caring, responsive and well led. Patients in the outpatients and diagnostic unit were protected from abuse and avoidable harm. Staffing levels were appropriate. There was a collaborative approach to care and treatment and staff had training to suit their roles. Staff were up to date with life support training and with their understanding of the Mental Capacity Act. All patients who provided feedback said that the staff were kind and caring, and locally the outpatient service was well led though further developments were needed as the service expands in size.

Baddow Hospital

Detailed findings

Services we looked at
Surgery and Outpatients and diagnostic imaging

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Detailed findings

Background to Baddow Hospital

Baddow Hospital is a privately run hospital on the South Eastern Healthcare Park two miles south west of Chelmsford City in Essex. The South Eastern Healthcare Park has planning permission for a total of four healthcare related service buildings, including Baddow Hospital which opened in June 2013 for private healthcare treatment after two years of extensive construction and remodelling.

Our inspection team

The inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, CQC

Inspection Manager: Leanne Wilson, CQC

The team included three CQC inspectors and a specialist advisor with a background in anaesthesia.

How we carried out this inspection

Pre-inspection:

The on-site element of the inspection was preceded by a comprehensive information-gathering process.

This phase involves collating data held by the CQC as part of our ongoing monitoring of the service. In addition to this, the service was asked to submit a number of documents as evidence of their performance around quality and service delivery.

Public involvement:

During the on-site inspection, we spoke with members of the public were invited to share their experiences of the service. This involved small group discussion, as well as the offer of individual interviews with the inspection team. We spoke to patients who came into talk with us. Attendees could submit comments via comment cards and we shared the website address where comments could be submitted.

While on site, we spoke to service users in clinical areas. The CQC left post boxes where comment cards could be submitted by patients, relatives and members of the public.

Internal stakeholders:

We held a number of focus groups that included: nursing staff, consultant medical staff and administrative and clerical staff. During the inspection, we talked to staff from all staff groups, allowing them to share their views and experiences with us.

Inspection:

The comprehensive inspection involved an on-site review of:

- Surgery
- Outpatients.

The on-site element of the inspection involved the team being divided into sub teams, each of which looked at one the service lines described above. The sub teams were led by an experienced inspector, supported by a clinical expert. The teams undertook a number of methods of inspections from interviews to direct observations of care.

Members of the management team were interviewed, as were members of the Medical Advisory Committee (MAC).

Post inspection

The comprehensive inspection programme included the option of carrying out an unannounced inspection. Based on the service we chose not to undertake an unannounced inspection.

Detailed findings

Facts and data about Baddow Hospital

- There are eight beds in Baddow with two overnight beds.
- The service currently has one NHS contract for Podiatry. All other patients at the service access the service through private insurance to paying fees privately.
- The Net Revenue for the service is £150,000
- The projected turnover for the service for 2014/15 is £1,000,000 and for 2015/16 is £2,500,000
- The service has a service manager registered with CQC.
- During a one year period to June 2014 there were 277 procedures undertaken in the operating theatre

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & diagnostic imaging.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Baddow Hospital currently provides a limited range of surgical services which include general surgery, plastics, gynaecology and urology. It has two overnight inpatient beds and eight private pod spaces on the day surgery ward. It has one operating theatre and one treatment room. The hospital has undertaken 305 procedures between July 2013 and October 2014. The service has plans to expand its surgical service in the near future.

Summary of findings

During the inspection the theatre and surgical ward areas were visited and 14 staff, both substantive and bank, were spoken to. This included medical staff, nursing and theatre staff, managers and administration staff.

We observed care and treatment during the inspection and also reviewed five patient care records. We received information provided by the hospital, and information that we requested on site. We also received information from seven patients who completed comment cards to inform us of their experience.

We found that the surgical service was safe, effective, caring, responsive and well led to meet the needs of patients having surgery at the hospital. The management at surgery level were clear about their roles and vision for the unit. We found that staff morale was high and that they worked in an environment that was open and transparent. Consultant staff were described as approachable and responsive by staff. However the service was not always well led because there was not a clear process for the assurance of the competency of staff in order to monitor performance.

Surgical areas were visibly clean and there were arrangements in place for the prevention and control of infection. Staffing establishment levels and skill mix were adequate across specialties currently undertaken. There was no formal admission criteria however the staff ensured that patients who were appropriate for the level of service were admitted and those who required complex interventions were not admitted to the hospital.

Surgery

Newly appointed staff have increased the knowledge base of the service. However mandatory training and induction is not provided for bank and agency staff. The hospital continues to develop as its workload increases.

Are surgery services safe?

Surgery services protected people from avoidable harm. There were arrangements in place for reporting of patient and staff incidents. Staff were aware of this process however the current level of reporting did not providesufficient evidence at this time to indicate both the level of reporting or how learning from incidents is shared and utilised.

The surgical environment was visibly clean and arrangements were in place for infection prevention and control and the management of medicines. Processes were in place for staff to recognise and respond to changing risks for patients, including responding to the warning signs in response to a patients deteriorating condition.

Staffing levels and skill mix are planned, implemented and reviewed to ensure that they are at an appropriate level. Any staff shortages are responded to quickly and covered with the use of bank or agency staff. The teams hand over was undertaken each day and was called the “10 at 10”, to ensure staff can manage risks to people who use services.

Incidents

- Data analysis prior to inspection showed that the absolute number of clinical incidents reported by the hospital was low; and the service had not reported any serious incidents that required investigation (SIRI).
- The service was in its infancy and staff reported that there have been no Incidents within surgery. Therefore there was insufficient evidence at this time to indicate both the level of reporting and how learning from incidents was shared and utilised.
- Systems and processes for the reporting of incidents was in place. Staff we spoke to understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible online. We were informed that all staff had access to this system however during interviews with staff it became apparent that this is sporadic.
- Recently appointed staff (both in the theatre and ward area) were not aware of the process to raise concerns and had no intranet access to use the reporting tools. One staff member described the process that would be

taken following a needlestick injury and despite not knowing what Incident form to use they stated they would seek advice and obtain the relevant form from the theatre manager.
- Staff confirmed that there was open communication with senior team members including the chief executive and registered manager. Staff stated that they felt they would be listened to and would not have any problems addressing concerns.

Cleanliness, infection control and hygiene

- No incidents of surgical site infection had been reported.
- We saw signed cleaning checklists had been completed by the employed cleaners for the month of November 2014. These were observed in the pathology and clerking room, ward area and treatment room.
- We observed the use of indicator stickers "I am clean" were in place. There was appropriate cleaning in place for the curtains, which separated individual pods, in the day case ward areas. However the curtains were noted to be too long and dragging on the floor. This could spread infection through dust collection from the floor.
- Toilet areas were cleaned and daily record check sheets were seen to be in place and were completed and signed by the domestic team.
- Staff had appropriate training in the decontamination of endoscopes. A tracking system was in place and records were seen for cleaning, decontamination and the processing of endoscopes. We saw that appropriate processes were in place to ensure the decontamination of endoscopes and that escalation was undertaken when necessary.
- We observed theatre staff cleaning appropriately between surgical cases and wearing personal protective equipment.
- We observed the flow through of patients within theatre; the design provided separate clean and dirty areas which were maintained with no cross contamination.
- Infection control support was provided from an external specialist nurse with advice from a consultant microbiologist.
- Clinical waste was segregated and supposed of through incineration to minimise the infection control risks.

Environment and equipment

- We received feedback from three patients commenting that the environment was very clean, welcoming and that the hospital had excellent facilities.
- Resuscitation trolleys and equipment were checked and records were kept.
- We observed appropriate fire extinguishers throughout the surgical areas. Fire training was included in mandatory training, staff we spoke to confirmed a practical fire drill scenario had just taken place in October 2014 and no concerns had been identified.
- We observed a hoist with a notice "not to be used". Staff informed us and we corroborated that this was a new piece of equipment and training was scheduled to take place.
- We saw one laser in theatre with appropriate laser goggles and signage. One member of the team had received laser training and was nominated as the laser trained operator. However we saw that laser documentation records were partly complete - no local rules were displayed or available and we observed inconsistency in the named operators documented and no record of competent users.
- We saw that easy access was available to the toilet areas in the day ward.
- There was an adequate system in place for monitoring of medical gases and we were informed and corroborated that weekly testing occurs and a back-up system was available should a failure occur.
- We observed individual patient lockers for storage of patients own valuables and medication in each pod in the ward area. The key for these lockers stayed with the patient and went with the notes to theatre.
- We were informed that emergency instrumentation sets were limited; however senior theatre staff undertook an assessment of instrumentation requirements as bookings were received. A process was in place to borrow additional equipment from local hospitals when required.

Medicines

- We examined the medicine storage area in theatre and the day ward. Medicines were stored correctly and securely throughout.
- We observed adequate security measures in place for the storage of controlled drugs (including CCTV). Keys were held by the operating department practitioner in working hours, out of hours keys were kept within a safe, with restricted staff access.
- The controlled drugs were checked and all accounted for – daily checks by two members of staff were recorded. We saw that administration of controlled

drugs was recorded. The stock balance of an individual preparation was confirmed to be correct and the balance recoded, however no recording of specific amounts administered / discarded were entered.
- No audit had been undertaken by pharmacy of the controlled drug record.
- We found that fridge temperatures were being regularly recorded. Acceptable parameters in temperature were displayed on drug fridges in theatre and staff were aware of action required if temperature changes occurred.
- We examined the pharmacy top up area in reception and found it clean and locked. A system was in place to regularly restock items.
- We were informed by staff that patient self-medication reviews took place as part of the pre-assessment. When necessary any issues were then discussed with the anaesthetist prior to the undertaking of any surgical procedure.

Records
- We reviewed five sample sets of medical records. Good examples of multi-disciplinary entries were seen in the records.
- All five records contained a Venous Thromboembolism (VTE) assessment – none had been completed.
- We reviewed the drug prescription charts; these were completed adequately however in all cases no maximum dosage was being recorded.
- There were no agreed or defined criteria in place for the admission of patients. Staff informed us that only the patients who were appropriate to the level of service are admitted. Patients with more complex needs were required to attend alternative services elsewhere.

Safeguarding
- Staff had received training and awareness on safeguarding. We reviewed the mandatory training figures for the service which showed that 100%of staff had received awareness training on safeguarding adults and children.

Mandatory training
- Mandatory training report was provided and staff were recorded as up to date.
- Patient consent and confidentiality training was provided and 100% of staff at the service had attended as part of Mandatory training.
- We saw that some clinically specific training courses were also recorded; however there was no evidence of updates or monitoring of staff competency in relation to staff skills including clinical observations.
- We found that clinically specific training courses were undertaken by staff, for example Yag laser and Novasure ablation system training.
- A programme for regular monthly training scenarios had been implemented, with feedback given to staff to enable learning. We reviewed the notes from the scenario in October.

Assessing and responding to patient risk
- We reviewed five sample sets of medical records and the recording levels of monitoring were good.
- The hospital used a national early warning score tool (NEWS). There were clear directions for escalation and staff spoken to were aware of the appropriate action to take if patients score fell into the various categories. We saw that NEWS was displayed above each bed in the ward area.
- We saw that an acute Illness management training tool called AIMS was included in mandatory training for clinical staff and seven out of nine staff had completed this.
- The policy for the deteriorating patient which was implemented in August 2014. A service level agreement was in place with neighbouring hospitals to transfer patients who require higher dependency or acute care. This was outlined in the unexpected patient admission pathway. There had been no incidence of patient transfer recorded.
- We observed the theatre team undertaking 'five steps to safer surgery 'procedures and using the recognised national world health organisation (WHO) checklist. Briefing paperwork was used to record full team briefing before and after the operating list. We observed effective communication between the team.
- Staff were seen to undertake appropriate checks to account for all consumables, swabs and instruments before, during and after surgery and records were completed.
- The instrument checklist was used for reference during the count but the columns for recording against each item were not completed.
- The hospital has established a resuscitation committee which includes clinical, medical and management staff. Minutes from two meetings were reviewed. The

outlined purpose of the committee was to discuss training, learning outcomes, resuscitation scenarios, auditing, updates and review any issues / events at the hospital.
- The resuscitation committee raised a potential concern regarding a lack of blood gas analyser and pacing defibrillator. We were informed that this was being reviewed and a risk assessment will be undertaken.
- VTE protocols were in place. We found though examining patient records that the use of flowtron boots in theatre and staff informed us that all patients receive anti embolitic stockings. We observed these used in theatre cases during the inspection.

Nursing staffing

- Nursing numbers for theatre were five whole time equivalent substantive posts with regular use of bank staff. Bank pool consisted of eight available staff and we were informed that five of the eight were used regularly and were familiar with the hospital.
- We were informed by staff that the staffing ratio in theatre was four staff per list – two registered nurses, one healthcare assistant and one operating department practitioner which was adequate. We saw a sample of the off duty rota which confirmed this ratio.
- Staffing levels were not co-ordinated to ensure competency of staff matched the complexity of surgery. We found that the off duty was produced for the hospital as a whole. Normally this was undertaken by the registered manager but occasionally by the non-clinical manager. No approval was sought from any senior clinical staff in theatre to ensure skill mix was adequate.
- We saw that a programme for induction for permanent staff, both clinical and non-clinical, was in place. However one member of staff informed us that they had not received an induction or mandatory training. They also said that they had not received a job description however they were aware of role requirements and were able to explain specific tasks such as checking emergency bells, stocking up of equipment in ward area and the correct disposal of laundry.
- There was no induction programme for bank / agency staff. We were informed by two members of bank staff that this was the case. A short local orientation had taken place on their first day but was not recorded.
- Agency staff were used occasionally in surgery obtained through two different nursing agencies. One agency had compliance and vetting procedures, which were reviewed, however for the second agency there were no proforma or vetting guidelines available.
- We saw that there was a theatre on call team allocated on the rota however staff told us that returns to theatre were rare and that the sustainability of the on call was limited due to the small numbers available to take part.

Surgical staffing

- There was no formal induction in place for medical staff.
- Medical cover on site during the day was provided by the consultant anaesthetist and consultant surgeon who were on site for the duration of the operating list and the recovery phase. The anaesthetist speaks with the senior theatre staff and assesses the patient status before leaving the hospital.
- Anaesthetic cover was arranged through a syndicate. The anaesthetist we spoke with confirmed that the anaesthetic group were happy with staff, equipment provided, pre and post op care and medical cover. He said they felt that the communication was excellent and that staff contact them when appropriate.
- We saw that there was a nominated advance life support available at all times when patients were on site. This person carried a bleep for emergency calls.
- Medical cover was provided overnight via an agency when required. Out of hours staffing was adequate, consisting of one doctor and two nurses, one of which was always a registered nurse. No concerns were reported by staff on medical staffing numbers.
- We were informed by the consultant surgeon that a process for cross cover was in place. The Consultant must inform the hospital if they are due to be away and give details and contact numbers for their nominated cover.
- We were informed by staff that a lone worker situation never occurs. They said the hospital was locked at night and that the external door buzzer rings through to all telephones.

Major incident awareness and training

- The service had business continuity plans in place should an event such as a loss of power or flood occur. Staff we spoke with during the inspection were aware of this procedure. The registered manager told us of an example where power had been affected by high winds and how this plan was used during the storms.

Surgery

Are surgery services effective?

Surgery services were effective. The service is not required to partake in national audits. The service did undertake local audits on subjects including consent and there were clear action plans in place to address any identified concerns.

Staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice. We viewed the specialised training provided to staff which demonstrated that they were competent. However staff competencies were not always monitored effectively.

Staff are supported to deliver effective care and this is monitored through appraisals and one to one meetings which were routinely undertaken. There was a clear and appropriate approach for supporting and managing staff when their performance is poor or variable, this was confirmed by the registered manger and underpinned by a local policy.

Consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. We checked consent to treatment forms which was taken prior to any treatment. The process for seeking consent was monitored through local audits being undertaken by the registered manager.

Evidence-based care and treatment

- We found that surgery as a service or the surgeons were participating in any national clinical audits because the service was still developing its care practice range.
- Local audits on record keeping, the safe surgery checklist and consent were undertaken by the registered manager. Where concerns were identified there were clear action plans in place to address concerns. The primary concern identified through the audits undertaken in September 2014 was record keeping by consultants; these concerns were addressed by the registered manager and the Medical Director on a one to one basis.
- We saw that data was recorded by the theatre sister on surgery start and finish times, but she informed us that this was not yet used for any specific analysis and that she was not aware of any specific key performance indicators to measure against.
- Clinical policies we reviewed including the resuscitation policy were written in line with the national guidelines of the Resuscitation Council UK.

Pain relief

- We saw that post-operative documentation included a pain scoring system and we observed that this was completed in a sample of five records seen.
- Patients were observed to be regularly asked about pain relief. Post operative care was provided on a one to one basis and pain monitoring was part of this one to one care.

Nutrition and hydration

- Nutrition and hydration was provided post operatively to patients. Patients were offered a selection of items to meet their needs and the items eaten were recorded to enable assessment by the medical teams prior to discharge.

Patient outcomes

- The service had not transferred any of their patients to another healthcare service. Analysis data confirmed no incidence of unplanned returns to theatre and no unplanned transfers had been reported. There had been no emergency laparotomies recorded.
- The service is not required to participate in national audits or the national bowel cancer audit as these services were not provided by the hospital at the time of our inspection.
- Over the period of one year up to October 2014 there had been one recorded unplanned readmission which was managed in line with the service's own policy on unplanned or unexpected readmissions.

Competent staff

- We recognised that staff appraisals were not consistent across all staff groups. One member of staff on the ward informed us that they had not received an appraisal whilst another told us that their appraisal had been actioned and had key areas for development identified.
- We were informed that the competency of staff was discussed as part of the employment process at interview. There was an agreed expectation from staff that any concerns over staff allocation would be raised at the ten minute team meeting each morning when forthcoming lists were reviewed.
- We were informed that there was no set process for adhoc surgical assistant provision or competency

checks. Any staff who attend were expected to join the staff bank. We were told by the theatre manager that the intention was to include competency checks and staff development discussions during appraisal.
- NHS contracted podiatry service had just been introduced and we established that staff training had been received prior to implementation.

Multidisciplinary working

- There was clear evidence of multidisciplinary working within surgery. Theatre staff worked across anaesthetics, scrub and recovery. All staff informed us that this was positive and previously they had not had the opportunity to do so in roles elsewhere. Two staff told us that this had been a fundamental consideration when they were considering taking a substantive post as they were able to maintain skills in all areas. We were told by staff in theatre that they were also utilised in clinic when no surgery was taking place.
- During the inspection there was one member of the administration team in theatre. Patient consent had been received and appropriate process applied. We observed teaching and explanations given to this member of staff from the surgeon. She informed us that in her role on reception she was often asked questions by patients and felt this had given her a greater understanding to deal with this situation.

Seven-day services

- The hospital undertakes the majority of its surgery services Monday to Friday. Staff informed us that very occasionally a Saturday operating list was provided, on Consultant request. When a patient stays overnight on a Friday staffing ratios remain at the same level as during the week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed the consent forms in use which were noted to have witness signatory section for use if the patient is unable to sign for themselves. There was also a "statement of interpreter" section for completion if applicable. This was a duplicate form with the second copy provided for the patient.
- We saw that risks and complications were highlighted; risk stickers and additional communication sheets were available as per Consultant preference.
- Staff in theatre were able to explain the consent procedure to us and the theatre manager was knowledgeable in regards to mental capacity and guardianship requirements.
- MCA and DoLS awareness was incorporated in the mandatory training as part of the vulnerable adults' course, 100% of permanent staff had received this training and further training was planned.
- We were informed by staff that one patient who had been assessed as unfit for surgery at Baddow Hospital had been assessed for dementia. Whilst this was not the only reason behind the decision that the patient was not fit for surgery it had been a contributing factor to their suitability for having surgery at the service.
- We were informed by a member of staff that on one occasion recently surgery was undertaken on a 15 yr. old (two days before their 16th birthday). The patient had given their own consent and the hospital booked, via a nursing agency, a registered children's nurse for the duration. This demonstrated that the consent and governance processes for proceeding with surgery worked well.

Are surgery services caring?

Surgery services were caring. We spoke with three inpatients using the service and received comments back from seven other patients who had used the service, all were very complimentary about the care they had received.

During the inspection we observed patients being treated with compassion, kindness, dignity and respect. Individual "pod" areas were created in the day ward area to provide privacy and dignity and screens were available in the recovery area within theatre should there be more than one patient at a time.

Patients who used the service were actively involved and encouraged to be part of the decision relating to their care. Support services to discuss decisions around treatment were available and patients understood and were happy to speak with staff about their surgery. The patient we spoke with understood their care, treatment and post recovery care requirements.

Compassionate care

- We saw that gowns, dressing gowns and slippers were available for patients in the day ward area to support dignity and privacy. Patients were encouraged to wear

their own night attire following procedures if they wished to do so. It was noted that the gowns were only one size and therefore not suitable for all patients. We were informed that there are plans to order a variety including larger sizes.

- We were informed by three patients we spoke with that they had received good explanations of care and were made aware of what was happening throughout. We received six patient comment cards which all made reference to positive care. Patients had written that they felt well looked after and that all their needs were catered for. Three of the comment cards mentioned the professional manner used by staff.
- The service has individual areas for patients to stay called "Pods" these respected the privacy and dignity of patients who had their own space to recover.
- One patient we spoke with informed us that they felt involved in their care and had been fully supported around their treatment and decisions prior to receiving surgery.
- The hospital had a process for patient satisfaction feedback in place. As part of this there was a prompt for the patient to name specific staff should they wish to do so. When this occurred a copy of the feedback was given to that member of staff. Examples of comments from patients included, 'I have never had better or nicer care, nothing too much trouble' and 'staff were exceptional in care and attention' and 'they were effective, helpful, patient with a sense of humour'.
- We spoke with patients during the inspection and one patient confirmed that the call bell was answered promptly, information was given clearly and that they felt listened to.

Emotional support

- We saw leaflets in the ward area for support and counselling however when talking with staff they were not aware of any specific counselling services.
- We were informed by staff that they felt supported by the management team and could openly communicate with them if the need arose.

Are surgery services responsive?

The surgery services were responsive. We found that staff were responsive to people's individual needs, and that good continuity of care was provided due to the dynamics of a small unit.

Surgery services had processes in place to ensure people's needs were organised. Bookings were reviewed by senior clinical staff in theatre and the hospital utilised a daily meeting to review forthcoming cases and identify specific requirements in a timely manner to enable any additional items to be obtained. We were informed that agreements were in place with local hospitals to support additional instrumentation requirements.

We found that not all information was available in other formats and language. We saw that patient guides were available but not in Braille format. Staff were aware of the availability of a language line but contact details lacked clarity. Staff informed us that training for patients with more complex needs, such as those living with dementia and those with learning difficulties, was lacking.

Service planning and delivery to meet the needs of local people

- We were informed by senior staff, of the bookings process, which included a clinical approval by a senior member of the theatre team and registered manager prior to finalisation. This ensured that the lists were managed and were not overbooked.
- The operating list was generated locally by the theatre sister. We saw that the list was circulated only to the appropriate locations which maintained patient confidentiality.
- We were informed that service level agreements were in place for NHS contract and that the service was working to obtain further NHS contract work, At the time of the inspection the service was not very busy and was still being built up to provide a variety of specialties to patients.

Access and flow

- Good continuity of care was evident throughout the patient journey, from initial pre-assessment through to discharge. The surgery team were observed working well and communicating well together and we received positive feedback from the patients.
- We were informed by staff that the medical team were approachable and supportive and the doctors confirmed to us that they felt the hospital was responsive. One consultant stated that staff could contact medical staff easily and at all times he felt staff made appropriate contact when required.

- The hospital wrote to the GP and insurance company with the outcome of the operation following discharge which ensured that the care pathway and records was up to date.

Meeting people's individual needs

- We reviewed the patient care pathway which showed there was a responsive approach to the patient's complete stay and an out of hour telephone number was provided to patients when they were discharged.
- We found that information on site did not clearly note any other format or language though the management team informed us that alternatives were available upon request.
- We were informed of one incident where a member of staff, who peaks Polish, helped to translate for a patient to ensure communication and support was maintained. We were informed that a language line was available however staff were not completely clear of how to contact or access this service.
- Staff informed us that no formal training was in place to increase awareness for patients with more complex needs such as those living with dementia and those with learning difficulties. We saw that safeguarding vulnerable adults was included as part of the mandatory training requirements for all staff.
- A range of leaflets on surgeries being offered by the service including a range of cosmetic services were displayed in the main reception area.
- The layout and the design of the building had factored in key design methods to influence to the ambience that patients experienced during their stay. The environment was designed towards a welcoming opposed to a fully clinical environment which the patients were complimentary about.
- Toilet areas were noted to be compliant with the disability discrimination act (DDA).

Learning from complaints and concerns

- We reviewed the three complaints and concerns that had been received by the service. The registered manager provided the response to the person but also evidence which demonstrated that lessons had been learnt from those complaints was robust. For example a complaint regarding overnight care with staff trained in advanced life support (ALS) had been resolved by ensuring that all staff who provide overnight care are ALS trained.

Are surgery services well-led?

There is clear statement of vision and values, driven by quality and safety and staff knew and understood the vision, values and strategic goals.

The service had set objectives for its trajectory and progression as a new service in the independent sector. The vision, values and strategy have been developed through a structured planning process with regular engagement from staff members. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place and the financial pressures are managed so that they do not compromise the quality of care.

The board and manager levels of governance within the organisation function effectively, though there was limited data to test this area. Structures, processes and systems of accountability, including the governance and management of partnerships and joint working arrangements were clearly set out.

Quality receives sufficient coverage in board meetings, and in other relevant meetings below board level. However the arrangements for the recording and monitoring feedback at staff meetings was not always consistent.

Vision and strategy for this service

- The service had a clear vision and strategy which was detailed through plans for the healthcare park where Baddow Hospital was situated. This plan was in place for the next five years.
- The Management team were clear on their progression for inclusion of a range of clinical specialties in the future as well as the development of a radiology centre.
- We reviewed the financial strategy and plan for the service which demonstrated that financial management was carefully considered with modest forecasts over the next 12 months. Despite the service being in its infancy the financial balance was managed and did not compromise the quality or safety of the service.

Governance, risk management and quality measurement

- We saw that a medical advisory committee (MAC) was in place and that representation from the medical team

and the registered manager was good. We were informed by one consultant that two medical staff from each specialty sit on the MAC to ensure a balanced and varied point of view.

- We reviewed the MAC minutes which demonstrated that practicing privileges and applications were discussed and reviewed by the MAC. We observed that some applications had been declined due to individuals living too far away. Initially not all applications had been reviewed by the MAC as many consultants new each other from working together previously elsewhere however there was a robust process in place for reviewing all new requests.
- We spoke with the chairman of the MAC who said he was confident that all staff had appropriate employment checks. Evidence from the minutes of the meetings and review of staff files supported this statement.
- Staff told us that they were not aware of any clinical governance meetings; we confirmed with the management team that staff meetings were held though they were not specifically for governance matters and the last meeting was not minuted.
- Appraisal rates for medical staff were monitored. We spoke with one consultant who confirmed that he currently operated across four hospitals. He stated that his practice was consistent in all venues and that he had an appraisal which was undertaken by one of the other hospital groups.

Leadership of service

- We were informed by staff the opportunity for continuing staff development was inconsistent. One experienced member of the clinical team stated that, despite holding a senior position, they had not received any specific leadership or management skills training. They said they were not aware of any opportunity for this but felt this would be beneficial.
- We saw inconsistency with team meetings and communication. We were informed by theatre staff that team meetings were sporadic. One member of staff informed us that they were not aware that team meetings had taken place nor had they seen any minutes. Initially meetings had taken place, in an informal setting, but were limited as there were only three staff members.
- The service also has a registered manger as required by their CQC registration. The service has a 'Chief Executive Officer' who is not employed by the service however they are part of the board. The use of the title Chief Executive could confuse members of the public if this role is not employed by Baddow Hospital.

Culture within the service

- There was a very open culture within the service. Staff were open and honest and were happy to show their service to the inspection team and show where they wanted to be in five years time.
- Staff members in theatres believed they would benefit from more oversight from the registered manager who had a clinical background, rather than the non-clinical support staff who support the management team, because the registered manager understood clinical demands and pressures of running a theatre service.
- The staff had confidence in the local and senior management team and felt that they could openly go and raise concerns to them.

Public and staff engagement

- The service continually sought the feedback from patients on their experiences. The service demonstrated examples of patient experience where it led them to make improvements with the service.
- We spoke with three patients during the inspection and they all informed us that they felt very engaged in the service running and were always invited to feedback their experiences.

Innovation, improvement and sustainability

- The service has plans to innovate and improve the service over the next five years. There was a clear plan financially to sustain the current services that are provided because the numbers were minimal the service was cautious with finances.
- The service has sustained a slow and steady growth during its first year of business. The approach of the service was positive in ensuring that they do not expand too quickly and by doing this they have sustained a continued level of positive patient care and experiences.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Outpatients includes all areas where patients undergo diagnostic testing, receive diagnostic test results, are given advice or are provided care and treatment without being admitted as an inpatient. This includes clinics where specialist advice and/or treatment are provided. Baddow Hospital treats adults and young people in the outpatient departments.

There were 5 consulting rooms on the hospital site. The hospital does not have a dedicated radiology department however there were plans in place to eventually expand the service to include a diagnostic imaging centre.

Summary of findings

During our inspection we spoke with 3 patients, received comment cards from a further seven patients and spoke with eight members of staff.

The outpatient and diagnostic service departments followed procedures to ensure that services were safe, effective, caring, responsive and well led and that patients in the outpatients and diagnostic unit were protected from abuse and avoidable harm. Staffing levels were appropriate. There was a collaborative approach to care and treatment and staff had training to suit their roles. Staff were up to date with life support training and with their understanding of the Mental Capacity Act. The Outpatient Departments were planning to expand the areas to meet increasing demands for clinical services which was part of the overall five year plan for the expansion of the healthcare park.

Staff were caring and compassionate and treated patients with dignity and respect. Staff were aware of, and supported, the service strategy to develop more outpatient and diagnostic services. Governance arrangements were effective to review performance and risks, although clinical risks needed more formal documentation and action. The culture was open and transparent and staff said their departments were well led. Patients were able to feedback on services and their comments were used to improve the service.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Openness and transparency about safety is encouraged. Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses; they are fully supported when they do so. Where any incidents had occurred the patients were communicated with openly and honestly.

There are clearly defined and embedded systems, processes and standard operating procedures to protect patients from avoidable harm and safeguarded patients from abuse. These procedures reflect national, professional guidance and legislation, were appropriate for Baddow Hospital's functions and were understood by all staff.

Whilst the majority of staff had received up to date training in subjects such as consent and safeguarding, not all bank or agency staff had received training from the service.

Staff were knowledgeable about responding to patient risks and identifying the risk of deteriorating patients. Staff were appropriately trained in basic and advanced life support. Resuscitation equipment was available and there was a clear process to transfer an unwell patient to a nearby acute service.

Major incident plans were in place and we observed learning from a recent event related to extreme weather where the service had ensured that the running of the service was maintained effectively.

Incidents

- Staff we spoke with were aware of how to report incidents using the incident reporting system through the online service. Four staff we asked specifically about incident reporting said that they were comfortable reporting any incident that may occur to the management team.
- There had been no incidents reported linked to the provision of outpatient services. There were no serious incidents requiring investigation (SIRI) reported. Therefore there was insufficient evidence at the time of the inspection to determine how robust reporting procedures were in practice.
- Due to the minimal numbers of incidents reported by the service in total since the hospital opened in June 2013 it is not possible to determine what learning from incidents has taken place. However we did view examples of communications from the service to patients following any event which were open and honest.

Cleanliness, infection control and hygiene

- The majority of equipment in the outpatient and diagnostic departments was single use only and this equipment was not reused.
- Decontamination practices for reusable instruments for minor operation procedures were compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.
- The equipment and environment within outpatients was noted to be visibly clean. However in the treatment room we observed a light which had a bloodstain on it, this was cleaned immediately by staff when identified.
- We saw signed cleaning checklists had been completed by the employed cleaners for the month of November 2014. These were observed in the outpatient and treatment rooms.
- We observed the use of indicator stickers "I am clean" were in place. There was appropriate cleaning in place for the individual rooms and sonography room.
- Toilet areas were cleaned and daily record check sheets were seen to be in place and were completed and signed by the domestic team.
- Staff were observed to be working bare below the elbows, with minimal jewellery on. We observed that staff worse gloves and aprons and eye protection for procedures in outpatients was also available.
- We observed staff using the alcohol hand gels available as well as wash their hands in between patients.

Environment and equipment

- The outpatient environment was purpose built in line with all Health Technical Memorandum requirements. The equipment that was in use was modern and state of the art.
- There was a contract for portable appliance testing these were conducted on an annual basis. A record of these checks were maintained.
- Resuscitation equipment was available and the trolley was shared with the surgery areas. The equipment was checked daily and sealed. Records to demonstrate compliance with these checks were viewed.

Outpatients and diagnostic imaging

Medicines

- Staff were aware of medicine management policies for reference purposes and there were appropriate systems to monitor stock control and report medication errors.
- Medicines were not stored in the outpatients department consulting areas.
- Medicines were stored securely in the treatment rooms and the person in charge held the keys to the secure drug cupboard. This meant that there were appropriate security arrangements to manage medicines safely.
- We examined the records maintained on the management of medicines and found that records matched the numbers of medicines in the cupboards. Therefore accurate records of medicines were maintained.

Records

- Patients records were stored on site and were always available for each outpatient appointment undertaken. No concerns or incidents had been reported where records were not available.
- We examined four sets of records and found that full details of outpatient appointments and minor treatments were recorded by nursing, medical and support staff. The writing was legible.

Safeguarding

- There was on an on line safeguarding training package for staff which had been completed by 100% of permanent staff. The safeguarding policies and procedures were understood and implemented by staff. However we identified that there was limited information which supported that bank or agency staff had received safeguarding training.
- Chaperones were offered in the outpatients department and all patients were chaperoned in their outpatient appointments.
- The theatre manager had been a member of the local independent safeguarding group and had attended an update training day in July 2014. There was an awareness that as the hospitals client base had changed there needed to be an increased awareness of the staff's responsibilities to ensure that the patients were protected from avoidable harm.
- There was an established recruitment process that included the requirement for two references and a current disclosure and barring scheme check prior to a new member of staff commencing employment.
- There had not been any safeguarding alerts or concerns for the outpatients and diagnostic departments since the service opened in June 2013.

Mandatory training

- Mandatory training was provided to all staff in outpatients. The majority of training was provided by taught sessons and included subjects such as fire safety, manual handling, information governance, infection prevention and control, safeguarding adults and children and equality and diversity. At the time of the inspection 100% of employed staff had attended the training.
- Staff who were employed on the bank or through agency had no recorded evidence that they had undertaken the mandatory training subjects.

Assessing and responding to patient risk

- We examined the training records which demonstrated that staff had received education in recognising deteriorating patient conditions. The outpatients and diagnostic department followed the national early warning score systems (NEWS). Staff were confident of actions to be taken in the event of a collapse.
- There had been no incidents of deteriorating patient condition or collapse in the outpatient department since opening in June 2013.

Nursing staffing

- Managers ensured the right staffing levels and skill-mix across all clinical and nonclinical functions and disciplines were sustained at all times of day.
- We examined the staff rotas which supported that each day when outpatient services were provided that there were sufficient staff numbers on duty to meet the needs of the patients.
- The current vacancy rate for outpatient departments was for an additional member of staff which was currently being advertised. Staff were willing to be flexible when needed and told us they liked the work and patient safety was a priority.

Medical staffing

- Over 30 consultants worked at Baddow Hospital and most were based at the neighbouring three NHS Trusts. Staff in outpatients and diagnostics confirmed a quick response from the consultants when needed.

Outpatients and diagnostic imaging

- There was a resident medical officer (RMO) present in the hospital at all times when a patient stayed at the hospital overnight, these were provided by locum staff and all were trained in advance life support.
- Staff told us that medical support was available throughout the day and evening and advice could be sought where needed.

Major incident awareness and training

- Staff were aware of the hospital's major incident plan and understood what action to take for example in case of fire and evacuation procedures.
- Consideration had been given to situations that may occur, for example, extreme weather conditions and how this could be managed. The registered manager gave us an example of a recent event where high winds had caused some disruption to power supplies. This was managed effectively.

Are outpatients and diagnostic imaging services effective?

The outpatients and diagnostic departments could demonstrate that there was a collaborative effective approach to care and treatment. Outpatient care and treatment plans were recorded and communicated with all relevant parties to ensure continuity of care.

All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. Staff received professional development and supervision, the appraisal rates were good and staff told us they felt valued and supported by the organisation.

There were timely multi-disciplinary team discussions to ensure patients' care and treatment was coordinated and the expected outcomes were achieved.

Evidence-based care and treatment

- Staff within the service were aware of the local policies and procedures. Four staff member we spoke with were able to clearly articulate the policies they needed to refer to, to undertake their roles.
- Due to the infancy of the service no local audits were undertaken around outpatients and diagnostic care. This was a planned activity to be undertaken as the service expanded.
- The registered manager undertook a local audit on the completion of records around outpatient care. Improvements were identified as being required and these had been referred to the consultants to make the improvements. We were informed that where records did not improved the consultants practicing privileges would be reviewed.

Pain relief

- Baddow Hospital had recently opened a pain service clinic which is run by a pain specialist consultant. The feedback from a patient who used the service was that it was very accessible to meet their needs.
- For the minor procedures undertaken in the urology clinic pain was assessed and pain relief administered if required for patients undergoing minor surgical procedures.

Patient outcomes

- Patient outcomes were not recorded for outpatient and diagnostic services.
- Participation and performance in national audit was not required for the level of service undertaken by Baddow Hospital.

Competent staff

- All medical staff with practicing privileges are required to submit a copy of their appraisal outcome and revalidation information to the registered manager once complete. Failure to provide this will result in a review by the MAC where a decision on continuing practicing privileges will be discussed. This was part of the service's policy on medical staff working at the hospital.
- Each year the service runs checks on the medical and nursing staff to ensure that their NMC and GMC professional registrations remain current.
- For the permanent staff working within outpatients these staff are provided with an annual appraisal and a staff development plan. 100% of permanently employed staff have received an appraisal. All other staff have provided a current appraisal completed by their main employer for their records.

Multidisciplinary working

- We observed clinical areas and saw that doctors, nurses, support staff and administration staff had multi-disciplinary team discussions to ensure patients'

care and treatment was coordinated and the expected outcomes achieved. Outpatient care and treatment plans were recorded and communicated with relevant parties to ensure continuity of care.

- We spoke with four members of staff who informed us that there was good team work with allied health professionals (AHP) that supported an integrated care pathway for patients.
- Service level agreements were in place for patients to receive diagnostic pathology and imaging tests. These agreements were with the local acute trust.

Seven-day services

- No acute function was provided by this service and so seven day services are not provided. The service operates Monday to Friday with some Saturdays at consultant request. A seven day on call service including out of hours and weekends is available for patient s to speak with someone about their care.

Access to information

- Information on specific procedures was provided by consultants and the hospital. General information on coming into the hospital was also sent out to patients prior to admission.
- Free access to additional information is available through the service's website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent was obtained at outpatients, and again during pre-assessment. The outpatient services supported informed consent and patient information outlined procedures and risks. Staff were aware of, and undertook, written and verbal consent practices. We examined four sets of notes which supported that consent was taken appropriately.
- Staff received training through an e-learning module. At the end of October 2014, 100% of all permanent staff had completed this training. Work was still ongoing to ensure all medical staff were up to date with the current requirements for consent to treatment.

Are outpatients and diagnostic imaging services caring?

We received feedback from three patients during the inspection as well as seven patients through comment cards. All patients were positive about the way staff treated them and said that they were treated with dignity, respect and kindness during their care.

People are involved and encouraged to be partners in their care and in making decisions, with any support they need. Staff spend time talking to people, or those close to them. They are communicated with and receive information in a way that they can understand. People understand their care, treatment and condition. People and staff work together to plan care and there is shared decision-making about care and treatment.

Staff respond compassionately when people need help and support them to meet their basic personal needs as and when required. They anticipate people's needs. People's privacy and confidentiality is respected at all times.

Compassionate care

- All three patients we spoke with told us they were treated with privacy, dignity and respect and they felt staff cared about them. Seven patients completed comment cards which also supported that staff were cared for with kindness, dignity and respect.
- We observed good interactions between staff and patients in the outpatient department and at the main reception desk.
- We spoke with three patients about their involvement in their care from the service. All three informed us that they felt engaged in their care and were involved in making the decisions about their care. All three said they felt encouraged to ask questions and believed that they had received the right level of care and support.

Emotional support

- There was a lead nurse for plastics services and urology services to support patient's individual needs. Counselling services were available through those nurses to cosmetic patients prior to surgery to ensure they were fully prepared and well informed.

Outpatients and diagnostic imaging

- Fertility services which are run from the centre but by a different provider, had counselling and support information displayed publicly for the female patients attending Baddow Hospital.

Are outpatients and diagnostic imaging services responsive?

The services provided were responsive to patient needs. Patients in outpatients were offered flexibility and choice of appointment times, dates and also if booking through private services offered a choice of consultant. When attending for future appointments were offered with the same staff to ensure continuity in care.

The environment had been designed to meet the needs of different such as those with visibility or disability concerns because all rooms were easily accessible.

Access to the service for NHS patients was arranged in a way where all partners in the patients care were involved from time of referral to discharge. The appointments system is easy to use and supports people to make appointments.

Information on how to make a complaint is available through the website and in the main patient leaflets, however there was no visual information on how to raise a complaint in the main areas.

Service planning and delivery to meet the needs of local people

- The outpatient service was planning on tendering for additional NHS contract to support a patients choice to attend Baddow Hospital for outpatient services. Currently Podiatry services are provided under the NHS contract.
- The service business plans cite the need to increase the variety of specialities provided by the hospital and in the past few months had included new specialities including gastroenterology. The service is continuing with its schedule to include a wider range of specialties including dermatology in the near future.
- The business plans support the development of the remaining site into a healthcare park which will include the provision of a diagnostics centre for people to have their diagnostic imaging and pathology tests undertaken on site.
- All clinic lists are planned by specialty which causes little or no disruption to patients being able to access the service. Currently due to the number of clinics no concerns regarding service delivery were noted at the time of the inspection.
- Each consultant room was near the main entrance which made the service accessible to the patients. The rooms were furbished in a way which made the process more comfortable for patients

Access and flow

- Patients who chose to use the service could access the service directly or through referral or recommendation by their insurance companies.
- NHS patients using the Podiatry service could access the choice to use this service through a contact held by the service with the NHS.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Services and clinics ran on time. If there were any delays, the receptionist's ensured people were kept informed of any disruption to their appointments or treatment.

Meeting people's individual needs

- Translation services could be accessed through language line for people whose first language was not English. However, there were no posters or written information available to inform people of the help available.
- Staff recognised the individual needs of patients with complex needs including those with learning disabilities, those living with dementia and mental health concerns. Each patient case referral is carefully considered to determine if the service can meet the needs of the patient.
- One case referral for a surgical case was declined and referred to another hospital because a patient had dementia. The registered manager informed us that they believe d their care needs could be better met elsewhere. This meant that the service was considerate of individual patient needs.

Learning from complaints and concerns

- We viewed the complaints log maintained by the service. There had been two complaints logged which had reference to outpatient services. Both were responded to by the registered manager and the communications were open an transparent.

- Where a complaint had been reported in the service improvement areas had been identified and lessons learned had been implemented. For example communications around appointments.

Are outpatients and diagnostic imaging services well-led?

There is clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

The board and other levels of governance within the organisation were in their infancy and the effectiveness of the systems was still being tested. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out and understood.

There were good examples of staff involvement in design and future developments for the outpatient and diagnostic department. Staff reported that the managers ensured they feel respected, valued, and engaged.

Vision and strategy for this service

- The service had a vision, strategy and business plan to look at developing the service over the next five years. The key objective the service aimed for was to provide good quality care. As the service as new it was also trying to establish a financial balance that supported the growth of the business.
- All staff were clear about the hospital's vision and values and were aware of the plans to expand and build the service to form part of a healthcare park.

Governance, risk management and quality measurement

- Records of team meeting and staff consultation demonstrated that risks at team and management level were identified and captured and staff recognised their role within the importance of risk management and improving the service.
- The service did not have a risk register though due to the service being new all risks that may become apparent when the service is busy are not yet known. Work is needed to develop an overarching risk culture within the outpatients department.

Leadership of service

- The staff were positive about the department managers and the registered manager. The registered manager had overall responsibility for the outpatients service with local staff working within the department. There were plans when the service grows to have a dedicated outpatient department lead. All staff we spoke with were complimentary about the registered manager stating that they were approachable.
- The vast majority of staff felt the managers knew their staff, played to their strengths and developed them as individuals. Staff said they were valued which helped during busy times where flexibility and good will was needed to provide a quality service.

Culture within the service

- There was an open and transparent culture. Staff were clear about where they were performing well and would be confident to challenge poor performance to improve quality of care.
- Staff were positive regarding team working amongst multidisciplinary professionals within the service and that there were good communication processes such as daily handovers and board rounds for the daily activities called the 'ten at ten'.
- All staff we spoke with said they felt valued and supported by the organisation.

Public and staff engagement

- Staff were engaged in the development and future of the service. All staff we spoke with were aware of the future plans for the expansion of outpatients and the plans to include more specialties and staff spoke highly of the future for Baddow Hospital.
- Patient surveys were undertaken routinely and patients were asked to feedback on their services in either paper format, through the website or through social media.

Innovation, improvement and sustainability

- There were good examples of forward planning and capacity management developments for the outpatients service which included the development of a diagnostic service and a dedicated outpatient area of the healthcare park.

Outpatients and diagnostic imaging

- The service had grown steadily over a year and the management team approached this cautiously to provide continuity of care for the existing patients, this was a positive approach to take.
- Financially the turnover and support for the service as well as NHS contract tenders being placed means that he service will continue to grow in size and sustainability will be tested the more the service grows.

Outstanding practice and areas for improvement

Outstanding practice

The environment and facilities provided at Baddow Hospital were outstanding.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should provide induction to all medical, bank and agency staff.
- The provider should provide all staff with meetings to discuss the clinical services. These minutes should be recorded.
- The provider should ensure that all staff training competencies on equipment are checked, monitored and up to date.
- The provider should ensure that management support and oversight of theatres is provided by the registered manager.
- The provider should develop and embed the governance systems further to ensure that they are robust.