Baddow Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Baddow Hospital is operated by Baddow Hospital Company Limited. The hospital provides surgery and outpatient services. We inspected both these services.

The service provided outpatient and surgery to a small number of children and young people under the age of 18 years. Due to the small numbers of children and young people who attended the service we have not rated or reported on children and young people's services, but included this in the reports for outpatients and surgery. Following our inspection the provider amended their statement of purpose on a voluntary basis to state that with immediate effect they would no longer see or treat any patient under the age of 18 years at the service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 September 2016, along with an unannounced visit to the hospital on 19 September 2016. The hospital was first inspected, but not rated, in 2014.

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 inadequate overall. Surgery was rated as inadequate and outpatients was rated as requires improvement.

In surgery we found:

- Staff we spoke with were not aware of any recent incidents reported by the surgical service or of any lessons learnt.
- There were two leads for safeguarding children and adults and neither were registered professionals nor trained in line with national guidance. They were also unable to demonstrate sufficient knowledge about safeguarding.
- Staff we spoke with were not familiar with the terms Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005.
- At the time of our inspection, there was no specific training on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We were not assured that staff would be confident in dealing with potential cases involving MCA and DoLS.
- There was no reference to Gillick competence or Fraser guidelines in the service policies on consent to treatment. There were no audits on Gillick or Fraser in the service.
- There were no records kept for the checking history of the difficult airway and spinal equipment trolleys.
- The service did not use a performance dashboard.
- There was no participation in national audits, and oversight and analysis of local audit was limited.

Summary of findings

- Staff we spoke with confirmed they had not received training on dementia or learning disability, whilst at the same time confirmed that patients living with these conditions accessed the hospital.
- The hospital did not have a risk register detailing risks known for patient safety, business continuity or any other service related risk.
- Staff nurse appraisal rates in surgery were low.
- The governance process was not effective and did not identify or manage risks effectively. The service was not aware of many of the risks identified throughout our inspection, such as safeguarding training and policies on consent.
- The concerns identified with the lacking governance process were similar to those identified at the last inspection in 2014.

However there were some areas of good practice including:

- There were reliable systems in place to prevent and control infection and we observed staff following infection control principles.
- Medicines were regularly checked, stored safely, and prescribed and administered appropriately.
- People's healthcare records were legible, up to date and stored securely.
- One-hundred per cent of staff had completed their mandatory training.
- Risk assessments were carried out for individual patient risks relating to treatment. Procedures were in place for the assessing and responding to patient risk.
- A sufficient number of suitably qualified staff was on duty at all times.
- Pain was assessed and managed appropriately.
- Multidisciplinary team working within the hospital and externally was effective.
- Access and flow through the service was seamless, and admission times were flexible dependent on patient request.
- Numbers of cancelled operations were low.

Within outpatients we found:

- There were two leads for safeguarding children and adults and neither were registered professionals nor trained to expected levels as per national guidance. They were also unable to demonstrate sufficient knowledge about safeguarding.
- Methicillin-Resistant Staphylococcus Aureus (MRSA) screening rates were low (between 19% and 50% for the period January to June 2016).
- At the time of our inspection, there was no specific training on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We were not assured that staff would be confident in dealing with potential cases involving MCA and DoLS.
- Staff we spoke with confirmed they had not received training on dementia or learning disability, whilst at the same time confirmed that patients living with these conditions accessed the hospital.
- There was no reference to Gillick competence or Fraser guidelines in the service policies on consent to treatment. There were no audits on Gillick or Fraser in the service.

Summary of findings

- The hospital was unable to provide exact data on referral to treatment times (RTT) but were able to demonstrate that they had never breached contractual waiting times for any NHS patients.

However, there were some areas of good practice including:

- All areas we inspected were visibly clean and well laid-out.
- All outpatient records we reviewed were clear and complete and records were stored securely, including within the consultation room.
- Nurse and medical staffing levels were sufficient to meet patient needs and all medical staff employed under practising privileges were up-to-date with revalidation.
- Staff were engaged through regular team meetings at a local level within outpatients and the administration team, and also through hospital wide communications.

Professor Ted Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	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 inadequate overall. The safe, effective and well-led domains were inadequate and the caring and responsive domains were good. There was a lack of information recorded around lessons learnt and practice changes from incidents. The two leads for safeguarding children and adults were not registered professionals or trained to expected levels as per national guidance. Staff were not aware of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). There were no records kept for the checking history of the difficult airway and spinal equipment trolleys. The service did not use a performance dashboard, which would support the monitoring of risk and safety in the service. There was no participation in national audits, and analysis of local audit was limited. Staff appraisal rates were low. Staff did not receive training in dementia or learning disabilities so may not have been competent in recognising and responding to patients with these needs. There was a lack of assessing the effectiveness of the service. The hospital did not have a risk register detailing risks known for patient safety, business continuity or any other service related risk. The governance process was not effective and did not identify or manage risks effectively. The service was not aware of many of the risks identified throughout our inspection, such as safeguarding training and policies on consent.
Outpatients and diagnostic imaging	Requires improvement 	We rated outpatients as requires improvement overall. The safe and well led domains were rated as inadequate, caring was rated as good, and responsive was rated as requires improvement. The effective domain was not rated. There was no reference to Gillick competence or Fraser guidelines in the service policies on consent

Summary of findings

to treatment. There were no audits on the application of the principles of Gillick competence or Fraser guidelines in the service. The service did not take part in or submit data for any national audits. The service was unable to provide exact data on referral to treatment times (RTT) although they stated they had never breached contractual waiting times for any NHS patients.

Summary of findings

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Surgery and Outpatients

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, ENT, pain management, maxillofacial, podiatry and foot and ankle surgery.

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

Our inspection took place on 5 September 2016. We also carried out an unannounced inspection on 19 September 2016. We undertook a further announced visit to meet with the provider of the service on 30 November 2016.

Our inspection team

The team that inspected the service was led by a lead CQC Inspection manager, and included two inspectors and one specialist advisor with a nursing background.

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

The hospital employs 32 doctors under practising privileges. There are four registered medical officers (RMOs).

We spoke with 12 members of staff including senior managers, managers, doctors, registered nurses (RN), theatre staff, healthcare assistants, administrative staff and cleaners, and with two people who had used the service. We also observed care, reviewed feedback forms, looked at the healthcare records of six people who had used the service and analysed information we requested from the hospital.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (April 2015 to March 2016):

- There were 1,320 day case episodes of care recorded at the hospital in the reporting period (April 2015 to March 2016); of these 67% were NHS funded and 33% were other funded.
- No patients stayed overnight at the hospital during the same reporting period.
- There were 7,085 outpatient total attendances in the reporting period; of these 50% were NHS funded and 50% were other funded.
- This included 10 children aged between 10 and 16 in outpatients, and two young people aged 17 in surgery.

Summary of this inspection

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

Track record on safety (April 2015 to March 2016):

- 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
- Three complaints

Services accredited by a national body:

- None

Services provided at the hospital under service level agreement:

- Diagnostic 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?

Requires improvement

We rated safe as requires improvement because:

- There was a lack of information recorded around lessons learnt and practice changes from incidents.
- Methicillin-resistant Staphylococcus Aureus (MRSA) screening rates were low (between 19% and 50% for the period January to June 2016).
- The two leads for safeguarding children and adults were not registered professionals or trained to expected levels as per national guidance. They were also unable to demonstrate sufficient knowledge about safeguarding.
- There were no records kept for the checking history of the difficult airway trolley.

However:

- There had been no healthcare associated infections (HCAIs) reported between January 2015 to August 2016, there were reliable systems in place to prevent and control infection and we observed staff following universal infection control principles.
- Medicines were regularly checked, stored safely, and prescribed and administered appropriately.
- Patient records were legible, up to date and stored securely.
- There were comprehensive risk assessments carried out, and procedures in place for assessing and responding to patient risk.

Are services effective?

Inadequate

- There was no participation in national audits, and oversight and analysis of local audit outcomes were limited.
- Monitoring outcomes was limited due to no participation or consideration for participation in national benchmarking, or Patient Reported Outcome Measures (PROMS) for procedures.
- Staff were not familiar with the relevant consent and decision making requirements of the Mental Capacity Act (2005), and the Deprivation of Liberty Safeguards (DoLS). Staff did not receive training on MCA or DoLS.
- There was no reference to Gillick competence or Fraser guidelines in the service policies on consent to treatment. There were no audits on Gillick or Fraser in the service.
- Staff nurse appraisal rates were low in surgery.

However:

Summary of this inspection

- Pain relief was well managed.
- There were care bundles in place for prevention of surgical site infection and cannulation.
- There was effective multidisciplinary team (MDT) working.

Are services caring?

Good

- People using the service were treated with dignity, respect and compassion.
- Patient survey results showed that people were very happy with the care they had received.
- People we spoke with, and records examined, showed people were involved in and understood their care and treatment.
- There was access to a member of staff for advice and support at all times, including out of hours.

However:

- The hospital did not submit Friends and Family Test (FFT) data.

Are services responsive?

Requires improvement

- We did not see evidence of good awareness of learning disabilities or specific training on how to meet the needs of patients with learning disabilities.
- Staff had an awareness of the need to adapt their approach when treating patients living with dementia and were able to give examples of this. However, in outpatients we were told that if a patient was in the later stages of Alzheimer's disease, for example, the service would not be suited to their needs and they would advise the family or carer to refer to a more appropriate facility. Though, this was not specified in the hospital's admission and discharge criteria.
- The hospital was unable to provide exact data on referral to treatment times (RTT) for outpatients but provided assurance though correspondence with commissioners that they had never been found to be breaching contractual waiting times for any NHS patients.

However,

- Pre-assessment appointments in outpatients were scheduled a week in advance of scheduled surgery; however the service could be flexible to meet patients' needs.
- The facilities were easily accessible and there was a hospital-wide audit to ensure facilities could meet the specific needs of patients with disabilities.
- Within outpatients there were sufficient cover arrangements to ensure patients did not have their appointments cancelled.

Summary of this inspection

Are services well-led?

Inadequate

- A number of the policies were not reflecting best practice or adhering to service policy. For example safeguarding children the policy reflected national best practice but the named leads were not trained to a sufficient level.
- There was a lack of assessing the effectiveness of the service. There were limited audits or outcomes looking at how the outpatient service was performing. For example, the service did not participate in national audits or undertake many local clinical audits.
- The service did not use a performance dashboard.
- The hospital did not have a risk register detailing risks known for patient safety, business continuity or any other service related risk at the time of inspection. There was no monitoring of risks through the governance process. A draft risk register was submitted following the inspection, however this contained no identified risks.
- The governance process was not effective and did not identify or manage risks effectively. The service was not aware of many of the risks identified throughout our inspection, such as safeguarding training and policies on consent, which would be identified if an effective governance process was present.

However:

- Staff told us they felt engaged in the service, and they could voice their ideas at hospital-wide meetings and face-to-face with managers.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Inadequate	Good	Good	Inadequate	Inadequate
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate

Inadequate

Surgery

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

Are surgery services safe?

Requires improvement

We rated the safe domain as requires improvement within surgery.

Incidents

- There had been no never events reported for surgery between January 2015 and August 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- During January 2015 to August 2016 there had been 26 clinical incidents reported by the surgery department, however, none of which were serious incidents. Examples of clinical incidents include equipment issues, medicines checking incident and patient injury.
- There was an incident reporting system in place, and staff were able to tell us what constituted an incident and knew how to use the system.
- We reviewed meeting minutes of the governance meetings from 2016; however there was a lack of information recorded around lessons learnt and practice changes from incidents.
- Incidents were investigated by the hospital management team, however due to a lack of information we could not be assured of how the learning from these incidents was disseminated to staff. For example, one incident related to a diathermy injury to a patient, there was no evidence to show how this incident was learnt from.
- We asked four members of qualified staff to tell us if they knew of any incidents that had been reported through the hospital and whether they had learnt anything from investigated incidents and none of the members of staff were able to tell us this.
- We also reviewed the latest weekly update (newsletter) which was circulated to all staff, the quarterly 'whole staff team' meeting minutes dated April 2016, and the latest departmental meeting minutes, and found no evidence that incidents reported and learning from incidents was disseminated to staff.
- Mortality and morbidity was reviewed and fed into service improvement. We looked at the last Medical Advisory Committee (MAC) meeting minutes dated March 2016 and found evidence of this. For example, a review of serious incidents was on the agenda, and throughout these meeting minutes there were records which showed discussion fed into service improvement. For example, it had recently been decided that patients should stay overnight if their operation duration goes beyond six hours following a discussion at this MAC meeting.
- However, we also found that the MAC meetings only took place twice yearly and this meant that review of mortality and morbidity did not occur regularly.
- Staff were aware of the principles of duty of candour.

- We also were shown a copy of the training presentation. The service had not needed to undertake duty of candour on any of the incidents that had been reported.

Clinical Quality Dashboard or equivalent

- The service did not use a performance dashboard, which would support the monitoring of risk and safety in the service.

Cleanliness, infection control and hygiene

- There had been no cases of MRSA, MSSA (Methicillin-sensitive staphylococcus aureus), E-coli or Clostridium Difficile (C.difficile) reported by the hospital from January 2015 to August 2016.
- Records showed that MRSA screening was low. For example, in April (31%), May (19%) and June (45%) 2016 the number of patients screened was always less than half.
- We saw that there were cleaning schedules throughout the hospital and that cleaning was carried out by cleaning staff employed by the hospital. Every area we visited was visibly clean and well organised.
- Staff demonstrated that they adhered to universal infection control principles. We saw staff practise good hand hygiene, and all staff used personal protective equipment appropriately and wore their uniforms bare below the elbows.
- Infection control training was part of induction training for all staff and records showed that 100% of staff had completed this training. Furthermore, staff confirmed that infection control updates were part of the hospital's mandatory training programme.
- Hand sanitiser and hand washing facilities were available throughout the hospital and there were notices reminding people to clean their hands. There were sufficient supplies of personal protective equipment, such as gloves and aprons, available for staff throughout the hospital.
- Throughout the hospital the "I am clean" green stickers were used, which notified staff when equipment was clean and last cleaned.
- Clinical waste was disposed of appropriately and in line with the hospital's clinical waste procedures. Yellow clinical waste bags were used, there were foot-operated waste bins, and sharps bins which were signed and dated and not over-filled throughout departments.
- There were up-to-date policies and procedures in place for infection prevention and control.Staff told us 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.
- The latest infection control report dated June 2016 presented data from January to June 2016. Results showed that there was 100% compliance with hand sanitising/washing per month, and there had been one reported surgical site infection treated with antibiotics during this period.

Environment and equipment

- Surgical areas within the hospital consisted of three operating theatres, one of which had laminar flow and another was used as a pain management room. There was a recovery area with two 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, though this was rare.
- There was one trolley with resuscitation equipment for the hospital. This was fully stocked and records for June, July, August and September 2016 showed that the resuscitation equipment had been checked daily when the hospital was open.
- We saw that there were adequate storage facilities and suitable levels of equipment for safe monitoring and effective treatment.
- We checked single use equipment throughout the hospital and found that this equipment was properly stored, in date and packaging was intact.

- We looked at records for the airway and spinal trolleys, however there were no records of checks completed for the airway trolley. Two members of theatre staff who were responsible for these checks confirmed our findings.

Medicines

- Records for June, July and August 2016 confirmed that controlled drugs were checked daily. Medicines for resuscitation were also checked daily with the emergency equipment.
- Medicines were stored securely in locked cupboards.We checked six stock medicines at random, one unit of blood and four bags of intravenous fluid, and found that these were in date and stored as per manufacturer's advice.
- We observed a nurse administer medicines to one person who used the service and saw that these were given in line with national standards such as those issued by the Nursing and Midwifery Council (NMC).
- We looked at the medicines records of three people who used the service and found that medicines were prescribed correctly, administered as prescribed and given at the correct time.
- There was a service level agreement (SLA) in place with a nearby NHS trust for pharmacy support.

Records

- Records were stored securely throughout the hospital either within metal lockable cabinets within inpatient areas, or behind closed doors within the hospital's internal medical records department.
- We checked six healthcare records of people who used the service and found that documentation was clear, accurate, up-to-date and legible. Assessment was thorough, and clinical care plans were tailored to need, and where a concern had been identified we saw that appropriate action was taken as a result and then recorded.
- For example, the healthcare records of one person who was undergoing an operation during our visit showed that relevant advice had been given prior to surgery about their medication.
- We looked at the pre-operative records of six people who had used the service. Pre-operative assessment paperwork was holistic and thorough. We found that an appropriate pre-operative assessment had been carried out and recorded in all of the records.
- Healthcare records were in paper format and kept onsite in individual patient folders. We looked at the healthcare records of six people who used the service and found that records were complete, and contained consultants' operating and outpatient department records for the person.
- There were registers kept, which we checked, for implants such as breast implants and these were fully completed with relevant traceability stickers attached.

Safeguarding

- The hospital had not reported any safeguarding incidents between January 2015 and August 2016.
- The training provided for both adults and children's safeguarding was done through an e-learning module. The training provided to all staff in surgery was level one for safeguarding adults and level one for children's safeguarding. Level one training compliance rates for both adults and children was 100%.
- The service provided care to potentially vulnerable adults and the minimum expectation would be for safeguarding level two training for adults. The service treated children and young people under the age of 18 years, therefore it would be expected that clinical staff involved in their care and treatment would be trained to safeguarding children level three.However, this was not the case.
- There were two members of staff who were allocated leads for adult and children's safeguarding. However, these members of staff were administrative staff, one of which was the administrative lead and the other a receptionist. Both were trained to level one on adults and children's through an e-learning package.
- This was a concern because they were not registered professionals, and this is not reflective of national guidelines for safeguarding. For example, guidance issued by the Royal College of Paediatrics and Child Health (RCPCH) on behalf of numerous contributing organisations states that, "All provider organisations

should have a named doctor or nurse for child protection" trained to level four (RCPCH: Safeguarding Children and Young People, roles and competencies for healthcare staff, Intercollegiate document, 2014).

- We spoke with one of the leads who confirmed they had not received any safeguarding training for adults and children. This member of staff was not able to demonstrate that they had sufficient knowledge to carry out this lead role. For example, we asked this person what Deprivation of Liberty Safeguards were and they could not explain this.
- We spoke with eight members of staff about safeguarding. All staff we spoke with were knowledgeable as to what constituted a safeguarding concern, how to raise matters appropriately and who the safeguarding leads for the hospital were.
- There were notices in staff areas, which reminded staff who the safeguarding leads were for the hospital.
- There was an up-to-date safeguarding policy dated August 2015 for children and adults, which staff could access via the intranet. The review date was August 2017.
- However, we were concerned that the section of the policy on training was not clear in terms of training requirements for staff which were outlined. For example, page seven of the policy read, "All staff working at Baddow Hospital will have the opportunity to attend training in relation to safeguarding adults relevant to their role in the service", and that, "Safeguarding training may be in the form of: internet online training, training course attendance/mandatory training, conference attendance, 1:1 learning, group learning, private reading, reflection, or other appropriate learning approach".
- The policy does not specify the requirements for lead role training and competency requirements in line with best practice.
- The policy also refers to safeguarding children update training. The policy states, "Child safeguarding update training will be provided as necessary, proportionate to the nature of the adult patient care service being provided and taking into consideration the frequency of child visitors in Baddow Hospital". Training evidence provided showed that 100% of staff were up to date with their level one training. However, staff were not trained to level two safeguarding children.
- We returned to inspect the concerns regarding safeguarding on 30 November 2016. Following this inspection visit, the provider amended their statement of purpose on a voluntary basis to state that with immediate effect they would no longer see or treat any patient under the age of 18 years at the service. This therefore eliminated the risks associated with the care and treatment of patients under the age of 18 years.
- However, further work was required to ensure that all clinical staff were trained to level two safeguarding children, and level two safeguarding adults as recommended by the intercollegiate document. The named leads trained for safeguarding at the time of this further visit were not clinical, as recommended. The management team informed us that sessions were booked and this was work in progress to complete this.
- The safeguarding policy detailed the Essex contacts for staff to make a referral for both safeguarding adults and children's concerns.
- Our concerns were heighted because a senior manager was not aware of training requirements for different staff levels.

Mandatory training

- Records showed that all staff had either completed their mandatory training within the past year or were booked onto refresher training in October 2016.
- 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 and infection control.
- Staff told us that the management of sepsis was covered in mandatory training.
- All nursing staff and support staff employed by the service had received training in basic paediatric life support. The registered nurses employed by the service had all received paediatric intensive life support training.

Inadequate

Surgery

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

- The hospital had an admission policy setting out safe and agreed criteria for selection and admission of people using the service. For example, those with a body mass index (BMI) of greater than 40 did not meet the hospital admission criteria since there were not facilities available to care for such patients safely.
- 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.
- We checked three patients' NEWS charts and found that these were fully completed and that scores were calculated accurately. We also spoke with two registered nurses (RN) on the ward area about how they would manage a deteriorating patient. Both RNs knew how to use the NEWS system and when and how to escalate concerns if a patient's condition deteriorated.
- There was a service level agreement (SLA) in place with a local NHS trust in the event of a patient's condition deteriorating during admission at Baddow Hospital. Any patient requiring additional clinical support would be transferred to the acute facility.
- There was an up-to-date policy and protocol in place for the deteriorating patient titled, The deteriorating patient policy with a review date of July 2018. Staff were aware of this policy and could access it via the intranet.
- The World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery was used for admitted patients. It was embedded into the provider's patient admission paperwork for those undergoing surgical procedures. We checked the healthcare records of three people who used the service and found that the WHO checklist had been completed fully.
- We spoke with two operating department practitioners (ODPs) and they told us that no surgery was undertaken without the WHO checklist being completed.
- Quantitative audits of the use of the WHO checklist were carried out; however, this audit was not regular despite the current hospital Audit policy issued August 2016 stating that this should be a monthly occurrence. Records showed that an audit had only been conducted in January, April and August 2016, and the number of checklists reviewed was inconsistent. For example, in April only 10% of healthcare records had been audited, and in August 100% had been completed.
- 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 duty and on site between 8pm and 7am.
- Staff told us that at the start of an operating list and as part of the surgical check the surgeon and anaesthetist always confirmed that they would be within a 30 minute return to the hospital for emergencies overnight. In addition to this there was an on call theatre team for overnight admission.
- We looked at the healthcare records of six people who used the service and found that comprehensive risk assessments had been carried out with correlating risk management plans. We saw that these risks were managed positively.
- 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

- There were 6.9 registered nurse whole time equivalents (WTE) and 6.2 WTEs other staff including ODPs and care assistants employed by the hospital who worked within the surgical service.
- In addition to this there were 16.3 WTE other hospital staff including administrative and cleaning staff.
- Staff told us that there was always a senior member of staff on duty per shift and for each area, and that nursing staffing levels were safe.
- Planned and actual staffing numbers for the ward area were displayed in public view on a board for the day and night shift.
- The hospital did not use an acuity tool to determine staffing numbers, instead staffing numbers were

assessed weeks prior to planned admissions, and then reviewed days ahead of admission and daily, and staffing numbers adjusted accordingly to ensure safe staffing levels.

- We attended the hospital-wide meeting called the, "10 at 10" meeting which occurred daily, and found that nursing staffing numbers were assessed and planned well in advance of admission and daily thereafter.
- There were up-to-date staffing policy and procedures in place titled, "Staffing" issued August 2015, which outlined minimum staffing levels. For example, when theatre operated there were always two nurses present in theatres.
- There were no staff vacancies for inpatient nursing staffing or healthcare assistants. There was one vacancy for a theatre scrub nurse.
- Recently two senior nurses had been appointed to work jointly as ward manager, safeguarding and infection control champions.
- The use of bank or agency nurses in inpatient departments was below average between April 2015 and March 2016 when compared to other independent acute hospitals that we hold this type of data for.
- There was no use of bank or agency healthcare assistants between April 2015 and March 2016.

Medical staffing

- Surgeons were predominantly employed by other organisations (NHS organisations) in substantive posts and had practising privileges to work at the hospital. Practising privileges means the grant of permission, by a person managing a hospital, to a registered medical practitioner to practice at that hospital.
- There were 32 consultants who had been granted practising privileges to work at the hospital, of which 26 had undertaken sessions at the hospital within the 12 months prior to our inspection.
- Consultant surgeons and anaesthetists were available at all times throughout the duration of their patients' stay.
- The hospital also employed four Resident Medical Officers (RMOs) on a locum basis for all overnight stays. A manager told us that this ensured flexibility in workforce and as per service demand, and that RMOs worked entirely night shifts between 8pm to 7am.
- 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.
- We also found that medical staffing was discussed and planned at the, "10 at 10" meeting which occurred daily.

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 in place dated August 2016, which outlined protocol and procedure in the event of an emergency or unexpected disruption to service provision.

Are surgery services effective?

Inadequate

We rated the effective domain as inadequate within surgery.

Evidence-based care and treatment

- We looked at the healthcare records of six people who used the service. These records showed that people's needs were assessed and care was planned and delivered in line with recognised guidance, legislation and best practice standards. For example, this included up-to-date Venous thromboembolism (surgical) CG46 guidance issued by the National Institute for Health and Care Excellence (NICE2007).
- We asked staff how they received information about changes to local policies and procedures, and changes to relevant national best practice guidance and legislation. However, staff told us that this was done informally and could not tell us examples of changes they were made aware of.

- There was no evidence of discussion or dissemination of such information minuted from meetings, such as the latest governance meeting dated February 2016, the theatre staff meeting dated July 2016 and the head of department (HoD) meeting from January 2016.
- However, there was a system in place for the developing, ratifying and reviewing of clinical policies and procedures, this included oversight of the process by the Medical Advice Committee (MAC).
- Staff we spoke with were able to access hospital policies and procedures via the intranet. We observed that staff adhered to local policy and procedure. For example, the deteriorating patient policy, because staff were able to describe to us how they had recently followed this policy and procedure in the event of patient suffering an epistaxis (nose bleed) which required further surgery and transfer of the person to a local NHS trust for further care and treatment.
- We checked five clinical policies and found that these were ratified by the MAC and had review dates. However, policies that referred to consent or safeguarding did not reflect current national best practice guidelines.
- There was a limited audit programme in place. Some local audits such as: hand hygiene, controlled drug, medical records, intravenous venepuncture and MRSA audits were undertaken. With the exception of the World Health Organisation (WHO) audit, which we have reported on fully in the 'safe' section of this report, audits were carried out regularly.
- However, there was limited evidence of audit analysis and action plan development. Although there was one comprehensive audit for infection prevention and control carried out quarterly, with a detailed report of findings, summary and details of action required.
- There were no audits undertaken specifically on medical outcomes or nursing care delivery.

Pain relief

- Observations confirmed that people's pain levels were assessed and managed appropriately. We spoke with two people who used the service and both confirmed that their levels of pain had been assessed regularly and managed effectively where required.
- We also looked at the healthcare records of six people who had undergone surgery recent to our visit and found that their pain had been regularly assessed and pain relief prescribed and administered in a timely way.
- Staff confirmed that there was always a doctor on site, including during the night for overnight stays. This meant that there was always access to further pain relief as necessary.

Nutrition and hydration

- We checked the fluid charts of four people who used the service and found that these were completed and calculated appropriately.
- We checked the healthcare records of six people who used the service and found that prior to admission people's nutritional and hydration needs were assessed, and again when they were admitted to the hospital.
- Healthcare records we looked at also showed that people's nausea and vomiting were assessed regularly following surgery, and from talking with staff, staff confirmed they managed nausea and vomiting appropriately where required.

Patient outcomes

- The Medical Advisory Committee (MAC) oversaw and provided scrutiny for clinical outcomes such as rates of surgical site infections, adverse incidents, serious incidents, unplanned return to theatre cases and complaints.
- Between January 2015 and June 2016 there had been no surgical site infection reported. We requested data from the service for July into September 2016; however, no data was available.
- We were informed that there had been one case of an unplanned transfer of an inpatient to another hospital in the reporting period April 2015 to August 2016. We requested additional data in respect of this, however none was provided.
- Between April 2015 and August 2016 there had been no unplanned readmissions to the hospital.
- There were care bundles in place for prevention of surgical site infection and cannulation.

- The hospital did not participate in any national audits, benchmarking or peer reviews, a senior manager confirmed this.
- Information about the outcomes of people's care and treatment was not routinely collected and monitored, for example there was not a performance dashboard in place.
- The service did not collect data for Patient Reported Outcome Measures (PROMs). 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- and post-operative surveys. PROMs have been collected by all providers of NHS-funded care since April 2009.
- The service has not considered participation in any national studies in respect of surgery through the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

Competent staff

- Appraisal rates for nurses employed by the service were 40%, which was below the target of 75%. Other staff appraisal rates were 6%.
- Registered nurses that we spoke with confirmed that they had either been revalidated in terms of their professional registration with the Nursing Midwifery Council (NMC), or were working through this process.
- All new staff underwent a comprehensive induction programme when they commenced employment at the hospital. Records showed that 100% of staff had completed this training.
- There was a system in place for the granting and monitoring of practising privileges. A practising privilege is defined as, "pMedical Advisory Committee (MAC) provided scrutiny of all applications and reviews for consultants' full practising privileges. Privileges were reviewed on a regular basis.
- One-hundred per cent of consultants had been revalidated in terms of their registration.
- Records showed that senior hospital managers took appropriate action where poor or variable staff performance was identified, and managed this effectively. Where possible support was given to staff to improve performance.

Multidisciplinary working

- We observed effective multidisciplinary team (MDT) working between staff. There was a good rapport, mutual respect and effective communication between staff from all disciplines and across the hospital.
- Staff we spoke with also confirmed that MDT working was good. One member of staff told us, "We all get on very well here across all staff levels, everyone values one another - it's great".
- There were also examples of external MDT working. For example, there was a service level agreement (SLA) with local NHS trusts for both pharmacy support and for patients who require transfer to an NHS trust due to deterioration in health.

Seven-day services

- The hospital was predominantly a day case hospital; however, overnight stays were available as per clinical need. The hospital did offer advice from an out of hours nurse advisor via telephone when the hospital was closed, which usually was between 8pm and 8am.
- Consultants were available for the duration of their patient's stay including overnight, whereby they were within a 30 minute return to the hospital.
- A Resident Medical Officer (RMO) was onsite for all overnight admissions.
- There was an on-call theatre team for any overnight admissions in case of urgent return to theatre, including an anaesthetist.

Access to information

- Staff we spoke with confirmed that they had access to the hospital's policies and procedures via the intranet system.
- Healthcare records were kept onsite, and we observed that staff had access to people's healthcare records.

- 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

- We were concerned that five out of eight members of staff we spoke with were not familiar with Deprivation of Liberty Safeguards (DoLS). Five could not demonstrate to us what mental capacity assessments were. Our concerns were heightened as a senior manager confirmed that people living with a learning disability or dementia used the service at times.
- The hospital had an up-to-date policy in place for safeguarding and consent to care and treatment, which were available to staff via the intranet. These policies made reference to obtaining valid consent, Mental Capacity Act (MCA) and DoLS. However, the information relating to MCA and DoLS was brief and did not outline legislative requirements, or provide sufficient background information on these subjects.
- There was no reference to Gillick competence in the service policy on consent to treatment. There were no audits on Gillick in the service.
- Five members of staff told us they had not received training on MCA or DoLS.
- We looked at the consent forms of four people who had undergone surgery and these were all accurately completed.

Are surgery services caring?

Good

We rated the caring domain as good within surgery.

Compassionate care

- We observed that staff consistently acted in a friendly and caring manner with people who used the service and those close to them.
- On the ward area we saw a number of examples whereby staff responded to patients' needs promptly, kindly and in a dignified manner.
- We spoke with two people who used the service and they spoke positively about staff and the care they had received. One person told us, "The care has been exceptionally good from start to finish".
- Patients' personal, cultural, social and religious needs were taken into account when plans of care were agreed following assessment. We looked at the healthcare records of six people who had used the service and this confirmed that assessments of these needs took place prior to the person attending the hospital.
- There were signs throughout the hospital informing people about chaperoning and that they could request a chaperone as required.
- Every person who used the service was given a patient satisfaction survey to complete on discharge; they could either drop the survey into a box at reception or post back to the hospital.
- We looked at 10 recent patient feedback forms and found all were "extremely likely" or "likely" to recommend a friend or family to the hospital. All these forms also had positive comments written on them by the patient.
- The patient feedback forms were audited on a monthly basis for all patients whether private or NHS. Audit results showed consistently positive feedback from patients. For example, there was an audit for patients who were referred from an NHS trust (they were referred to Baddow Hospital due to extended waiting times at the NHS trust).
- We looked at feedback from July 2016 for 12 people who had used the service who were referred from another hospital. The feedback was entirely positive and one person commented that the service they received was, "Excellent, the nurses couldn't do enough for you and the care and attention I received couldn't have been better".
- We also checked another audit, which involved patient feedback about the hospital when they were referred from a different NHS trust to the one above. Feedback from six people who used the service at Baddow Hospital wrote positively about their experience.
- The hospital did not submit Friends and Family Test (FFT) data.

- 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 looked at the healthcare records of six people who used the service and found that people were involved in planning their care from admission to discharge.
- During our observations we saw that staff communicated with people effectively so that they understood their care, treatment and condition.
- Both of the patients we spoke with confirmed that they felt involved in and understood the care they had received.
- We observed a patient be discharged following surgery and found that the patient and his partner were given all the relevant discharge information required, and were given time to ask questions.

Emotional support

- Staff told us that 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, however, staff told us that the hospital had good external links with other organisations and specialist advice would be sought as required.
- People who used the service could speak with a member of staff at all times, for advice and support. Out of hours there was a dedicated nurse advisor employed by the hospital who was available via the telephone.

Are surgery services responsive?

Good

We rated the responsive domain as good within surgery.

Service planning and delivery to meet the needs of local people

- We found that the facilities and premises were appropriate for the services that were planned and delivered.
- The hospital was purpose opened for private healthcare treatment in 2013 after two years of extensive construction and remodelling.
- Surgical areas within the hospital consisted of three operating theatres, one of which had laminar flow and another was used as a pain management room; a recovery area with four bays, an inpatient ward consisting of eight day stay beds, known as “pods” with retractable screens for privacy, and an additional two bedrooms with en-suite facilities.
- All of the departments were spread over the ground floor.
- Operating sessions took place Monday to Saturday between 8am and 12.30pm, and 1.30pm to 5.30pm. All specialities covered at the hospital were able to use the theatres.
- People who used the service 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 user-friendly website.

Access and flow

- People had access to initial assessment, diagnosis and urgent treatment in a timely way.
- Staff told us that appointments and admission times were arranged at the convenience of the patient. We spoke with five people who used the service who confirmed this.
- In the Provider Information Return (PIR) the provider reported they had cancelled six procedures for a non-clinical reason (due to consultant schedule) in the last 12 months; of these 100% (six patients) were seen within three days of the cancelled appointment.
- We observed that theatre lists ran seamlessly and that patients were regularly updated about the time of their procedure.

Inadequate

Surgery

- Referral to treatment times (RTT) were monitored only for NHS patients. In the past 12 months 100% of NHS patients were seen within the 18 week recommendation.
- Discharge planning happened as early as possible, usually at the pre-assessment phase whereby social circumstances and discharge from hospital were assessed.
- Following discharge the patient's consultant completed a discharge summary of which one copy was sent to the GP.

Meeting people's individual needs

- Throughout the service we observed that staff responded to patient needs promptly.
- Every department was clearly signposted, on the ground level, and all areas were accessible to people who were wheelchair users.
- Staff told us that translation services were available which they knew how to access.
- There was a good range of food and drinks available for a range of dietary needs for admitted patients.
- Seven members of staff confirmed they had not received training on dementia or learning disability, whilst at the same time confirmed that patients living with these conditions accessed the hospital.
- We spoke with two people who had used the service and all confirmed that food and beverage availability and choice was good. One patient told us, "Food was good and they offer me drinks all the time".
- Staff told us that light meals were available during the day, such as sandwiches and toast, and where a patient required an overnight stay they were provided with a choice of warm meals.
- In reception, there was access to water 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' newsletter and notices displayed throughout the hospital.

Learning from complaints and concerns

- The provider had a suitable complaints policy in place. Staff we spoke with were familiar with how to handle a complaint in line with this policy.
- There had been three complaints reported between April 2015 and March 2016. All complaints had been responded to in the timeframes set by the service's policy.
- No complaints had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.
- Staff described the value of dealing with a person's concerns straight away before it developed into a more significant complaint, although they told us they would escalate the concern to a senior member of staff as needed.

Are surgery services well-led?

Inadequate

We rated the well led domain as inadequate within surgery.

Vision and strategy for this this core service

- There was a clear provider vision with which staff were familiar, "To ensure that we maintain a high standard of health care delivery that is patient and staff focused. To establishing a good financial balance for business growth enabling the company to develop Baddow Hospital and The Essex Health Care Park further".
- Staff within surgery understood the vision for the service to be the best day surgery service that they could be.

Governance, risk management and quality measurement

- The Medical Advisory Committee (MAC) met twice per year. We reviewed the minutes of the last two meetings held, which showed good representation from all specialties. The service did not hold any separate clinical governance meetings. The undertaking of meetings to monitor the quality of the service twice per year meant that we were not assured that there was sufficient oversight on the quality of the service.

- There were 32 consultants who had been granted practising privileges to work at the hospital, of which 26 had undertaken sessions at the hospital within the 12 months prior to our inspection.
- Practising privileges were routinely reviewed at the MAC and each practitioner was required to submit evidence to maintain their privileges on a yearly basis.
- The service has not had to take any action in relation to practising privileges of a doctor; however the registered manager was able to articulate what would be done in the event that there were concerns regarding a member of medical staff.
- A number of the policies were not reflecting best practice or adhering to service policy. For example the safeguarding children policy reflected national best practice but the named leads were not trained to a sufficient level and facilities were not risk assessed as to whether or not they could meet the needs of children. There was also no risk assessment on staffing levels with regards to the staff training levels on safeguarding of children.
- There was a lack of assessing the effectiveness of the service. There were limited audits or outcomes looking at how the outpatient service was performing. For example, the service did not participate in national audits or undertake many local clinical audits.
- The service did not use a performance dashboard and so were not able to consistently monitor the quality performance of the service on an ongoing basis.
- The hospital did not have a risk register detailing risks known for patient safety, business continuity or any other service related risk at the time of inspection. There was no monitoring of risks through the governance process. A draft risk register was submitted following the inspection, however this contained no identified risks.
- The governance process was not effective and did not identify or manage risks effectively. The service was not aware of many of the risks identified throughout our inspection, such as safeguarding training and policies on consent, which would be identified if an effective governance process was present.
- The concerns identified with the lacking governance process were similar to those identified at the last inspection in 2014.
- We spoke with three members of staff on the ward and they told us that a ward meeting had not happened recently, and that when they did take place these were not minuted. However, there were regular theatre unit meetings, which were minuted and well attended.

Leadership / culture of service related to this core service

- The surgery service leadership team locally were the theatre manager and ward manager. The two roles were supported by the senior management team of the chief executive, medical director and hospital manager.
- Staff spoke highly of their seniors within the surgery service. They said that they felt respected, valued and well-supported by managers.
- We listened to the "10 at 10" meeting, and found that staff of all levels felt able to voice their opinion and were listened to by managers.
- We observed good interactions between the teams and the senior management team, with an 'open door' approach to staff speaking with them about any concerns or developments.

Public and staff engagement

- There were regular patient events held at the hospital, which were informative sessions. For example, there was one titled, 'Body Beautiful Evenings', which were hosted by a cosmetic and aesthetic surgeon.
- Staff told us that they felt engaged in the service, and they could voice their ideas at hospital-wide meetings and face-to-face with managers. We asked five members of staff to give us an example of an idea they had which led to change in service provision, however, no members of staff provided us with an example.

Innovation, improvement and sustainability

- There were no innovations or improvements noted in relation to the surgery service.
- The service was looking at opportunities regarding surgery and to expand to be a dedicated high quality day surgery service in future. To support this they were building an additional theatre and expanding the ward to increase day surgery sustainability options.

Requires improvement

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the safe domain as requires improvement within outpatients.

Incidents

- Between September 2015 and August 2016 there were no serious incidents in outpatients. There were no never events. Never events are defined as
- Staff said they knew what to do in the event of an incident and that there was an incident form to fill in but they had never had to do one or been involved in a root cause analysis or investigation following an incident.
- We reviewed a hospital-wide incident log for the period September 2015 and September 2016, which documented 18 incidents in total including one "potential near-miss". Three were categorised as "staff incidents" but no further detail was provided.

Clinical Quality Dashboard or equivalent

- The service did not use a clinical quality or performance dashboard, which would support the monitoring of risk and safety in the service.

Cleanliness, infection control and hygiene

- All outpatient areas that we inspected, including waiting areas and two consultation rooms, were visibly clean.
- There were hand sanitiser dispensers located throughout the outpatient areas; however during our inspection we did not see staff using them regularly when moving between areas.
- We saw a member of housekeeping staff carrying out cleaning duties in the reception and corridor areas using personal protective equipment as appropriate.
- Clinical waste bins in outpatient consultation and pre-assessment rooms were clearly marked and in a separate area. Clinical waste was disposed of appropriately and in line with the hospital's clinical waste policy and procedures.
- The examination couch in the consultation room we inspected was made from wipe-clean material to minimise the spread of infection.
- Cleanliness audits and infection control audit outcomes have been reported on under surgery.

Environment and equipment

- The resuscitation trolley for the hospital was kept near the entrance of theatres behind controlled access doors within the theatre department. Resuscitation equipment checks have been reported on under the surgery section of this report.
- There was emergency equipment for outpatients including a defibrillator stored behind the main reception desk.

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).

- Prescriptions were documented clearly in the six outpatient records we reviewed.
- Prescription pads were not stored in the rooms of outpatients but were securely stored in the building.

Records

- We reviewed six outpatient records and found they were complete, clear and organised.
- Records were stored securely in a locked drawer in the reception area. The lead outpatients nurse told us that she would obtain the records for the pre-assessments scheduled for that day in the morning and stored them in a locked cabinet in the treatment room where her appointments took place until the time of each appointment. We checked and this was locked and secure. This meant privacy and confidentiality of patient details was maintained, in accordance with the hospital wide Protocol for Data Protection.
- Data provided by the hospital showed that between January and March 2016, there had been no instances of patients being seen in the outpatients department without all relevant medical records being available.
- Medical records were created and stored on site so they were always accessible for follow-up appointments, as per hospital policy. Individual consultants did not take patient records off site.
- We asked about arrangements for the transfer of records for NHS patients where other facilities might need access to their medical records, the outsourcing manager, whose department oversaw NHS services, confirmed that if a patient needed to be referred to an NHS service the patient would manage this themselves and that there was no automatic transfer of records.
- We reviewed a records audit dated September 2016 and found there was good completion of records at the pre-assessment stage. However, not all stages of the booking form were consistently completed, in particular the sections on allergies and equipment required.

Safeguarding

- The training provided for both adults and children's safeguarding was done through an e-learning module. The training provided to all staff in outpatients was level one for safeguarding adults and safeguarding level one for children's safeguarding. Level one training compliance rates for both adults and children was 100% in outpatients.
- The service provided care to potentially vulnerable adults and the minimum expectation would be for safeguarding level two training for adults. The service treated children and young people under the age of 18 years, therefore it would be expected that clinical staff involved in their care and treatment would be trained to safeguarding children level three.However, this was not the case.
- There were two members of staff who were allocated leads for adult and children's safeguarding. However, these members of staff were administrative staff, one of which was the administrative lead and the other a receptionist. Both were trained to level one on adults and children's through an e-learning package.
- This was a concern because they were not registered professionals, and this is not reflective of national guidelines for safeguarding. For example, guidance issued by The Royal College of Paediatrics and Child Health (RCPCH) on behalf of numerous contributing organisations states that, "All provider organisations should have a named doctor or nurse for child protection" trained to level four (RCPCH: Safeguarding Children and Young People, roles and competencies for healthcare staff, Intercollegiate document, 2014).We spoke with one of the leads who confirmed they had not received any safeguarding training for adults and children. This member of staff was not able to demonstrate that they had sufficient knowledge to carry out this lead role. For example, we asked this person what Deprivation of Liberty Safeguards were and they could not explain this.
- There were notices in staff areas, which reminded staff who the safeguarding leads were for the hospital.
- There was an up-to-date safeguarding policy dated August 2015 for children and adults, which staff could access via the intranet. The review date was August 2017.
- However, we were concerned that the section of the policy on training was not clear in terms of training requirements for staff which were outlined. For example, page seven of the policy read, 'All staff working at

Requires improvement

Outpatients and diagnostic imaging

Baddow Hospital will have the opportunity to attend training in relation to safeguarding adults relevant to their role in the service', and that, 'Safeguarding training may be in the form of: internet online training, training course attendance/mandatory training, conference attendance, 1:1 learning, group learning, private reading, reflection, or other appropriate learning approach'.

- The policy does not specify the requirements for lead role training and competency requirements in line with best practice.
- The policy also refers to safeguarding children update training. The policy states, 'Child safeguarding update training will be provided as necessary, proportionate to the nature of the adult patient care service being provided and taking into consideration the frequency of child visitors in Baddow Hospital'. Training evidence provided showed that 100% of staff were up to date with their level one training. However, staff were not trained to level two safeguarding children.
- We returned to inspect the concerns regarding safeguarding on 30 November 2016. Following this inspection visit, the provider amended their statement of purpose on a voluntary basis to state that with immediate effect they would no longer see or treat any patient under the age of 18 years at the service. This therefore eliminated the risks associated with the care and treatment of patients under the age of 18 years.
- However, further work was required to ensure that all clinical staff were trained to level two safeguarding children, and level two safeguarding adults as recommended by the intercollegiate document. The named leads trained for safeguarding at the time of this further visit were not clinical, as recommended. The management team informed us that sessions were booked and this was work in progress to complete this.
- The safeguarding policy detailed the Essex contacts for staff to make a referral for both safeguarding adults and children's concerns.
- Our concerns were heighted because a senior manager was not aware of training requirements for different staff levels.
- All staff members in outpatients we spoke with told us they knew what to do in the event of a safeguarding concern and would seek advice from the safeguarding lead. However, we were not assured that the safeguarding training was rigorous enough to give staff full awareness as to the potential safeguarding situations. For example, one member of staff in outpatients told us that safeguarding was not a major concern for them "due to the clientele" they were treating and the services offered.
- We asked about recognising domestic violence and were not satisfied that there was adequate awareness of it. The safeguarding lead told us that it was included within the online safeguarding training but there was no specific course on it, or initiatives to encourage staff awareness.
- Following our inspection we were informed by the service that they had booked clinically registered staff on the required training to ensure that the safeguarding requirements were met at levels three and four; however this was yet to be achieved.

Mandatory training

- We reviewed the mandatory training records for all staff in outpatients and saw that all staff were up to date or booked for refresher e-learning training in October 2016. New starters had completed mandatory training in August 2016.
- We reviewed the training schedule, which covered topics including but not limited to fire safety awareness, health and safety, manual handling, safeguarding level one and two for adults and children, basic life support and infection control.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We have not rated the effective domain within outpatients.

Evidence-based care and treatment

- We saw the hospital-wide audit schedule which included details of who was responsible for reporting, and how often audits must be carried out.

Requires improvement

Outpatients and diagnostic imaging

- The hospital took part in a variety of internal audits, including hand hygiene and completion of patient care records.
- The hospital did not take part in or submit data for any national audits.

Pain relief

- Pain relief was not usually an issue owing to the type of services offered, however the lead nurse told us that patients would occasionally call after their 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.

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, but the lead nurse told us that some consultants preferred to see patients themselves.
- For NHS-funded patients, follow-up arrangements would depend on the contract with the NHS trust.
- There were no audit outcomes specific to outpatient services.

Competent staff

- There were 32 consultants who had been granted practising privileges to work at the hospital, of which 26 had undertaken sessions at the hospital within the 12 months prior to our inspection.
- Staff had the appropriate skills, competencies and qualifications to carry out their roles in accordance with the hospital policy on Requirements relating to workers.
- Appraisals were done annually for all staff. We saw a schedule of appraisals showing staff were all either up-to-date with appraisals or booked in for one if they were due an appraisal. Records showed that all staff appraisals were up to date.
- The lead nurse told us that there were good training and development opportunities for staff and that "as long as it will benefit the service, managers are open" to staff going on courses. They had recently been on a travel vaccination course and were looking to introduce it for more staff.
- We also spoke with a healthcare support worker who told us they had recently undertaken an online pre-assessment course and a wound care course and had been supported to do this as they felt it would develop her skills and competencies.
- The induction checklist for all new staff included (but was not limited to) familiarisation with cardiac arrest bleep, resuscitation trolley and the nurse call bell system.

Multidisciplinary working

- The lead nurse for outpatients said that multi-disciplinary team working was good between staff and we saw staff communicating well with each other.
- There was evidence of good multi-disciplinary input into all of the patient notes we reviewed.
- 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.

Seven-day services

- The lead nurse for outpatients told us that consultants were often flexible and worked to accommodate the needs of patients, for example by adding 'urgent' patients to their list for the evening and running evening clinics.
- The opening hours for the service were Monday to Friday 8am to 8pm and Saturday 8am to 2pm.

Access to information

- The lead nurse for outpatients told us she was always able to access the relevant patient information within the paper patient records.
- There was an outsourcing team who were responsible for managing the contracts with NHS trusts. One

member of this team told us that in terms of transferring information, the NHS-funded patient would have to manage that themselves, but that accessing information for these patients was not an issue.

- In minutes from the Heads of Department meeting from July 2016, there was a reminder to staff to ensure that booking forms and referral letters were in outpatient notes to ensure they were readily available to all staff who required it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In all six records we reviewed there was evidence of consent. The hospital policy on consent recommended that consultants obtain written consent for any intended procedure; but in the case of verbal consent being obtained it would be clearly documented in the patient's notes.
- In the pre-assessment appointment we observed, the nurse explained that on the day of the procedure the patient would have to sign a consent form. The nurse took the time to make sure the patient understood this.
- We asked about assessing Gillick competence (a standard to assess whether a child of 16 or under . The lead nurse told us it would be a matter for the particular consultant to decide but showed a clear awareness of it and gave examples of when discussions about Gillick competence would need to take place.
- There was no reference to Gillick competence or Fraser guidelines in the service policies on consent to treatment. There were no audits on Gillick or Fraser in the service.
- At the time of our inspection there was no specific training on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS); however, the HR manager who held the data on staff training told us that training had been booked for later in the year.
- We were told there was "an awareness" of the Mental Capacity Act and Deprivation of Liberty Safeguards. However, there was no clear evidence to assure us that staff would be confident in dealing with potential cases involving MCA and/or DoLS. We spoke with two operating department practitioners and found they were not familiar with DoLS.

Are outpatients and diagnostic imaging services caring?

Good

We rated the caring domain as good within outpatients.

Compassionate care

- The hospital did not submit Friends and Family Test (FFT) data; however, there were feedback cards available on the reception desk for patients. The six feedback cards we saw were consistently positive with all patients reporting they were 'extremely likely' to recommend the hospital.
- We spoke with one patient as no others were available on either the announced or unannounced inspection. They said that all staff had been "very helpful" and had "no complaints" about the service.
- Privacy and dignity of patients was maintained; for example, in the pre-assessment appointment we observed, the nurse asked the patient at each stage whether the patient was still comfortable with an observer being in the room.

Understanding and involvement of patients and those close to them

- We observed a pre-assessment appointment with a patient and saw that the nurse took the time to explain the procedure to the patient and ask if the patient had any concerns. The nurse gave the patient additional information to take home and ensured the patient felt comfortable at all times.

Emotional support

- There was no internal dedicated staff member for emotional or psychological support. However, the lead nurse explained that staff would look into external options for patients requiring emotional support. They gave a recent example of a patient receiving bad news at an appointment and the nurse had taken the time to research local services for counselling and emotional support for the patient. They also told us consultants were proactive in advising patients on forums and resources available for support.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated outpatients as requires improvement for the responsive domain.

Service planning and delivery to meet the needs of local people

- We saw a disability audit form which aimed to ensure the service 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.
- We observed the hospital daily '10 at 10' meeting where staff went through the plan for the day to ensure they could deliver services in a timely manner.
- The lead nurse in outpatients told us that staff would be flexible to accommodate patients' needs, 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.
- Pre-assessment appointments in outpatients were scheduled a week in advance of scheduled surgery; however, the service could be flexible to meet patients' needs, for instance if they were going to be away at that time. The lead nurse for outpatients told us that they could arrange a telephone assessment if the patient was not able to come in the week before; however, if patients had specific risks such as a heart condition the service would insist on a face-to-face pre-assessment appointment.
- If the patient was under 18 they would also insist on a face-to-face appointment. However, this formed a very small minority of the work; the lead nurse told us she had only seen "about four or five" under-18s between March 2015 and September 2016. Data provided by the hospital showed there had been 10 outpatient attendances by patients aged between 10 and 16 and two attendances for surgery by patients aged 17.

Access and flow

- For private patients, appointment times would be agreed mutually between the patient and their consultant so waiting times depended on their preferences.
- The hospital was unable to provide exact data on referral to treatment times (RTT) but provided assurance that they had never breached contractual waiting times for any NHS patients. RTT was measured for NHS patients as per the clinical commissioning group (CCG) contract. There was no data available for private patients because they could sometimes be seen the next day if needed, or at a time convenient for them.
- Staff were encouraged to keep patients aware if the service was running late with appointments; however, the lead nurse told us that she had never known outpatients appointments to be delayed by more than 30 minutes.
- Two administrative staff confirmed that waiting times were monitored by the IT system but was not audited as we were told it was "unusual" for clinic appointments to run late.
- Within outpatients there were sufficient cover arrangements to ensure patients did not have their appointments cancelled. The lead nurse told us that she had never known an outpatients appointment to be cancelled by the service and had never had to cancel appointments.

Meeting people's individual needs

- Staff had an awareness of the need to adapt their approach when treating patients living with dementia and were able to give examples of this. However, the lead nurse in outpatients told us that if a patient was in the later stages of Alzheimer's disease, for example, the service would not be suited to their needs and they would advise the family or carer to refer to a more appropriate facility. However, this was not specified in the hospital's admission and discharge criteria.
- Seven members of staff confirmed they had not received training on dementia or learning disability, whilst at the same time confirmed that patients living with these conditions accessed the hospital.
- However, the hospital's admission criteria specified that patients

Requires improvement

Outpatients and diagnostic imaging

- The environment was well laid-out and spacious with clear signs and a welcoming reception area. All outpatient areas we inspected were free from clutter and health and safety hazards, in accordance with the hospital's health and safety policy.
- Patients reported to main reception at the front of the hospital; the waiting room was next to reception. Patients were then guided to the relevant outpatient consultation room at the time of their appointment. All outpatient areas were on the ground floor and easily accessible.
- There were five consultation rooms and one treatment room with incorporated consultation area and examination bed. A member of administration staff told us the service was waiting on an extra room to be reintroduced following planned changes to the layout of the hospital site.
- There was a range of information for patients in the waiting area, including but not limited to a self-pay price guide clearly setting out treatments and fees, the hospital 'Health Matters' newsletter, and a guide to data protection and patient records.

Learning from complaints and concerns

- The outpatient service had not received any formal patient complaints between September 2015 and August 2016.
- The lead nurse told us that if complaints were received, they could be discussed at Heads of Department meetings which took place every two weeks.

Are outpatients and diagnostic imaging services well-led?

Inadequate

Surgery was the main activity of the hospital. Where our findings on surgery also apply to outpatient services, we do not repeat the information but cross-refer to the surgery section of this report. We have rated outpatients as inadequate for being well led.

Vision and strategy for this this core service

- There was a clear provider vision with which staff were familiar, "To ensure that we maintain a high standard of health care delivery that is patient and staff focused. To establishing a good financial balance for business growth enabling the company to develop Baddow Hospital and The Essex Health Care Park further".
- Staff within outpatients understood the vision for the service to be the best outpatient service that they could be.

Governance, risk management and quality measurement for this core service

- All governance, risk management, quality measurement and MAC information has been reported on under the surgery section of this report. There was one process for the entire hospital.

Leadership / culture of service

- The outpatients department had a dedicated lead and was supported by the hospital manager. Staff spoke highly about the leaders of the service and described a 'family feel' to the service.
- All staff we spoke with told us that they would have not have any worries about raising concerns or speaking up in the service.

Public and staff engagement

- Public and staff engagement has been reported on under the surgery section of this report.

Innovation, improvement and sustainability

- Innovation, improvement and sustainability has been reported on under the surgery section of this report.
- There was no specific innovation noted for outpatients.
- Sustainability of the service was assured through the provision of NHS outpatient work, which the service provided under contract.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Must improve governance, risk management, incident reporting processes and policy updates.
- Must improve arrangements for safeguarding adults and children.
- Must ensure that emergency equipment is checked daily and recorded.
- Must improve staff awareness of Mental Capacity and Deprivation of Liberty Safeguards.
- Must review processes and knowledge of Gillick competency and Fraser guidelines.
- Must improve staff appraisal rates.

Action the provider SHOULD take to improve

- The provider should consider providing dementia awareness training to staff.
- Consider participating in national audits
- Consider expanding on local audit, studies and learning opportunities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. Systems and processes were not fully established or operated effectively to prevent abuse of service users. This was because the leads in the service were not of a suitable background or training for the roles of safeguarding leads. There was no specific training on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). There was no reference to Gillick competence or Fraser guidelines in the service policies on consent to treatment. There were no audits on Gillick or Fraser in the service. Regulation 13(2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014** **The governance processes and risk management systems in the service were not effective or embedded. The provider was not aware of risks, which could have been identified through good governance processes.** **The provider did not assess, monitor or improve the quality and safety of the services provided in the carrying on of the regulated activity. The service did not have a risk register, policies and procedures were not all written in line with best practice. This meant that risks identified were not mitigated and could have impacted upon the health, safety and welfare of service users.** **The provider had not recorded that it was safe for use in theatres.** **The provider had not evaluated or improved their practice in respect of the processing of the information following the previous inspection in 2014.** Regulation 17(1)(2)(a)(b)(d) (f)