Circle Health Group Limited

The Winterbourne Hospital

Inspection report

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Date of inspection visit: 8 and 9 June 2022
Date of publication: 15/09/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out a comprehensive inspection of The Winterbourne Hospital on 8 and 9 June 2022. The service was inspected in January 2016 and was rated as requires improvement in safe, effective and well led with good in caring and responsive. The service was rated as requires improvement overall.

The Winterbourne Hospital provided the following services: surgery, outpatients and diagnostic and screening procedures. We inspected all of these services during this inspection. The inspection was unannounced.

We rated safe as good in surgery and diagnostic imaging. In outpatients, it was rated as requires improvement. Effective was rated as good in surgery. We do not rate effective in outpatients or diagnostic imaging. Caring was good in surgery, outpatients and diagnostic imaging. Well led was rated as requires improvement for surgery, outpatients and diagnostic imaging.

Our rating of this location stayed the same. We rated it as requires improvement because:

- During the recruitment of some staff, not all the required information was obtained prior to them starting work at the service.
- Not all staff followed policy when completing care records.
- There was a lack of escalation reporting and oversight of some areas.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to health information. Key services were mostly available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs and made it easy for them to give feedback. Patients could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and staff were committed to improving services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement because: • Although we found the service largely performed well, it did not meet legal requirements relating to governance. This is in relation to improving quality of record keeping and recruitment. • Not all clinicians were observed to practice effective handwashing and cleaning of surfaces between patient care. • Not all staff were trained to the appropriate level of adult and children safeguarding. • The service did not have a competency framework with the required training for each staff role. • The service did not consider the provision of chairs for bariatric visitors and carers. However: • The service had enough staff to care for patients and keep them safe but did not always have enough nurses. The service-controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services.

Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Surgery

Good

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity,

Summary of findings

took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- The recruitment and selection procedures did not ensure all appropriate checks were confirmed before staff were employed.
- There was a lack of formal risk assessments, escalation and oversight checks.

We rated this service as good in safe, effective, caring and responsive and requires improvement in well led.

Diagnostic imaging

Good

This was the first inspection of diagnostic imaging as a standalone service. At this inspection we rated it as good:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Contents

Summary of this inspection

Background to The Winterbourne Hospital

The Winterbourne Hospital is part of Circle Health Group Limited. In January 2020, Circle Health Holdings Limited (Circle) acquired the BMI Healthcare Limited group. The hospital is located in Dorchester and serves the local population treating privately funded patients and NHS patients. Surgery is provided for inpatients and day-case patients. The hospital did not provide services for children or young people under 18 years. The hospital had 31 beds, two operating theatres, a minor operations room, diagnostic imaging department, ambulatory care area and outpatient department.

The provider is registered to provide four regulated activities:

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

During this inspection, we looked at the following services: surgery, outpatients and diagnostic and screening procedures. We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services.

Hospital activity:

From June 2021 to May 2022 there were 939 NHS-funded admissions and 9,385 NHS-funded outpatient and diagnostic attendances at The Winterbourne Hospital.

From June 2021 to May 2022 The Winterbourne Hospital had provided 2,619 private patient admissions and 29,559 private outpatient and diagnostic attendances.

Track record on safety for the period from June 2021 to May 2022:

One death had occurred within 30 days of surgery.

No never events had been reported - A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

No external review or investigations have been undertaken.

There were no incidences of healthcare acquired infections.

The service had received 22 formal complaints in the last 12 months.

No Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) reportable incidents have occurred.

Summary of this inspection

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 service.

How we carried out this inspection

The team that inspected this location comprised of one CQC inspection manager, three CQC inspectors, a medicines inspector and two specialist advisors. During the inspection we spoke with staff including the management team. We reviewed documents and records kept by the service. We also spoke with patients and their family/carers.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service had improved their ambulatory care pathway and day case theatre by creating a theatre for patients to be seen and treated in a day. This enabled patients to have continuity of care and staff for their procedures.
- The Winterbourne Hospital was recognised with a National Joint Registry (NJR) Quality Data Provider award. The NJR Quality Data Provider award scheme has been developed to offer hospitals a blueprint for reaching standards relating to patient safety through NJR compliance and to reward those who have met targets in this area.
- The Winterbourne Hospital had taken part in an external employee survey. They achieved an 84% response rate and an outstanding rating.

Areas for improvement

Action the service MUST take to improve:

Overall

- The service must have effective recruitment and selection procedures and ensure all appropriate checks are confirmed before they are employed. (Regulation 19 (2) (a) and Schedule 3).

Surgery

- Governance arrangements must ensure issues are escalated and rectified in a timely manner (Regulation 17 (2) (b)).

Outpatients

- The service must ensure accurate, complete and contemporaneous records are maintained in respect of each service user. (Regulation 17 (2) (c)).
- The service must ensure staff are trained to the appropriate level of adult and children safeguarding (Regulation 18 (1)).

Action the service SHOULD take to improve:

Surgery

Summary of this inspection

- The service should ensure that items on the resuscitation trollies are in date (Regulation 12).
- The service should ensure where medicines requiring temperature-controlled storage are recorded, any escalation or action is recorded and actioned if the temperature was out of the expected range (Regulation 12).

Outpatients

- The service should ensure all clinicians practice effective handwashing and cleaning of surfaces between patient care. (Regulation 12).
- The service should ensure the record tracking audits are completed in line with policy. (Regulation 17).
- The service should consider the provision of chairs for bariatric visitors and carers.
- The service should consider using a competency framework to show and record the required training for each staff role.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Surgery	Good	Good	Good	Good	Requires Improvement	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Requires Improvement	Good
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Outpatients

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Outpatients safe?

Requires Improvement

This was the first inspection of outpatients as a standalone service. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and most but not all staff completed it.

Most staff received and kept up to date with their mandatory training. The service employed six healthcare assistants and three nursing staff when at full establishment. Records showed most staff had completed the required training. Nursing staff sickness and vacancy prevented 100% training completion rates. Training records did not state the staff roles required to complete each training update.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and told us they knew how to apply it, but not all staff were trained in safeguarding children.

Nursing staff received training specific for their role on how to recognise and report abuse. Ninety percent of staff had received training on protecting people at risk of radicalisation (PREVENT).

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Requires Improvement

Outpatients

Most staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff told us they would inform the level four safeguarding lead if they had concerns. No safeguarding referrals had been made by the department in the 12 months before the inspection. Records showed 90% staff had received level two safeguarding training and one staff member received level three safeguarding training.

Not all staff had received safeguarding children level one or two training. This is not in line with the intercollegiate guidance by the Royal College of Nursing. Records showed nine staff were trained to safeguarding adults' level two and only three staff to safeguarding children level two. We requested the reasoning for the staff levels required to complete each safeguarding training, but this was not provided. Following the inspection, we saw evidence of safeguarding children level one and two training compliance at 100% for nursing staff including healthcare assistants.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records showed the patient and visitor chairs were cleaned regularly. A desk in consulting room three required repair. Staff told us this had been reported to the maintenance team and a temporary repair had been completed with tape. This presented an infection control issue as the surface could not be fully decontaminated. Records showed this repair had been completed within a week of the inspection.

Patient-Led Assessments of the Care Environment (PLACE) Lite results showed the service performed well for cleanliness in August 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). The May 2022 environment and personal protective equipment (PPE) audit showed 100% compliance. Most but not all staff were seen to wash their hands often and use alcohol hand gel. The April 2022 hand hygiene audit showed 100% compliance. Following the inspection, senior leaders told us the audits observed 20 episodes of hand hygiene. We observed the couch roll being replaced after patient care but did not observe staff disinfecting the couch between use.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Each nurse and healthcare assistant had responsibility for ensuring a clinical room was clean. Housekeepers cleaned the outpatient department after each clinic day. The privacy curtains were disposable and due to be changed a week after our inspection. Staff told us the housekeepers replaced the curtains every six months.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment and recorded their findings. The resuscitation trolley checks were completed by healthcare assistants and nurses. One month of daily checks for April 2022 was not available to view at the time of inspection. This information was requested and sent after the inspection. Weekly nurse checks had been completed in March 2022.

The service had enough suitable equipment to help them to safely care for patients. The estate manager had oversight of equipment requiring servicing and the safety testing within the department.

The service had suitable facilities to meet the needs of patients' families. The waiting area had enough seats for chaperones to sit with patients and to remain socially distanced from others. However, there was no bariatric seating available if a visitor or family member required this. Following the inspection, leaders told us a bariatric chair would be provided as part of the upcoming reception refurbishment.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. The sharps bins were stored safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us they would take patient observations and contact the resident medical officer (RMO) to review the patient. Nursing staff received training in adult immediate life support and healthcare assistants were trained in adult basic life support. They used recognised tools to assess conditions and escalate them to medical staff, for example they used the situation, background, assessment and recommendation (SBAR) and the National Early Warning Score (NEWS2). They knew who to call and what to do if there was a medical emergency. They would use the emergency alarm to call the resuscitation team (medical team with special equipment available to be mobilised quickly to treat cardiac arrest). Staff were trained in sepsis within a mandatory training module. Venous thromboembolism (VTE) training was not required in line with the Circle Health Group policy, but staff had access to a VTE champion should they have any concerns.

Patients attended follow up appointments in the nurse led clinics after minor surgery. Staff managed specific risk issues relating to their surgery and escalated concerns to the patient's consultant. If the consultant was not available, staff knew how to escalate their concerns to the RMO.

The service had access to mental health liaison and specialist mental health support. Staff told us how they would support patients with mental health concerns including anxiety. We observed an emotional support dog attended an appointment with a patient, during the inspection.

Staff shared key information to keep patients safe. Shift changes and handovers included necessary key information to keep patients safe. A communications book and diary contained information for the attention of all staff.

Nurse staffing

Requires Improvement

Outpatients

The service had enough support staff but not enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave staff a full induction.

The service had enough support staff to keep patients safe but had reduced numbers of nursing staff. The nursing staff was reduced by two whole time equivalents (WTE) due to long term sickness and vacancy. A nurse was available two days each week. Healthcare assistants supported the consultant clinics, treatments and provided post-surgery assessments but were not qualified to manage medicines. Leaders managed the reduced nursing availability by preparing the medication for consultants, before each clinic.

Managers calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. The number of healthcare assistants matched the planned numbers. The service had low sickness and turnover rates for healthcare assistants. However, there was one WTE vacancy and one WTE long-term sickness within the nursing staff. Leaders told us they had successfully interviewed and recruited to the nursing vacancy during the inspection.

Staff received a full induction.

The service did not use bank or agency nurses as leaders told us the service required consistency of staff. On days when there was no nurse, the service was supported by the clinical lead for outpatients and ambulatory care.

Records

Nursing staff kept detailed records of patients' care and treatment. However, consultant records did not always contain up to date or legible information. Records were stored securely and easily available to all staff providing care.

Nursing staff kept comprehensive patient notes and all staff could access them easily. However, there was no consistent approach by consultants to ensure a record of their consultation was retained by the hospitals and some consultants did not follow hospital policy on record keeping.

Important information about patients was not always shared effectively and could compromise safe care in the event of hospital admission. We reviewed 12 patient files. Four records had no evidence of outpatient care or consultations. Consent forms were not always legible. Of the eight records with consultant care recorded, five were not legible. Of the 12 outpatient records, one had handwritten contemporaneous notes and one had a typed clinic note stored in the patient records. This meant the hospital did not always have an accurate record of patient care and consent to treatment.

Patients did not always remember receiving a consultation letter. Four letters following the outpatient consultations were shared with the patient's GP, but not the patient. Most letters did not include the date the patient was seen in outpatients, and only contained the date the letter was typed.

We observed five consultations in three outpatient clinics. Two consultants did not make handwritten notes or dictation during the appointments. The consultants told us this was due to time pressures. This was not in line with the hospital's record keeping policy. On day two of our inspection, we reviewed those records again and found there was no evidence

these patients had attended their outpatient appointment. However, we observed one consultant make contemporaneous handwritten notes and dictated a letter which was immediately converted to text. Senior managers told us plans were in place for the hospital to transition from paper to electronic patient record keeping in October 2022. One of the provider's anticipated outcomes of this was improved compliance with record keeping policy.

Records were stored securely in a locked cabinet in a locked room with a keypad to prevent unauthorised access. A new filing cabinet had been ordered as the existing filing cabinets could not store all the patient records needed for all the consultant clinics.

When patients transferred to a new team within the hospital, there were no delays in staff accessing their records. The service used an electronic system to locate files. Each file had an individual bar code and could be scanned in or out of a department. This meant staff could find patient records quickly and easily. The records filing system was audited every 90 to 120 days to check the records were in the correct location, but the computer showed the audit was overdue. The audit was completed during the inspection, the outcome showed the reviewed records were tracked correctly.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. All medicines used were prescribed. Staff completed medicines records accurately and kept them up to date. Prescriptions and consultation records were completed in accordance with the policy of the service.

Staff stored and managed all medicines and prescribing documents safely. Where medicines required temperature-controlled storage, records were made that showed they were stored in the recommended range.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Information was given to patients by the consultant during the consultation and further advice or counselling was given by the pharmacy team at the point of dispensing.

Medicines were stored in a locked cupboard behind a locked door to prevent unauthorised access. The cupboard was clean and tidy, and the medicines were in date. The medicines fridge was locked, and the temperature recording audit showed checks were being completed daily and showed temperatures were within acceptable range. There was a clear system for staff to follow if the fridge went outside the acceptable range. Medicines disposal was facilitated through the onsite pharmacy.

Staff learned from medicine safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Requires Improvement

Outpatients

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents. Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, staff procured an alternative brand of dressing in response to low and no harm incidents identifying faulty wound dressings.

Managers debriefed and supported staff after incidents. Information from patient safety alerts were disseminated to staff verbally and in emails, daily hospital "comm cell" meeting minutes and printed in the office.

Are Outpatients effective?

Inspected but not rated

This was the first inspection of outpatients as a standalone service. We do not rate effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff told us they did not have training specifically in relation to the Mental Health Act 1983 but said this was covered in their safeguarding adults training. Staff could not remember an example of where a patient was subject to the Mental Health Act but told us how they would raise concerns about a patient's mental health or ability to consent to treatment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Staff made sure patients had enough to eat and drink. A self-service drinks station providing hot and cold drinks was located in the waiting area so patients could help themselves. The hot water machine was out of order on the second day of inspection but had been reported to the catering department. Patients who had to wait in the department for an extended period of time could purchase food from the hospital's canteen menu. This catered for those with specialist nutrition and hydration needs.

Pain relief

Staff assessed if patients were in pain and gave pain relief in a timely way.

Staff asked if patients had any pain and told us they would give pain relief if required, but this was not usually needed. We observed staff using a recognised pain scoring tool. Nursing staff made sure patients were comfortable during appointments including post-surgery wound assessments.

Requires Improvement

Outpatients

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This included audits of the World Health Organisation (WHO) surgical checklist for minor operations completed by the outpatient service. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

We were told that patients were normally on a pathway associated with a different department and their treatment outcomes were monitored in other areas, most often by surgery. Please refer to the surgery report for more information.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development, but a competency framework was not available.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full meeting minutes when they could not attend.

Managers identified any training needs their staff had and usually gave them the time and opportunity to develop their skills and knowledge. The clinical workload was prioritised above nurse training and development due to current nurse vacancy and sickness levels.

Managers made sure staff received specialist training for their role, but the expected competencies for each role were unclear. Records showed a percentage of staff had obtained or were working towards competencies including minor operations but did not show the number or role of staff members required to complete the competency. We requested the competency framework for each staff role in the outpatient department, but this was not provided.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss care improvements. Nurses and healthcare assistants attended the outpatient team meetings. These were held every one to two months, but did not include consultants. We saw regular communication between consultants, nursing and support staff during the inspection.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff told us they would refer patients for mental health assessments by an external mental health team if they showed signs of mental ill health including depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from consultants and other disciplines within the hospital. The service operated five days a week from 8am to 8pm Monday to Friday. If patients needed to be seen by a nurse or doctor at the weekend, they could be seen by a nurse from a ward or by the resident medical officer.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Staff gave patients support and advice to lead healthier lives, including wound healing advice. For example, we saw a consultant refer to non-surgical management of a condition, when surgery would not improve the patient's health.

We were told patients were normally on a pathway associated with a different department and most of their health promotion information was given during pre-operative assessments. Please refer to the surgery report for more information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent, but consent records were not always legible. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal and written consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. A consent form was available for staff to record the best interest decisions when patients were unable to consent to investigations or treatment. Those close to the patient could record their involvement in the decision-making process.

Staff made sure patients consented to treatment based on all the information available. We saw corporate Circle Health Group (CHG) and consultant's own "patient information for consent" leaflets available for procedures.

Staff recorded consent in the patients' records, but the consent forms were not always clear. We reviewed eight consent forms on site. Of these eight forms, three were not legible and two were partly legible. The clinician name and role were only recorded on one of the eight consent forms, so it was not known who had obtained consent, or if the patient was

fully informed of all the risks and benefits. We spoke with one patient who said one consultant they had seen did not thoroughly discuss the risks and benefits of their procedure. However, we saw one form contained printed information for the procedure and a second used a sticker to explain the potential risks. After the inspection, senior leaders informed us that consent forms included a patient addressograph with the name of the treating consultant.

Images on the front of patient records could be ticked to indicate that a patient was at a higher chance of falling; had cancer; dementia or mental capacity concerns. However, all clinical staff we spoke with were not aware of the meaning of these symbols.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), but the exact number of staff trained was not clear. The training was included in the level two safeguarding updates. We asked for records of the number of staff who had completed MCA and DoLS and consent training. Information provided was not consistent about the number of staff who had completed the level two safeguarding updates and did not identify the staff roles who were required to complete this training. However, staff would contact the safeguarding lead if they needed to escalate any concerns.

Staff could describe and knew how to access policy on MCA and DoLS. The corporate CHG mental capacity, deprivation of liberty and restrictive practice policy was updated on 17 May 2022 following concerns raised at a CQC inspection of another CHG hospital. At the time of our inspection, the updated version was not available on the consultant portal. Staff were not aware the CHG policy had been updated. Following the inspection, the service confirmed that the MCA policy had been updated and was available on the consultant portal.

Are Outpatients caring?

Good

This was the first inspection of outpatients as a standalone service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. We saw staff take time to interact with patients in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff asked patients if they wanted to see their post-surgery results in the mirror and understood if patients required more time.

Emotional support

Requires Improvement

Outpatients

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They told us about other members of staff from the hospital who they could involve, to give patients additional emotional support.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff made notes on the clinic list to identify patients who may require additional support, for example when a patient experienced anxiety. Staff supported a patient to attend their appointment with an emotional support dog, during the inspection.

Staff told us they undertook training on giving or breaking bad news.. Staff told us how they demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them. Staff encouraged patients to attend outpatient appointments with someone close to them if they had dementia, or if they wanted some additional support.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff spoke with patients, families and carers in a way they could understand, using communication aids where necessary. Staff wore a visor instead of a face mask, when mask wearing was mandatory due to the coronavirus pandemic, to allow deaf patients to lip read.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback cards were visible in the outpatient waiting area. Staff told us they would give feedback cards after outpatient procedures. Feedback from patients for February to April 2022 was between 98% and 100 %for the provider being very good or good.

Staff identified actions when patient feedback comments suggested areas for improvement. Records showed leaders monitored the progress of three issues from the March and April 2022 patient feedback.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. We saw written feedback from two patients and spoke with six patients who said they felt the service was 'excellent' and nursing staff were 'helpful throughout'. However, we spoke with a patient who said some clinics did not run to time, but they did not mind as the consultant was 'most communicative'.

Are Outpatients responsive?

Requires Improvement

Outpatients

Good

This was the first inspection of outpatients as a standalone service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service had accessible parking and accessible toilets. Facilities and premises were appropriate for the services being delivered. Outpatients was on the ground floor, accessible from the hospital reception.

The service had systems to help care for patients in need of additional support by providing chaperones for patients.

Managers monitored and took action to minimise missed appointments. Patients received an automated text message 24 hours before their outpatient appointment. Managers ensured that patients who did not attend appointments were contacted and their appointment rebooked.

The service worked with the local commissioners and trust to support the needs of the local population.

Meeting people's individual needs

The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access the hospital safeguarding lead or emergency mental health support for patients with mental health problems, learning disabilities and dementia. Staff told us they encouraged a carer or advocate to attend outpatient appointments when patients required it.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available in the outpatient department.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw a poster on the information board in staff room which showed how to access interpreters and signers. Staff spoke of using interpreters. Staff could print information leaflets in languages other than English. Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Requires Improvement

Outpatients

Managers worked to keep the number of cancelled appointments and treatments to a minimum. In the last 12 months 38,944 patients attended appointments, 3,346 patients cancelled their appointments and 2,047 patients had their appointment cancelled. Where clinic cancellations occurred, these were mostly due to social distancing requirements in response to COVID-19. We saw staff telephoning patients to delay a future appointment by two days, when the consultant was going to be unavailable.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients and their families could give feedback on the service and their treatment. Feedback forms were available on a leaflet display by the hospital reception desk. We were told each patient was given a 'How well did we do?' feedback form at the end of their consultation. However, we did not see any feedback forms being given to patients.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. In the last 12 months, the outpatient department received 20 complaints. Complaints had increased in March and April 2022 with seven complaints in these two months.

Are Outpatients well-led?

Requires Improvement

This was the first inspection of outpatients as a standalone service. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. The outpatient department leadership team had recently changed, with the lead for outpatients and ambulatory care being in post for two months. This was a new role across the two services, and was line managed by the Clinical Services Manager for outpatients, pre-assessment, ambulatory care, pathology and the ward.

Staff told us the senior management team were visible and approachable. Nursing staff told us their line manager was a supportive leader, however as they were new to post, staff often referred to higher management, who continued to manage their competencies. There were plans for the outpatient and ambulatory care lead to take over competency management, however nurse vacancy had delayed this.

Requires Improvement

Outpatients

For our main findings please refer to the surgery report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services through excellent patient care.

Staff said the vision for the service centred around providing the highest possible standards of patient care and putting the patient first. The outpatient team had created their own vision for the department, displayed on a whiteboard in the staff area. Staff told us they were committed to this vision and gave us examples of the high standard of patient care they provided.

For our main findings please refer to the surgery report.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had made leadership changes in the six months before the inspection. The newly appointed nurse lead for outpatients also led the ambulatory care service. Despite the reduced nurse staffing levels due to sickness and vacancy, staff told us the culture had improved and described the team 'as a family'. All staff we spoke with described a positive culture. Staff felt supported, respected, valued and were positive and proud to work in the organisation. Teams and staff worked collaboratively and shared responsibility.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. However, the shortage of nursing staffing had delayed some staff development to prioritise the care of patients.

For our main findings please refer to the surgery report.

Governance

Leaders mostly operated effective governance processes, throughout the service and with partner organisations, but there was an ongoing breach of regulations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Managers held team meetings and made sure minutes were shared with staff who could not attend. Meetings were held at one to two-month intervals, instead of every month, while nurse staffing was reduced. However, the minutes clearly showed evidence of learning from incidents, audits and complaints, review of risks, information about training and changes to policy.

Requires Improvement

Outpatients

Hospital wide communication through 'comm cell' emails provided the team with awareness of the performance and risks within the service.

However, the service did not meet the regulatory requirements for record keeping. This was a breach previously identified at other locations managed by the corporate provider.

We reviewed ten staff recruitment records and saw that Disclosure and Barring Service checks (DBS) were completed. However, we found not all pre employment checks were complete. Three of these employees had no photographic identification. However, since the inspection the service had escalated the lack of clarity within the Circle Health Group policy and have escalated this to the corporate Human Resources (HR) team.

For our main findings please refer to the surgery report

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. The service did not have its own risk register as all risks were logged on the hospital's risk register.

The service completed audits to monitor the service provided. Where audits were not 100%, actions were taken to improve care.

There were no examples of where financial pressures had compromised care.

For our main findings please refer to the surgery report.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information was used to measure improvement, not just assurance. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

For our main findings please refer to the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local health care professionals to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Requires Improvement

Outpatients

Patients and their families could give feedback on the service and their treatment. Patient feedback forms were on display by the hospital reception desk. The service also monitored patient feedback provided through online reviews.

Staff were invited to take part in satisfaction surveys.

For our main findings please refer to the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Leaders and staff aspired to continuous learning, improvement and innovation, however staff told us nurse staffing levels had reduced the ability to deliver innovation at the current time.

For our main findings please refer to the surgery report.

Good

Surgery

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

Are Surgery safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.
The mandatory training was comprehensive and met the needs of patients and staff. Nursing staff received and kept up-to-date with their mandatory training. We reviewed ward and theatre staff mandatory training rates and they were 93%.

The mandatory training met the needs of patients and staff. Mandatory training included life support, consent, fire safety, infection prevention and control, equality and diversity, information governance and medicines management.

All staff had completed training on recognising and responding to patients with dementia.

The Winterbourne Hospital had a venous thromboembolism (VTE) champion who sits on the corporate VTE group and were partly responsible for re-writing the assessment tool and policy. (Venus thromboembolism refers to a blood clot that starts in a vein).

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they had time to complete their mandatory training in their work hours.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
Nursing staff received training in adult and child safeguarding. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Ninety-eight percent of staff had completed

safeguarding adults level two training and 92% of staff had completed safeguarding children level two training. One hundred percent of staff that required safeguarding adults' level three had completed this training. However, the information provided did not highlight training figures for each job role. Therefore, we were unable to determine whether healthcare assistants had completed safeguarding training appropriate for their role.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There had been one referral in the last 12 months. We reviewed this referral and appropriate immediate action had been taken and was subsequently closed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Due to the pandemic the service had not been inspected by patient led assessment of clinical environment (PLACE). PLACE assessments are usually an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public.

The Winterbourne had signed up to PLACE lite assessments until the PLACE assessments restart in September 2022. PLACE Lite is recommended good practice to complement the annual PLACE collection. The PLACE Lite audit was undertaken in August 2021, and this showed they achieved 100% for cleanliness across the whole site.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff bare below the elbows and wearing PPE to safeguard patients and themselves from possible cross infection. The monthly infection prevention and control audits for surgery showed 100% compliance from March to April 2022. These audits included hand hygiene, the use of PPE and overall environment.

Staff cleaned equipment after patient contact.

Staff worked effectively to prevent, identify and treat surgical site infections. Winterbourne Hospital provided hip and knee replacement patients with a surgical wound post discharge questionnaire and stamped addressed envelope for patients to return within 30 days. Patients were telephoned if the hospital did not receive this form.

Decontamination of surgical equipment was undertaken by a third party off site.

In March 2022 the Winterbourne Hospital had received a five-star food hygiene rating.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Good

Surgery

All patient rooms were single occupancy. Rooms were bright, clean and had wet room facilities.

The PLACE Lite audit had rated the overall condition, appearance and maintenance as 100%. There were no items of equipment in theatres that were out of service. At the time of our inspection, all items of equipment in theatres had been serviced.

Patient call bells were available and we saw staff responded quickly when used.

The Winterbourne had two theatres, both with laminar airflow systems (systems to circulate filtered air in theatres). There was also a minor operations room which was used for patients who did not require a general anaesthetic as part of their treatment.

Staff carried out daily safety checks of specialist equipment. The service had enough suitable equipment to help them to safely care for patients. There were two resuscitation equipment trollies on the wards and one in theatres. Staff carried out daily and weekly safety checks of specialist equipment. There was oxygen and emergency equipment available. We checked the dates of items on the resuscitation trollies and found out of date equipment on two of the trollies; in the ward corridor and in Chick Wing. We raised this at the time of our inspection and items were replaced immediately where possible. No issues were identified with the resuscitation equipment in theatres.

Staff disposed of clinical waste safely. Waste was segregated into clinical and non-clinical waste. Sharps were disposed of safely in designated labelled sharps bins. Theatres operated a one way system for clinical waste.

A track and trace system was implemented to monitor implants, any equipment used in the patient's body for example, prosthesis used in theatre. This was in case any issues in the future were identified with equipment and patients could be traced. This was monitored daily when in use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient at pre-admission clinic using recognised tools.

Different pre-operative assessments were carried out for surgery that required general anaesthetic and local anaesthetic with same day discharge. Pre assessments for patients requiring local anaesthetic and same day discharge were completed by the ambulatory care department. Pre assessments for patients requiring general anaesthetic were completed by the pre assessment team. These pathways were separated to enable continuity of care for patients. The pre assessments were completed to make sure patients were fit to have their surgery at this location. We observed a pre-operative assessment for a patient undergoing general anaesthetic. This included a medical history, allergies and physical observations.

Staff monitored patients using the national early warning score (NEWS2) and if they were concerned about possible sepsis, they informed the resident medical officer (RMO). The RMO, with advice from the consultant and/or anaesthetist, would make the decision about prompt transfer to the local NHS hospital to commence urgent treatment. There were sepsis boxes available for staff, which contained equipment needed for a patient with suspected sepsis.

Good

Surgery

There was a service level agreement for the transfer of patients using services to NHS in the event of complications from surgery. The signed agreement had lapsed due to the pandemic but the local trust had advised The Winterbourne Hospital the agreement would stand. Within the last 12 months, five patients had been transferred to the NHS post-surgery due to deterioration of their condition.

Staff completed risk assessments for each patient at pre-admission clinic using recognised tools.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

The Winterbourne Hospital ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. We observed staff completing the checklist in theatres. Monthly audits of the WHO checklist were completed, we saw evidence of 100% compliance from June 2021 to May 2022.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants, healthcare assistants, operating department practitioners and surgical assistants needed for each shift, in accordance with the numbers and needs of patients.

Senior staff on the ward told us they had four qualified nurse vacancies on the ward. They had recruited to these posts and used bank and agency staff to fill these vacancies.

Theatres had 31 contracted staff and three regular bank staff and had not used agency staff in five years.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe.

A resident medical officer (RMO) was on duty 24 hours a day and had access to the consultants if needed in an emergency.

Surgery was consultant delivered, and led, for both private and NHS patients.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Good

Surgery

Patient notes were paper based, comprehensive and all staff could access them easily. We observed four patient records and all were up-to-date. Patients who had undergone surgery had a pathway booklet and some were specific to the surgery received. These booklets included the documented care and treatment from pre-admission, through to discharge of the patients.

Records were stored securely.

Discharge summaries were communicated to the patients GPs. The discharge letter was sent electronically on the day of discharge and a copy of the letter remained in the discharge booklet.

A documentation audit was completed every four months. This covered all areas. The most recent result was from December 2021 to March 2022 which showed 88% compliance. This rated the service 'amber' as they had not met the hospital's 95% target for a 'green' rating. An action plan had been devised to address the shortfalls. For example, the bed rail risk assessment had not always been completed on admission.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed five patient medicine charts and these all had their prescriptions written correctly. There were no gaps in the record of administration that were unexplained.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. For two patients we saw there had been a review of the antimicrobials prescribed. We also saw patients had their pain relief needs reviewed.

Staff completed medicines records accurately and kept them up-to-date. The five patients' records seen were all completed.

Staff stored and managed all medicines and prescribing documents safely. Where medicines required temperature-controlled storage these were recorded, however, there was no recording of any escalation or action if the record was out of the expected range.

Staff followed national guidance to check patients had the correct medicines when they were admitted or they moved between services. We saw that people had their medicines reconciled within 24 hours of admission. This was completed Monday to Friday by pharmacy staff. If the admission took place at the weekend, the reconciliation was carried out by a member of the nursing team which was then reviewed by the pharmacy team after the weekend.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team but notifiable incidents were not always reported to the relevant authorities. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good

Surgery

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the provider's policy. Staff received feedback from investigation of incidents. Staff learned from safety alerts and incidents to improve practice.

The Winterbourne Hospital had a recent never event in theatre. The incident occurred in May 2022 and an investigation was ongoing. The hospital had held a swarm meeting (Swarming is used to problem solve at the time and place of an issue by the people who are affected) and 48-hour flash alert had been distributed. The duty of candour had been followed and initial lessons learned shared at a theatre departmental meeting.

There had been a patient death within 30 days post-surgery in July 2021. We reviewed the incident investigation report and action plan. The lessons learned were shared with teams. In early 2022 the hospital made the decision not to take patients with sleep apnoea due to the death that had occurred. This was because the guidelines on managing this group of patients post operatively were not conclusive enough. The anaesthetists were looking for a corporate policy before considering treating patients with this condition at The Winterbourne Hospital again.

Every morning a representative from departments across the hospital attended the communication cell. This meeting was a forum for staff to discuss and share incidents, safeguarding concerns, complaints and compliments from all departments. A swarm meeting would be initiated from this if required.

Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation if and when things went wrong.

Are Surgery effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The Winterbourne Hospital completed 17 audits per year and these were linked to national guidance and quality standards and professional guidance. We reviewed the results for some of these audits and saw compliance at 97% or above.

The Winterbourne Hospital monitored patients identified at risk of sepsis. We reviewed the sepsis audit from March 2022 to May 2022. This was used to review patients who had scored a NEWS2 score of three or more and triggered the sepsis pathway. (A score of three or more would indicate a medical review was needed quickly). The audit compliance was 100% for NEWS2 and 95% for antimicrobial stewardship.

Good

Surgery

Staff followed the National Institute for Health and Care Excellence (NICE) guidance. For example, in theatres, we observed staff completing instrument, swab and needle counts pre and post-surgery, which formed part of the World Health Organisation safety checklist.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food or fluids for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Patients waiting to have surgery were not left without food or drinks for long periods. Diabetic patients were prioritised on the day of surgery.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it. Patients we spoke with confirmed they did not have to wait long for their pain relief.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The Winterbourne Hospital participated in relevant national clinical audits. For example, patient reported outcome measures (PROMs). PROMs is a data set which assesses the quality of care delivered to NHS patients from the patients' perspective and covers four clinical procedures, hernia repair, varicose veins, hip and knee replacements. The hospital only provided data for hip and knee replacement. This was done using pre- and post-operative questionnaires.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The PROMs data for NHS-funded patients from November 2016 to February 2021, was similar to other organisations. The Oxford knee score for The Winterbourne Hospital was 90% which was close to the national average of 94%. The Oxford hip score for The Winterbourne Hospital was 99% which was above the national average of 97%. The Oxford score is the patient reported outcome questionnaire.

Good

Surgery

Private Healthcare Information Network (PHIN) data was collected on, volume and length of stay, patient feedback, hospital reported adverse events, consultant self-pay fees, consultant reference, infections, health improvements and never events and was submitted by the hospital through the PHIN Hospital and Consultation Portal. PHIN Data showed The Winterbourne Hospital was compliant with both of these.

As of quarter two of 2022, The Winterbourne Hospital was due to provide data to Q-PROMS (this is the same as PROMS but for cosmetic surgery). This was due to be processed for abdominoplasty, mammoplasty and rhinoplasty.

There were recording systems for documenting details of specific implants, for example the National Joint Register (NJR). The National Joint Registry was set up by the Department of Health and Welsh Government in 2002 to collect information in England and Wales on joint replacement operations and to monitor the performance of implants, hospitals and surgeons. The theatre staff had won an award in 2021 from NJR for being a 'quality data provider'.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw most surgery staff were in date with their appraisal. Those who were not were either on long term leave or were new members of staff.

Theatre staff competencies were reviewed at their annual appraisal. Ward staff completed competencies and if they had not completed a competency, they did not undertake the role without supervision. Ward competencies included admission, discharge, catheter care, aseptic technique, medicines management and point of care testing. We reviewed these for a member of staff and found they had achieved a satisfactory level of capability for all assessed competencies.

Consultants scope of practice was monitored. We heard of a recent example where the theatre team challenged a consultant who wanted to perform a new procedure. This went to the clinical chair and the surgeon was found to not have enough experience to undertake the surgery. Cosmetic surgeons received 360-degree appraisal.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers made sure staff had access to meeting notes when they could not attend.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, there was a ward huddle, communication cell meeting and three handovers every day. Departments held regular multidisciplinary meetings with such as theatre recovery, pre assessment and extended recovery. Surgery staff agreed an on-call rota and were available for post-operative patients. A multidisciplinary team reviewed patients that had died within 30 days of surgery.

Good

Surgery

Staff worked across health care disciplines and with other agencies when required to care for patients. The Winterbourne Hospital worked with local NHS Trusts and social services when required.

The Winterbourne hospital did not have a cancer specific service.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants visited their patients on the wards daily. Patients were reviewed by consultants depending on the care pathway. A resident medical officer (RMO) was available to provide medical advice and treatment 24 hours a day.

Staff could call for support from the RMO who could arrange some diagnostic tests, 24 hours a day, seven days a week. There was also support from pharmacists and out of hours theatre and recovery staff.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The Winterbourne Hospital was able to signpost patients to relevant information promoting healthy lifestyles.

Staff at the pre-admission clinic assessed each patient's health during their clinic appointment and provided advice to live a healthier lifestyle to improve their recovery post-surgery. This included information leaflets on nutritional advice, smoking cessation, stress management and alcohol consumption.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available. Patients were given information at their pre assessment clinic appointment or over the telephone about their surgery and recovery post-surgery.

Staff clearly recorded consent in the patients' records. We observed signed consent forms in the four patients records we reviewed.

Staff received training on the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their safeguarding adults training. Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care.

The Winterbourne had no patients subject to a Deprivation of Liberty Safeguard at the time of the inspection.

Good

Surgery

Are Surgery caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We spoke with seven patients and they all said staff treated them well and with kindness.The April 2022 quarterly quality and innovation report (QQIR) results showed The Winterbourne Hospital received 99% either very good or excellent from patients regarding their overall quality of care and overall impression of nursing care. It also showed 100% of patients said they were always treated with respect and dignity.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed and helped them maintain their privacy and dignity. During our inspection, we observed one patient was extremely anxious and staff allowed extra time with this patient.

Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them. We reviewed comments from the patient satisfaction survey and one said "the overall support, empathy and professionalism was excellent".

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. The feedback we received from patients during the inspection was positive.

Good

Surgery

Staff spoke with patients, families and carers in a way they could understand. We reviewed comments from the patient satisfaction survey, and one said “very friendly staff throughout. Informative and left me at ease” and another said, “questions were always answered clearly”. Patients were given a discharge pack when they were able to leave hospital, and this had important information and advice.

Patients and their families could give feedback on the service and their treatment.

Are Surgery responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population.

Facilities and premises were appropriate for the services being delivered.

The Winterbourne Hospital had systems to help care for patients in need of additional support or specialist intervention. For example, a dementia link nurse to support staff caring for patients living with dementia.

Managers monitored and took action to minimise missed appointments. Automated text messages were sent to patients 24-hours before their appointment to act as a reminder. Managers ensured that patients who did not attend appointments were contacted. This was either by telephone or email and appointments were rescheduled.

The Winterbourne hospital had started an ambulatory care pathway since September 2022 and approximately 700 patients had been seen through this pathway since then. It was a care pathway to utilise theatre three for patients requiring local anaesthetic or sedation with same day discharge. These patients were pre-assessed and followed up by staff working in ambulatory care which provided continuity of staff for patients. This also meant there was less waiting time for patients requiring day surgery.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services.

All rooms were single occupancy to reduce the risks of cross infection and each had en-suite facilities. Height adjustable beds and other equipment were provided to meet the needs of patients. Patients could reach call bells and staff responded quickly when called.

Anxious patients were offered rooms near to the nursing station and were able to keep their door open if preferred.

Managers made sure staff, and patients could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Staff made sure patients living with dementia, received the necessary care to meet their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

We were told of a patient who had suffered an assault and did not want male staff in the operating theatre or during recovery. This was accommodated.

Access and flow

People could access the service when they needed it and received the right care. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed.

The Winterbourne Hospital had worked with the local NHS trust during the COVID-19 pandemic to help maintain surgery services. During this period, they had to delay some of their elective surgery to facilitate those NHS patients with a greater clinical need.

The current contract meant The Winterbourne Hospital delivered approximately 50 surgeries per month for NHS patients. The Winterbourne Hospital had a contractual requirement of 18 weeks referral to treatment for NHS patients. Patients on the waiting list were managed in line with waiting list policies and NHS contract requirements.

Since the COVID-19 pandemic, there had been reduced consultant capacity to provide NHS slots. This was managed and reported to the local clinical commissioning group and reviewed at contract meetings. Consultant slots were flexed at specialty level to meet demand of referrals received. There had also been a specific action plan for orthopaedics to assist with the orthopaedic waiting list.

Managers worked to keep the number of cancelled operations by the service to a minimum. A total of 605 operations were cancelled between June 2021 and May 2022. Reasons for their cancellation were documented. When patients had their operations cancelled, managers made sure they were rearranged as soon as possible. There were 14 NHS patients that were not re-booked. These were not re-booked due to several reasons, for example, patients unfit for surgery, personal reasons and treatment no longer suitable.

Managers and staff worked to make sure that they started discharge planning as early as possible. This was started at the pre-admission clinic where patients were given information about their post operation recovery and when they would be able to mobilise. This was part of the patient pathway.

Learning from complaints and concerns

Good

Surgery

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of learning from complaints.

Complaints numbers were monitored, for example, theatres had received one complaint between June 2021 and May 2022. The hospital had received 22 complaints in the last 12 months.

Are Surgery well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience to run the service. The registered manager had been in post since 2012 and was registered with Care Quality Commission (CQC). There was a director of clinical services who had been in post since 2018. The clinical chair of the medical advisory committee had been in post since December 2020. The post was created to add consultant input to the management team. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Leaders were visible and approachable. Staff told us they thought highly of the management team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and a set of values. The provider's described their main purpose as "provide the high quality, safe and compassionate care our patients need and expect". There were four key principles and eight values based on their purpose. The values included compassion, collaboration, commitment, selflessness, agility, bravery, tenacity and creativity. There were realistic departmental strategies for achieving the priorities and delivering good quality sustainable care. During the pandemic, The Winterbourne Hospital had provided NHS support.

Culture

Good

Surgery

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with told us they were proud to work at The Winterbourne Hospital. We were told managers were approachable, staff were supported and they felt valued.

The hospital had taken part in an external employee survey that looked at motivation, confidence, senior managers and wellbeing and had achieved an outstanding rating.

The culture centred on the needs and experience of patients who used services. In March 2021, the provider had introduced the Circle Operating System (COS). COS is an established methodology to empower staff to work together to be safe and effective and recognise that everyone has a responsibility to contribute towards this goal. It focused on six key areas to help achieve this. One example of COS is a swarm. (Swarming is used to problem solve at the time and place of an issue by the people who are affected).

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff were encouraged to report all incidents as they were a learning opportunity. Staff confirmed they could raise any issues with their line manager, other senior staff or the freedom to speak up guardian (FTSUG) on site. The provider also had a corporate FTSUG member of staff.

Managers had access to policies, procedures and support to address behaviour and performance inconsistent with the vison and values, regardless of seniority.

Governance

Leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, not all information required for safe recruitment of new staff had been obtained and there was an ongoing breach of regulations in relation to record keeping.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improvements made as required. We saw evidence of the audits and minutes of monthly or quarterly meetings where staff discussed these and other topics. The majority of audits demonstrated high compliance.

In May 2021 the provider had introduced a governance assurance framework to demonstrate transparency from locations to board. This showed how each of the committees or steering groups at locations fed into regional teams and then into the provider and board as required and how information was fed back to locations.

Good

Surgery

All levels of governance and management functioned effectively and interacted with each other. We reviewed minutes of several meetings, for example, clinical governance meetings, executive leadership meetings and the medical advisory committee (MAC). The MAC minutes included discussion around actions from previous meetings, clinical governance, medical policy, risk register and practicing privileges.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

The provider ensured surgeons had an appropriate level of valid professional indemnity insurance. As part of the review of surgeons and consultants practising privileges, they had to provide evidence of their insurance cover. The provider had set up a format for each location to follow, which included information required under national guidance on appraisals for doctors. We reviewed and saw the required evidence had been obtained. This information had to be provided so they could continue to provide treatment. As part of monitoring each consultant who worked under practising privileges had to have an interview every two years with the registered manager. These meetings included scope of practice, review of activity and meeting the requirements of practising privileges.

We reviewed ten staff recruitment records and saw that Disclosure and Barring Service checks (DBS) were completed. However, we found not all pre employment checks were complete. Three of these employees had no photographic identification. However, since the inspection the service had escalated the lack of clarity within the Circle Health Group policy and have escalated this to the corporate Human Resources (HR) team.

The service did not meet the regulatory requirements for record keeping. This was a breach previously identified at other locations managed by the corporate provider.

Management of risk, issues and performance

Leaders did not have sufficient oversight of processes. They did not always escalate appropriately. However, leaders and teams used systems to manage performance effectively. They identified relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were eight out of date items and two missing items on the resuscitation trollies on the wards. There was no oversight that the daily/weekly checks had been completed or that actions had been taken. Some items on the trolley had been amended from the guidelines, such as sizes of Laryngoscope blades and handle. We were told this had been verbally agreed due to the fact the hospital did not treat children, therefore a small size would not have been required. However, there was not a written risk assessment to demonstrate this so new or other staff members could refer to this.

Some of the out of date items had been identified on the checklist, but action had not been taken to replace these. Two of the out of date items and the two missing items that were identified during our inspection were replaced immediately. We were told that items that had been ordered were displayed on the whiteboard in the ward. We reviewed the whiteboard and there were four items on order. This did not correspond with our findings. We were told there had been some supply chain issues with some pieces of equipment but there were no written risk assessments to demonstrate they should remain on the trolley in case of an emergency.

The Winterbourne Hospital had a recent incident in theatre. The incident occurred in May 2022 and an investigation was underway. The hospital had followed its own operating system procedure following an incident.

Good

Surgery

The organisation had assurance systems and performance issues were escalated through clear structures and processes. A communication cell meeting was held every day with a representative from each department in attendance. This offered the opportunity for all departments to raise concerns and share information. There were processes to manage current and future performance, which were reviewed and improved through a programme of audit. We were sent minutes of five hospital clinical governance meetings where we saw incidents, learning and actions discussed.

The provider was registered with the Medicines and Healthcare products Regulatory Agency (MHRA) Central Alerting System (CAS) so they received alerts that may be relevant to the services they provided. These were cascaded down from the providers head office to each location and then passed to staff for any action. There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was a good incident reporting culture. The hospital had reported 64 incidents in the last quarter. There were eight risks on the locations risk register.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data were consistently submitted to external organisations as required.

Information was used to measure performance and improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings.

Staff had sufficient access to information. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

There were arrangements to ensure data was submitted to external bodies as required. For example, data was sent to UK Health Security Agency for the monitoring of surgical site infections. The provider had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, were in line with data security standards.

Data systems were secured and monitored. Staff told us they had a secure log in for each computer and these timed out if they were not used in a set time. Staff told us they logged out or locked the computer when they needed to leave their desk.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people who used services, and those close to them. In May 2022 the quarterly quality and innovation report showed that 99.1% of patients said they would be 'likely' or 'extremely likely' to recommend the hospital. One hundred percent of patients answered 'yes definitely' when asked if they were involved in decision making and if they felt they were treated with dignity and respect.

Good

Surgery

The hospital had taken part in an employee survey and achieved an 84% response rate. The results of this survey rated The Winterbourne Hospital as outstanding to work for. The scale of ratings went from good, very good, outstanding and world class. Staff were actively engaged and their views reflected in the planning and delivery of services and in shaping the culture.

Senior managers visited all areas of the hospital and met with staff. Staff were kept up to date with important information.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in appropriate research projects and recognised accreditation schemes across all specialities. For example, The Winterbourne Hospital was recognised with a National Joint Registry (NJR) Quality Data Provider award. The NJR Quality Data Provider award scheme has been developed to offer hospitals a blueprint for reaching standards relating to patient safety through NJR compliance and to reward those who have met targets in this area. This location had received a 2020/2021 award for reaching and maintaining these standards.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic imaging safe?

Good

This was the first inspection of diagnostic imaging as a standalone service. At this inspection we rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training.

Radiographers working in the department received immediate life support training, which included training in how to recognise and act on anaphylaxis (a severe and potentially life-threatening allergic reaction). Staff told us they would inform the resident medical officer if they had any concerns about patients and inform the patient's consultant for advice.

Staff received dementia awareness training and were required to complete this once. Staff told us there was no refresher training required.

Managers monitored mandatory training and alerted staff when they needed to update their training. The department lead had oversight of training compliance and staff received reminders about when their training was due.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Records showed all staff had received level two or level three adult safeguarding training appropriate to their role and child protection training at level two.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Good

Diagnostic imaging

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children accompanying adults visiting the department.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical and waiting areas were visibly clean and had suitable furnishings which appeared clean and well-maintained. We saw cleaning schedules which showed daily cleaning of the department.

Staff followed infection control principles including the use of personal protective equipment (PPE). Audits included the use of PPE and overall environment, and patient equipment as part of the overall infection prevention and control practices were expected. Results showed 100% compliance against eleven standards. Audits were carried out every two months in accordance with the hospital's audit schedule.

We saw staff cleaned equipment after every patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. All diagnostic services were accessed on the ground floor next to the main reception area, which meant it was easy for patients with reduced mobility to access the service. There was one x-ray machine and one MRI scanner and access to both areas was restricted to authorised staff. Relevant equipment was labelled in line with the Medicines and Healthcare Products Regulatory Agency guidelines (2021), which recommends all equipment taken into the MRI environment is clearly labelled as MRI safe.

Safety and warning notices were displayed, and equipment was well maintained. We saw records of quality assessment processes to ensure imaging equipment was maintained and working within safe limits of radiation and in line with manufacturer's guidance.

Staff had access to a medical physic expert (MPE) for advice if they had any concerns about imaging equipment. This service was provided through a corporate contract. The MPE visited the service at least annually.

Lead aprons were available for radiographers if required and for staff in the operating theatre if imaging was used during surgical procedures. There was an audit schedule to assess lead aprons annually and actions were recorded to ensure any concerns were acted upon.

Staff disposed of clinical waste safely. Waste was segregated into clinical and non-clinical waste. Bins were emptied regularly, and sharp boxes were labelled and kept closed when not in use.

Substances hazardous to health were stored securely and in line with Health and Safety Executive Regulations.

Assessing and responding to patient risk

Good

Diagnostic imaging

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration communicated effectively to staff working in the MRI and x-ray lounge.

Radiographers knew about and dealt with any specific risk issues. They used safety risk assessments in line with national guidance for patients who attended for diagnostic imaging. For example, radiographers used a 'pause and check' system. This was a six-point checklist, which radiographers must carry out before an image was taken.

There were effective systems to ensure justification of exposure to radiation. All x-ray scans were reviewed by a radiologist who signed to justify the exposure to radiation. Checking of associated risks was completed and documented. Staff had access to a folder with authorised referrers. Each consultant was listed with information about to their speciality and this was reviewed and updated annually or as required.

Staff had access to a radiation protection advisor and there were three radiographers who had completed radiation protection supervisor training. There was an annual radiation protection meeting which had been held recently.

Staff used a form to ask sensitive questions about the possibility of patients being pregnant and to assess risk in patients who may have undergone gender transitioning.

Staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough radiographers and administration support to keep patients safe and ensure the service ran smoothly. The department had an imaging department manager, two MRI radiographers, and an MRI healthcare assistant. In the x-ray department there were two part time radiographers and a part time healthcare assistant.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Clinical leadership was provided by a consultant radiologist who worked under practising privileges. For more information, please see the surgery report.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Records were stored securely. Paper-based patient records were stored in locked cabinets and all computer records were password protected. Staff used an electronic records tracing system to ensure patient files could be easily located. For more information, please see the surgery report.

Medicines

Good

Diagnostic imaging

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when administering, recording and storing medicines. Staff in the MRI and x-ray department followed protocols which provided information about the scans required and where medicines (contrast media) was prescribed. Radiographers administered contrast media as prescribed using patient specific directions.

Medicines were stored safely in locked cabinets. Staff reported there were no issues with getting medicines they ordered. The department kept a small stock of medicines. All medicines we checked were in date.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were shared with department leads by the Clinical Director of Services, who would share those which were applicable to the service. Safety alerts were also discussed with consultants if these impacted on the treatment they would usually prescribe.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff told us they raised concerns and reported incidents and near misses in line with provider policy**.** There was an electronic incident reporting system which staff were familiar with. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff were aware of when incidents were reportable in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The manager confirmed they had not been any reported IR(ME)R incidents in the last 12 months prior to our inspection.

Managers investigated incidents. Managers debriefed and supported staff after any serious incident. Staff told us the hospital had introduced 'Stop the line' which was designed to empower anyone who have any concerns about potential harm to patients, to ask for the activity to be stopped, and any issues would be discussed. The hospital had also introduced a 'Swarm' process where all staff involved with an incident were gathered to discuss an incident or near miss in order to identify how improvements could be made.

There were processes to ensure staff, including radiologists were informed of any patient safety alerts. These were shared in the hospital daily communication meeting and shared with staff in the department.

Are Diagnostic imaging effective?

Inspected but not rated

This was the first inspection of diagnostic imaging as a standalone service. We do not rate effective in diagnostic imaging

Evidence-based care and treatment

Good

Diagnostic imaging

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There were local rules/work instructions for imaging procedures undertaken by staff. These were version controlled and reviewed and updated regularly. Protocols were stored electronically, and staff knew where and how to access them.

The service participated in relevant Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) audits. The service was required to submit data on a monthly basis. Results were reviewed by an external radiation protection advisor (RPA). The service accessed RPA and medical physicist expert (MPE) services through a service level agreement with an NHS trust. This was a corporate level agreement to provide RPA and MPE services to all of the provider's locations. Staff told us the RPA and MPE were easy to get hold of and visited the unit at least once a year. They continued to provide close monitoring of the service and staff had access to specialist support from the company who supplied the equipment. All relevant staff had been trained to use the equipment and assessed as competent.

There were corporate policies which staff were required to read when they were updated. Policies were stored electronically, and version controlled.

Pain relief

Staff assessed and monitored patients to see if they were in pain.

Staff did not routinely manage patient's pain as patients were in the department for a short while.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

There were systems and processes to assure the accuracy of reporting of images. The service used national standards to benchmark the effectiveness and safety of imaging. Audit outcomes confirmed the service was compliant with Ionising Radiation (Medical Exposure) Regulation standards, such as lowest radiation dose to achieve good imaging.

Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvements over time. There was a clear programme of regular audits which were carried out to monitor the safety and effectiveness of the service. Audits results were reviewed by the RPA and discussed in meetings.

Managers used information from audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. The manager explained staff were involved in drawing up action plans if improvements were required.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Good

Diagnostic imaging

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Relevant staff were registered with the Health and Care Professions Council and supported to revalidate their registration as required. The provider had an induction programme for newly appointed staff. The service used a competency assessment framework to assess competence for the imaging procedures they were required to undertake.

Managers supported staff to develop through yearly, constructive appraisals of their work. Records shared with us following the inspection demonstrated when the next appraisals were due.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff knew each other well and worked with multidisciplinary colleagues as required.

Seven-day services

Key services were available to support timely patient care.

The diagnostic services were offered Monday to Friday from 8am to 6pm.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff received training about how and when to assess whether a patient had the mental capacity to make decisions about their care. Staff were required to complete safeguarding vulnerable adults at level two. Staff received dementia awareness training as part of their mandatory training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. All relevant staff had completed relevant training in consent.

Staff used a corporate consent form for all interventional procedures which included a 'needle to skin' process for patients to provide written consent to planned procedures.

Staff clearly recorded consent in the patients' records.

Are Diagnostic imaging caring?

Good

This was the first inspection of diagnostic imaging as a standalone service. At this inspection we rated it as good.

Good

Diagnostic imaging

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff introduced themselves and interacted with patients. They were friendly and checked patients' pain level, encouraging patients to improve their mobility whilst ensuring they were safe.

There were changing room facilities available for patients who needed to change into a gown for their procedure. This ensured patients privacy and dignity was maintained. The service had chaperone arrangements for any intimate examinations or procedures and if patients requested a chaperone to be present. The service had a chaperone policy which set out the responsibilities and training required of staff when they acted as chaperones.

Patients said staff treated them well and with kindness. We spoke with three patients who all confirmed staff were professional and kind in their interactions with them.

Staff followed policy to keep patients' care and treatment confidential. Patient confidentiality was respected.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff in the MRI and x-ray scanning suite took account of and supported patients who may suffer from claustrophobia related to the scanning process. Staff took time to explain the procedure and to settle the patient in once they were in the scanning room. Staff ensured patients had a call bell and communicated with them at regular intervals during the scanning process, to keep them informed and gain assurance they were coping well during the scanning.

Staff gave patients time to ask questions and took time to explain what happened next.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients understood their care and treatment. Staff checked with patients their understanding of the imaging they were booked in for and to confirm the site to be X-rayed or scanned. This also offered patients an opportunity to raise questions to enhance their understanding of the imaging process.

Staff spoke with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff speak with patients in a manner they understood. Staff did not use medical jargon but used every day terminology to explain procedures and/or answer questions.

Good

Diagnostic imaging

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff also encouraged patients to complete feedback cards following their imaging procedures. Data from the NHS Friends and Family survey for diagnostic imaging feedback was currently collected and collated as part of the Outpatients survey. We looked at the average scores from December 2021 to April 2022 which showed between 97% and 100% of patients who returned the questionnaire thought the service was very good.

Patients gave positive feedback about the service**.** Patients told us they were pleased with the care and treatment they had received in the department.

Are Diagnostic imaging responsive?

Good

This was the first inspection of diagnostic imaging as a standalone service. At this inspection we rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of patients. The departments were open between 8am and 6pm. Most appointments would be available within 24 to 48 hours.

Facilities and premises were suitable for the services being delivered. All scanning facilities were at ground floor level meaning patients with reduced mobility could easily access their imaging appointments. There were enough seats for patients waiting and toilet facilities if required. There were refreshments for patients waiting in the main reception area.

Managers monitored and took action to minimise missed appointments. Staff ensured patients who did not attend appointments were contacted. Staff told us there were very few missed appointments. There were processes for staff to follow if patients did not attend.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and took account of cultural, social and individual needs of patients as far as possible. Most imaging appointments were outpatient appointments although staff also carried out imaging procedures for inpatients and for patients having surgery.

Staff had identified a number of patients had arrived at the department and were unable to clearly read and complete the consent forms. Staff therefore provided reading glasses available at reception for patients to borrow to help them complete the forms.

Good

Diagnostic imaging

Staff took care to ensure patients were as comfortable as possible. Staff in the MRI and x-ray service took care to provide reassurance and ensured patients wore ear protectors to reduce the noise during scanning procedures. The ear protectors had built-in two-way communication system which meant staff could communicate effectively with patients during scans and patients could listen to music of their choice during scanning sequels. Staff also ensured patients had a call bell and informed patients they could stop the scan at any time.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. We were told there were no waiting lists and patients attended for their imaging procedures as soon as practically possible.

Managers and staff worked to make sure patients did not stay longer than they needed to. Appointments were scheduled to minimise waiting times when patients arrived for their booked imaging procedure. During the inspection, we observed staff attending to patients promptly when they arrived in the department.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Feedback cards were available to enable patients to give feedback. These forms were sent to the corporate headquarters to be reviewed and themed before they were shared with staff.

Staff understood the policy on complaints and knew how to handle them. The manager investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Records showed the imaging department had received one complaint in the 12 months prior to inspection. This had been investigated and resolved within one week of receipt.

Are Diagnostic imaging well-led?

Requires Improvement

This was the first inspection of diagnostic imaging as a standalone service. At this inspection we rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good

Diagnostic imaging

All staff we spoke with confirmed the executive leadership team operated an 'open door' policy and they would feel confident to raise concerns with managers or senior managers if required. Staff in the department were aware of who the executive leadership team were.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve.

The hospital had a strategy document from 2021 to 2023. For our main findings please see the surgery report.

The staff in the imaging department also had created their own departmental vision, to "provide an outstanding imaging service for our patients and relatives". This included:

- Everyone will be treated with respect;
- Patients will be treated with the first class care your loved one would expect;
- Quality: provide the best high standard of service; and
- Staff must be professional, supportive and considerate to each other.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

For our main findings please refer to the surgery report.

All staff said they felt valued and enjoyed working at the hospital, and in the department.

All staff we spoke with were aware of who the freedom to speak up guardian was and of their role. Staff confirmed they felt they could raise concerns without the fear of retribution.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

For our main findings please refer to the surgery report.

Good

Diagnostic imaging

Staff collected data to confirm audits were completed as required under the Ionising Radiation (Medical Exposure) Regulations. Data was collected and submitted as required. Audit results were discussed in meetings with the radiation protection advisors and action plans were agreed if required. Audits included compliance with quality assurance and compliance with diagnostic reference levels for imagining. These audits demonstrated patients received the lowest and recommended exposure to radiation to achieve the best imaging quality, reporting turn around and reporting accuracy.

The service participated in corporate audit programme as required.

We reviewed ten staff recruitment records and saw that Disclosure and Barring Service checks (DBS) were completed. However, we found not all pre employment checks were complete. Three of these employees had no photographic identification. However, since the inspection the service had escalated the lack of clarity within the Circle Health Group policy and have escalated this to the corporate Human Resources (HR) team.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

For our main findings please refer to the surgery report.

At the time of the inspection there were currently no risks in the imaging department which required escalation to the risk register. Staff we spoke with confirmed this.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We reviewed the policies in the diagnostic imaging department and found most corporate files were out of date by five months. Local documents however were in date. We discussed this at the end of the inspection with the hospital leadership team and they subsequently assured us the corporate documents had been reviewed in December 2021, and confirmed the documents were fit for purpose. The new documentation was due for a relaunch in June 2022.

Staff were aware of data collected for audit purposes and how this was used to make improvements where this was required.

All radiographers we asked, were knowledgeable about policies, local rules/work instructions and where to find these.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Good

Diagnostic imaging

For our main findings please refer to the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

For our main findings please refer to the surgery report.

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
Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures Family planning services	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The service must have effective recruitment and selection procedures and ensure all appropriate checks are confirmed before they are employed. (Regulation 19 (2) (a) and Schedule 3).

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance arrangements must ensure issues are escalated and rectified in a timely manner (Regulation 17 (2) (b)).

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure accurate, complete and contemporaneous records are maintained in respect of each service user. (Regulation 17 (2) (c)).

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Family planning services	The service must ensure staff are trained to the appropriate level of adult and children safeguarding (Regulation 18 (1)).

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.

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This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	The service must ensure staff are trained to the appropriate level of adult and children safeguarding (Regulation 18 (1)).