West Midlands Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

West Midlands Hospital, part of the Ramsay Health Care UK Operations Limited offers private hospital treatments, procedures, tests and scans to patients from Halesowen and surrounding areas. The hospital offers a range of surgical procedures, cancer care, rapid access to assessment and investigation and a physiotherapy service. Since September 2015, no children under 18 years received care and treatment at the Hospital.

Patients are admitted for elective surgery, day case surgery/treatment or outpatient care. There are no urgent admissions. Facilities include 34 beds each with ensuite facilities; 29 of which were available for use at the time of the inspection. There are three theatres and a three bay recovery area. There is no dedicated High Dependency Unit (HDU). There is an agreement in place with the local acute NHS trust to transfer patients, should their health deteriorate and they require specialist medical support. Staff were supported with medical input to stabilise patients prior to transfer. The hospital has outpatient facilities, and plans are underway to relocate the outpatient department to a separate site one mile from the main hospital. The hospital also offers services to NHS patients on behalf of the NHS through local contractual agreements and seventy-two percent of its activity is NHS funded care.

Prior to the CQC inspection visit, the CQC considered a range of quality indicators captured through our monitoring processes. In addition, we sought the views of a range partners and stakeholders. Key elements of this process were the focus groups we held with healthcare professionals and feedback from the public.

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

• Safe

• Effective

• Caring

• Responsive

• Well-led.

Our key findings were as follows:

West Midlands Hospital was selected for a comprehensive inspection as part of our independent healthcare inspection programme. The inspection was conducted using the Care Quality Commission's Independent Health inspection methodology.

The inspection team included CQC inspectors, doctors, nurses and senior managers with experience of working in the independent healthcare sector. The inspection took place on 2 December 2015, with an unannounced visit on 12 December 2015. The inspection team looked at the following core services: surgery, and outpatient and diagnostic imaging services.

Are services safe at this hospital

- Incident reporting was variable, the majority of incidents were reported and lessons learned shared among staff, however, medication errors were not routinely reported.
- A Duty of Candour Policy was in place, however staff we spoke with were not fully aware of what it meant in practice and further training was required.
- Staff were aware of their responsibility to safeguard adults and children.

- The resident medical officer (RMO) was available 24 hours a day seven days per week.
- Consultants were responsible for their patients throughout their inpatient and day case stay.

Summary of findings

- There were sufficient staff to meet people's needs across surgery and outpatients and diagnostic services.
- The 5 steps to safer surgery, World Health Organisation (WHO) surgical checklist was completed appropriately, however the document was retained in theatre for a period of time and not kept in patient's records directly after completion.
- Completion of the WHO safety checklist for interventional radiology needed to be improved to meet national standards and practiced consistently.

- There was no process in place to assess and record ward nurses competencies at the hospital and the equipment register to record which staff are competent to use items of equipment was out of date and did not include night staff.

Are services effective at this hospital

- Local policies and care pathways to treat patients followed national guidance. There was some participation with national audits and benchmarking clinical practice across Ramsay Health Care UK Operations Limited, however this was limited.
- Staff understood their responsibilities relating to consent and were clear about their responsibilities under the Mental Capacity Act 2005.

- Patient reported outcome measures (PROMs) data for knee replacements demonstrated the service had a better than average expected health gain for these procedures.
- Readmission rates for surgery were 'similar to expected' compared to the other independent acute hospitals.
- There was a robust process in place for checking staffs' General Medical Council (GMC), Nursing and Midwifery Council and Allied Healthcare Professional registrations.

- Consultant competencies were assured through the NHS annual appraisal, and the GMC revalidation process. They were also assured through the clinical review process which formed part of the biennial review. However, we saw the biennial review did not take place every two years but every five years. We were not confident a five yearly check was frequent enough to review consultants' performance and practice. However, any trends or patterns relating to concerns with a consultant's performance was discussed at the monthly MAC meeting.
- Information confirmed 100% of consultants had an in-date appraisal (based on 15 months expiry) and had supplied in-date evidence of indemnity.
- There was no process in place to assess and record ward nurses competencies at the hospital. The equipment register to record which staff were competent to use items of equipment was out of date and did not include night staff.

Are services caring

- Staff were caring and compassionate and treated patients with dignity and respect.
- For the NHS equivalent Friends and Family Tests, hospital scores for both privately funded and NHS funded patients showed the results of 98% of 59 respondents said they would recommend the hospital.
- The 2015 patient led assessment of the care environment (PLACE) audit scored the hospital, 89.3% for privacy and dignity.

Are services responsive at this hospital

- Patient operations and procedures were rarely cancelled.

  Care planning for patients with complex needs such as patients living with dementia or a learning disability was well managed from pre-admission to post-discharge.

Summary of findings

The complaints procedure was robust. The hospital had received 44 complaints in 2014, complaints had been investigated and supported by actions for improvement.

The complaints leaflet which provided details relating to the Independent Healthcare Ombudsman was out-of-date and contained incorrect contact details.

- Complaints were reviewed at the monthly heads of departments meeting, led by the Quality Improvement Lead, governance meetings and the medical advisory committee (MAC).

Are services well led at this hospital

- Staff were aware of and understood the vision and values of the hospital.
- The hospital did not routinely retain copies of patients' records for all patients who attended the outpatients department. This is a legal requirement and failure to hold these records meant there was a breach of regulation 17- HSCA, 2008, (Regulated Activity) Good Governance of the Health and Social Care Act (2014)
- Senior managers had not ensured the process underpinning the WHO check list for interventional radiology was completed in a consistent manner or audited.
- Senior managers had not ensured there was a formal process in place to manage patients when consultants needed to cancel clinics at short notice.
- The Hospital Risk Register did not provide an accurate comprehensive reflection of the key risks across Surgery or OPD services and senior managers did not have clear oversight of what risks should be included on the register.
- There were missed opportunities to discuss and learn from incidents which demonstrated similar trends and not all consultants were aware of incidents which had been reported. For example, the hospital reported six surgical site infections (SSI) all relating to abdominal wounds. There was no route cause analysis (RCA) to look at common links and this was not discussed at the MAC. We saw this was a missed opportunity for the hospital to look at patterns and learn from SSI's.
- Governance arrangements were in place for teams and departments to discuss learning from complaints, incidents and audits. However, further work was required to review and disseminate lessons learned from medication incidents.
- The senior management team conducted daily huddles to instantly communicate clinical and non-clinical issues.
- There was a supportive and open culture and staff felt that department and senior managers were approachable and supportive. However, 57% of ward nurses and 50% of heads of department had not received recent performance appraisal.

We saw several areas of good practice including:

- Endoscopy services had been accredited by Joint Advisory Group (JAG) for GI endoscopy in 2014.
- A Quality Improvement Lead had recently been appointed to strengthen governance arrangements and was making good progress.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that hospital staff have access to all necessary information, including maintaining an accurate, complete and contemporaneous record on the hospital site in respect of each patient.
- Ensure all medicines are handled and stored safely.
- Ensure all medication errors including 'missed doses' are reported appropriately.
- Ensure all medicines for general use are ordered and kept separately from individual patient medicines

Summary of findings

- Ensure the WHO check list for interventional radiology is competed appropriately for each procedure carried out and audited at regular intervals.
- Improve external multidisciplinary team management of patients with cancer in accordance with NICE guidance.
- Review the frequency of 'Biennial reviews' which the hospital is currently undertaking every five years.
- Formalise the nursing competency assessment process.
- Update the equipment register and include all staff who use equipment.

In addition the provider should:

- Ensure there is a robust and formalised process in place for cover arrangements for consultants.
- Ensure the completed 5 steps to safer surgery, (WHO) surgical checklist is promptly included within patient's records.
- Ensure Complaints leaflets contain correct information.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgical services required improvement. Surgical safety checklists were in use; however compliance with this safety measure was not audited at regular intervals. Hospital staff, including senior managers, were not aware of who their Medicines Safety Officer was. The handling and storage of medicines required improvement. Theatre corridors were cluttered with equipment and supplies. Boxes were obscuring access to the lifts during our inspection which made the area unsafe , although this was addressed and the area was cleared during our visit. There was a mixed picture in respect of incident reporting and dissemination of lessons learned required improvement. There were appropriate systems in place to respond to the deteriorating patient. The hospital was visibly clean and there were appropriate systems in place to prevent and control healthcare associated infections. There were adequate levels of medical, nursing, therapy and support staff. There were no external multidisciplinary team (MDT) arrangements in place with a local NHS trust for patients' cancer care and treatment. However, internal MDT working was good. Generally, patients were well cared for on the ward and in theatres. Pain control was well managed and patients' hydration and nutritional needs were well supported. Some national and local audits were completed to benchmark practice and performance against best practice and against other providers. The endoscopy unit was accredited with the Joint Advisory Group (JAG) on GI endoscopy, which assures compliance with national standards. Staff were aware of and understood the vision and values, known as the 'Ramsay way'.

Summary of findings

There was a positive culture for staff training and staff told us their line managers were approachable and supportive. However, completion of staff performance appraisals required improvement.

Outpatients and diagnostic imaging

Requires improvement 

Outpatients and diagnostic imaging overall was rated as 'requires improvement'. The hospital had an unsatisfactory patient record management system and informal process for dealing with consultant absences. The WHO checklist for interventional radiology was not completed in a consistent manner and was not audited.

Infection prevention and control practices and procedures were effective. Incident reporting was consistent and staff were confident that incidents would be acted upon. Learning from incidents was regularly shared with staff. Medicines were stored securely and safely.

Sufficient numbers of suitably qualified staff were available to keep patients safe from harm. Staff were up to date with mandatory training, including safeguarding training.

Care and treatment was provided in line with national guidelines and information about outcomes of people's care was collected and monitored, and used to improve services for patients. Staff were suitably qualified and received ongoing training supported by a range of policies and procedures.

Multidisciplinary working was good between departments.

Outpatients and diagnostic imaging staff at all levels provided compassionate, dignified care.

Services were mostly responsive to people's needs. The appointments system was efficient and patients found it easy to use. Premises were mostly fit for purpose; however, the outpatients department waiting area had limited space and parking was limited. There were plans to relocate the services to a separate local site.

Patients with complex needs, such as those who had learning disabilities or who lived with dementia, were well supported. Staff had access to

Summary of findings

printed information in languages other than English, and an interpretation service was available for staff to use if patients preferred to use a different language.
Staff were aware of and felt a connection with the hospital's vision and values. A culture of prioritising safe, high quality, compassionate care, of openness and candour and of mutual respect between staff of all levels was evident.
Senior managers, heads of departments and members of the medical advisory committee met and communicated regularly and effectively. Staff told us managers at all levels were approachable and supportive. However, radiology staff had not received performance appraisals.

Summary of findings

Contents

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Services we looked at

Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to West Midlands Hospital

West Midlands Hospital was originally a residential property and prior to becoming operational as a surgical hospital facility in 1988, it had been both a GP practice and a nursing home.

The hospital currently delivers both NHS and privately funded activity across a range of specialties. West Midlands Hospital, part of the Ramsay Healthcare group, offers private hospital treatments, procedures, tests and scans to patients from Halesowen and surrounding areas. The hospital offers a range of surgical procedures, cancer care, rapid access to assessment and investigation and a physiotherapy service. Since September 2015, no children under 18 years received care and treatment at the hospital.

West Midlands Hospital has 34 inpatient beds, six outpatient department (OPD) consultation rooms, three physiotherapy treatment areas, a gym area and an off-site hydrotherapy pool. There are three theatres with recovery bays and an endoscopy room, one of them with a laminar flow ventilation system. The hospital's medical outpatient service is for consultation only. The hospital offers a range of medical treatment or surgical procedures including general surgery, gynaecology, urology, plastics and ophthalmology.

Patients are admitted for elective surgery, day case or outpatient care. There are no urgent admissions.

Facilities included 34 beds each with ensuite facilities, 29 of which were available for use during the time of our inspection. There are three theatres and a three-bay recovery area. There was no dedicated High Dependency Unit (HDU). The hospital has outpatient facilities, and at the time of our visit, plans are underway to relocate the outpatient department to a separate site one mile away from the main hospital. The hospital offered services to NHS patients on behalf of the NHS through local contractual agreements. Seventy-two percent of its overall activity was NHS funded care.

Prior to our inspection visit, we considered a range of quality indicators captured through our monitoring processes. In addition, we sought the views of a range partners and stakeholders. Key elements of this process were focus groups with healthcare professionals and feedback from the public.

West Midlands Hospital was selected for a comprehensive inspection as part of our independent healthcare inspections programme. The inspection was conducted using the CQC's new methodology. The inspection team inspected the following core services:

- Surgery
- Outpatients and Diagnostics.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper Care Quality Commission (CQC)

The team included an inspection manager; a pharmacy manager, inspectors; a consultant surgeon, a senior nurse manager, a theatre nurse specialist and managers in radiology and outpatients. Many of our experts had current experience of working in the independent sector.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of this inspection

• Is it well led?

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local Clinical Commissioning Group and Healthwatch. Patients were invited to contact us with their feedback. We carried out an announced inspection visit on 2 December 2015 and an unannounced inspection on 12 December 2015. We invited all hospital staff (clinical and non-clinical) to two focus groups, however, these were poorly attended. We spoke with staff individually as requested. We talked with patients and staff from all the wards areas and outpatient services. We observed how people were being cared for, spoke with carers and/or family members, and reviewed patients' records of personal care and treatment.

Information about West Midlands Hospital

There were 6,077 visits to the theatre between July 14 and June 15. The five most common procedures performed were:

- Diagnostic oesophago-gastro-duodenoscopy (OGD) including forceps biopsy, biopsy urease tests and dye spray (311)
- Multiple arthroscopic operations on knee (including meniscectomy, chondroplasty, drilling or microfracture) (223)
- Diagnostic colonoscopy, including forceps biopsy of colon and ileum (195)
- Diagnostic flexible sigmoidoscopy (including forceps biopsy and proctoscopy) (145)
- Phacoemulsification of cataract, with lens implant - unilateral (including topical or local anaesthetic) (125)

The Hospital contains the following:

Doctors & dentists working under rules or privileges

119

Doctors & dentists employed

0

Nurses:

21.9

- Inpatient departments

11.2

- Theatre departments

6.3

- Outpatient departments

4.4

Operating department practitioners (theatre)

6.0

Care assistants:

5.3

- Inpatient departments

0.0

- Theatre departments

4.0

- Outpatient departments

1.3

Other hospital wide staff:

41.1

- Allied health professional

6.3

- Administrative and clerical staff

22.1

- Other support staff

12.7

Core private services provided by West Midlands Hospital:

Diagnostic imaging

Endoscopy

Gynaecology

Services accredited or recognised by a national body

Summary of this inspection

Joint Advisory Group (JAG) accreditation for GI endoscopy services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Information about the service

West Midlands Hospital provides both day surgery and inpatient treatment for patients across a range of specialties. Surgical specialities are: orthopaedics, general surgery, breast surgery, ear, nose and throat surgery, gynaecology, urology, cosmetic surgery and ophthalmology. The hospital provides care and treatment for adults over 18 years. No children under 18 years have received care and treatment since September 2015.

Between July 2014 and June 2015, 1,458 overnight patients and 4,619 day case patients were admitted to the hospital. There were 6,077 visits to theatre recorded in that time.

The hospital has 34 beds, of which 29 are currently in use. The hospital has three theatres: one has laminar flow ventilation (a specialist system of circulated air filtered to reduce the risk of airborne infection), one provides treatment for major and minor procedures and one provides endoscopy and minor surgery. There is a three bay recovery area. Theatres are used Monday to Sunday for surgery specialities. There is no dedicated high dependency unit (HDU), however, there was an agreement in place with the local acute NHS trust to transfer patients, should their health deteriorate and they require specialist medical support. Staff were supported with medical input to stabilise patients prior to transfer.

We visited outpatients, radiology, theatres, the endoscopy unit, the ward and the recovery (post anaesthetic) area during our announced inspection on 2 December 2015 and during our unannounced inspection on 12 December 2015. We spoke with the managers for both theatres and the ward area during both our visits. We spoke with 24 staff and nine patients and looked at 13 patients' records.

Summary of findings

Surgery services were found to require improvement under the safe, effective and well led; however they were good for caring and being responsive to people's needs.

- Medicines management and safety required improvement. The theatres department was cramped and the corridor environment was cluttered with equipment which hindered patient access and posed a risk to patient safety.
- The arrangements for governance and performance management did not always operate effectively or consistently.
- Information and analysis of incidents were not used proactively to identify opportunities to reduce risks and drive improvements in care.
- There was no multi-disciplinary team arrangement with the local NHS for cancer patients' care.
- Staff annual appraisals rates required improvement to provide assurance that staff were competent and supported in their roles.
- Systems, processes and standard operating procedures for storage of some medicines were not always reliable or appropriate to keep people safe.
- Participation in external audits and benchmarking was limited. The results of monitoring were not always used effectively to improve quality.

Requires improvement

Surgery

- Patients were treated with kindness and with compassion and felt involved in decisions about their care and treatment.
- Services were responsive to meet the needs of the patients. The admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs.
- Patients were protected from abuse and avoidable harm and openness and transparency about safety was encouraged.
- Staff reported incidents and near misses appropriately apart from in medicines management where improvement was required.
- Numbers of staff including medical, nursing, therapy and support staff were sufficient to meet patient's needs.
- The hospital was visibly clean and there were appropriate systems in place to prevent and control healthcare associated infections.
- Patients were well cared for on the ward and in theatres and pain control was well managed.
- There was evidence of good multidisciplinary working and out-of-hours services were provided when needed.

Are surgery services safe?

Requires improvement

We have rated this service as requires improvement for safe. This is because:

- Systems, processes and standard operating procedures for storage of some medicines were not always reliable or appropriate to keep people safe. Missed doses were not reported as medicines errors.
- Lessons learned from incidents were not always shared among all staff.
- The theatre department was cramped and challenged for space. Equipment and supplies were stored in the corridors without an appropriate risk assessment.
- There was no regular audit in place to monitor completion of the WHO '5 steps to safer surgery' checklist despite this being on the hospital's policy.

However we also saw:

- There were clearly defined and embedded systems, processes and standard operating procedures to keep the departments clean and to protect people from the risk of infection.
- Patients' records were comprehensive, up- to-date and safely stored.
- Staffing levels and skill mix (the range of types and levels of ability of a workforce) were planned, implemented and reviewed to keep people safe at all times. Short notice absences were responded to quickly and adequately to ensure that sufficient staff were on duty.

Incidents

- There had been no deaths in the hospital during the reporting period, July 2014 to June 2015.
- The hospital had an electronic system for reporting incidents and near misses. The transition from paper reporting of risk to electronic reporting took place in the six months preceding our inspection. Not all staff had received training on the new system, however, there was a programme of training in place and all staff were expected to be fully trained by the end of March 2016. Between 1 June 2014 and 31 June 2015 there had been a total of 109 incidents reported. Theatre and ward staff provided examples of concerns which they would report

and learning which had comes from these incidents. These included cancelled operations, faulty equipment and returns to theatre. This demonstrated an open reporting culture within the organisation.

- There was no information available about learning from medicine incidents within the West Midlands Hospital or shared learning between hospitals within the corporate organisation. There was a system to report medicine errors however the ward manager and matron told us that West Midlands Hospital had no medicine errors to report for the last four months. There was no criteria for medicine errors that should be reported. The hospital did not consider a missed dose of a medicine as an error and therefore did not report omissions and did not learn from them. A missed dose should be considered a medication error because it has the potential to cause harmful side effects.
- Managers reviewed and discussed appropriate incidents during clinical governance meetings, heads of departments meetings and Medical Advisory Committee (MAC) meetings. We saw examples of minutes of each of these meetings, which included discussions about reported incidents. However, we saw some incidents which had been through a root cause analysis (RCA) process had not been discussed at MAC meetings and consultants who were not present at the MAC meetings did not always receive updated information.
- Staff felt supported to report incidents and told us they had reported cancelled operations, faulty equipment, wound infections, readmissions and incidents where patients had returned to theatre. Staff told us and we saw evidence that these incidents were investigated and learning was shared with them individually and in ward meetings.
- There had been an increase in incident reporting from April 2015 to June 2015 from one per 100 patients discharged to three per 100 patients discharged. Hospital managers told us this was due to the implementation of the new electronic reporting system and an improvement in safety reporting culture within the hospital. Generally, staff had a good understanding of the different levels of harm from low to serious incidents, but told us they would always discuss incidents with their line managers for clarity.

Duty of Candour

- Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Staff were aware of the hospital's Duty of Candour policy ensuring patients always received a timely apology when there had been a defined notifiable safety incident, however they were unclear about the full meaning of this regulation. They told us they had not received adequate training or information.
- Staff were able to describe what they would do practically. A senior manager told us that staff received information about duty of candour via a discussion session which was included on the Nursing and Midwifery Council training sessions.
- The theatre manager told us that they would always speak to a patient if their operation was cancelled due to resource shortages. They said they would apologise and the operation would be rebooked within seven days. This would be documented in the patient notes.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- West Midlands Hospital participated in the National Safety Thermometer. This is a measure of harm free care delivered to patients relating to pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (blood clots). West Midlands Hospital reported harm free care apart from one venous thromboembolism for July 2014 to June 2015.
- Contracts for care and treatment delivered at private hospitals but funded by the NHS have a target of 95% completion of for venous thromboembolism (VTE) screening. For the time period July 2014 to June 2015, West Midlands Hospital had achieved 99% compliance against this target.

Cleanliness, infection control and hygiene

- The hospital had appropriate policies and procedures in place to manage infection prevention and control (IPC). An IPC policies and procedures file was accessible on the ward and in theatres. Staff were aware of and showed us the location of these policies.

- There was adequate hand-washing facilities and hand sanitising gel available. We observed staff washing their hands between seeing patients and using sanitising gel. The 'bare below the elbows' policy was observed by staff.
- There was appropriate staff and patient attire in theatre and evidence based guidelines for decontamination of operating site being followed.
- When staff entered or left the operating theatres they changed their clothing appropriately to minimise the risk of infection to patients.
- Patient who required urinary catheter insertion had their risk of infection minimised by having a clear plan for insertion, maintenance and removal of the catheter.
- We observed the insertion of a peripheral venous cannula, it was administered in a clean and effective way that minimised the risk of infection to the patient.
- The hospital undertook hand hygiene audits, which included observation of staff hand washing. This showed 100% compliance for correct hand washing for August 2015. Infection control training formed part of the hospital's mandatory training day held annually for all staff. We saw the hospital had achieved its target of 85% compliance with this training at the time of our inspection.
- Managers carried out monthly infection control audits on the ward, theatres and recovery. An action plan was in place to address any identified shortfalls.
- The hospital's 2015 Patient Led Assessment of the Care Environment (PLACE) audit identified a score of 99.7% for cleanliness.
- Information provided by the hospital identified that from 1 June 2014 to 31 July 2015 there had been no cases of methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile, escherichia coli or methicillin-susceptible staphylococcus aureus (MSSA) infections. There were 11 post-operative wound infections reported during this time. Six were for abdominal wounds, two for knee surgery and three for other surgery sites. We saw although managers had carried out investigations into the causes of these infections, detailed root cause analyses had not occurred and there was no analysis to look at potential trends or patterns. This meant that the hospital did not have a robust system in place to learn lessons from these incidents, to improve the safety and quality of care and treatment delivered.
- During their surgical pre-assessment appointment, patients were given a questionnaire which formed a risk assessment for potential infections such as MRSA. If assessed to be at risk, patients were screened. Patients were only admitted for surgery if no infection was identified. Patients with infections were offered suitable treatment and reassessment. This policy complied with the Department of Health 2014 guidelines.
- We saw staff complied with the hospital's policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- We saw the ward areas including patients' rooms were visibly clean. We saw and domestic staff confirmed that cleaning schedules were in place and cleanliness audits were undertaken. The cleanliness audits we saw identified if improvements were needed and confirmed that this was addressed.
- The hospital did not have a sterile services department on site. Arrangements were in place for sterile services to be accessed at another Ramsay Healthcare site. There were suitable arrangements in place to ensure that the flow of dirty to clean equipment was in place and to reduce the risk of contamination whilst the equipment was awaiting collection.

Environment and equipment

- Resuscitation equipment was available on the ward and the theatres so that patients could be immediately resuscitated.
- Equipment was visibly clean, regularly checked and ready for use.
- We saw that theatre staff followed the Association of Anaesthetists of Great Britain and Ireland guideline for checking anaesthetic equipment prior to each operation to ensure safety.
- We saw that patient moving and handling equipment was available and had been appropriately maintained and serviced. Staff told us and we saw there was suitable and sufficient equipment available to support the type of surgical procedures undertaken.
- The management of waste was appropriate with designated areas for the appropriate segregation, storage and disposal of waste.
- Equipment, implants and instruments were appropriate in in compliance with the The Medicines and Healthcare Products Regulatory Agency(MHRA) requirements.

- Emergency call bells for patient and staff use automatically bleeped the emergency team members detailing the location and enabled fast responses to emergencies.
- Closed-circuit television (CCTV) was installed in the car park and hospital entrances which increased patient and staff security.
- The theatre department was cramped and challenged for space. Equipment and supplies were stored in the corridors without an appropriate risk assessment. During our inspection, we found boxes obstructing the exit from the lifts in the theatre department. Managers were aware of this. When we highlighted the risk to safety the lift area was cleared. On our unannounced follow-up inspection the area was clear and easily accessible. Plans were in place to relocate the current outpatient department to another site allowing for redesign of the space available on site to include storage and extension of the theatre department.

Medicines

- There was no onsite pharmacy at West Midlands Hospital, however pharmaceutical services were provided by a local NHS trust. We spoke with two clinical pharmacists and two pharmacist technicians from the local NHS trust who explained that the pharmacy team visited the hospital three days a week to check patients' prescription charts and ensure the hospital had sufficient supplies of medicines. Any concerns or advice about medicines were communicated to the prescribing doctor. Nursing staff told us that they could also contact the pharmacy at the local NHS trust for pharmacist advice if needed including out of hours. We saw that this arrangement worked effectively.
- Medicines were stored securely in locked cupboards. Controlled drugs which require special storage and recording arrangements were stored following hospital policy and safe guidance procedures.
- Medicines requiring cool storage were stored in locked medicine refrigerators and records showed that they were kept at the correct temperature up until November 2015. On our unannounced inspection, we found that for the 12 days of December 2015 in theatre one and theatre two, some daily checks had not been completed. In theatre one, five daily checks (out of 12) were missing and in theatre two, four daily checks (out of 12) were omitted. We alerted staff to these omissions. Without daily checking of fridge temperatures the integrity of medicines may be compromised. Fridge temperature checks were not audited to ensure compliance.
- Ambient room temperature in medicines areas were not recorded
- If patients were allergic to any medicines, this was recorded on their prescription chart.
- We saw evidence that the ward manager received patient safety alerts about medicines from NHS England. Managers told us that action would be taken and safe practice reviewed if it was necessary.
- The Ramsay Group pharmacist visited West Midlands Hospital once a year to inspect the hospital for quality and safety. The last visit before our inspection was in January 2015. It resulted in an action plan for improved security of medicines in theatres. The matron told us the action plan was discussed within the clinical teams. As a result of this action plan lockable cupboards had been installed for all medicines and security of medicines in theatres was improved.
- Ramsay's Group Chief Pharmacist is the Medicine Safety Officer (MSO) for the company. Following a stage 3 directive from the NHS England and MHRA patient safety alert: Improving Medication Error Incident Reporting and Learning (March 2014) the hospital/organisation should have a named Medicine Safety Officer (MSO). The MSO has the responsibility to oversee medication error incident reporting and be the named contact for the MHRA and NHS England" At the time of the inspection we found that hospital staff including senior managers were not aware who the MSO was. However, following the inspection we were informed that the Ramsay Group Pharmacist was the named MSO and visits the hospital once a year.
- The hospital did not have a safety forum in which staff could raise medicine and medicines management concerns. The matron told us that there was a clinical governance meeting however medicines were not usually discussed at this meeting. There was a corporate pharmacy group but the ward manager did not know how often they met although minutes were sent out. This meant that the hospital did not have robust governance and oversight of risks for the safe use and handling of medicines.
- Cytotoxic medicines requiring refrigeration were normally stored in the same refrigerator as other medicines. Cytotoxic medicines are hazardous

substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and are used predominantly for chemotherapy treatment. There were no cytotoxic medicines stored at the time of our inspection as the hospital rarely provided chemotherapy treatment. We were told that cytotoxic medicines if required would be stored on a separate shelf in the medicine refrigerator to reduce the potential risk of contamination of other medicines. The oncology sister had undertaken a risk assessment and recommended that a separate refrigerator should be available for the safe storage of cytotoxic medicines. We were informed by the matron that a separate refrigerator had been requested for storage of cytotoxic medicines only. On our unannounced visit on 12 December 2015, we saw the new fridge that stored chemotherapy medicines was empty, however when we spoke to staff they told us they had acted on our concern from initial inspection and now kept cytotoxins separately.

- Medicines were not always kept within their original container. We found loose strips of medicines which had been removed from their original container inside a locked medicine cupboard for use by the resident medical officer (RMO). This was unsafe practice and did not follow hospital policy. There was a potential risk for the wrong medicine to be picked and placed into another container. We raised this concern whilst on site, the medicines were immediately reviewed and placed in the correct container.
- Medicines labelled for patients were sometimes placed into general medicine stock when the patient had not taken them home. Mangers told us it was standard policy that if medicines had not left the premises they were re-used to limit financial waste. We explained, this may cause risk when patient labels were left on medicines and we were told this practice would be reviewed.

Records

- The hospital used a paper-based records system for recording patients' care pathways. These documents covered the patient's journey from pre-operative assessment and admission through surgery to discharge. Different care pathways were available for the different types of surgery undertaken at the hospital, for example gynaecology, and hip and knee replacement.
- All patient records were stored securely and in locations where confidentially could be assured.
- NHS medical records were available for patients whose treatment was funded by the NHS.
- We looked at pre-assessment information in 13 patient records and saw that staff had clearly documented any tests and investigations undertaken and had recorded patients' medical and social histories prior to them being admitted for surgery.
- The documentation gave an easily accessible record of the patient's journey through the hospital including the procedures undertaken.
- All documentation was legible, dated and signed.
- Staff completed risk assessments during pre-assessment appointments and followed them up on the ward. All patients had a pre-assessment prior to surgery as detailed in the hospital policy, without this surgery would not proceed.
- We saw thorough completion of pre-assessment checks, for example, venous thromboembolism (VTE) (where a blood clot forms in a vein) assessments, consent process and early warning score charts.
- Consultants completed documentation detailing the operation performed and staff filed this in the patient's notes before patients were transferred to the ward. The operation notes we looked at had been typed, enabling clear communication. Ward staff would challenge consultants in instances when this had not been completed.
- Surgical documentation complied with the Department of Health Review of the Regulation of Cosmetic Interventions 2013. This meant documentation was in place to detail product quality, after care and record keeping. This included a register of all cosmetic implants.

Safeguarding

- The hospital had an identified member of staff who was the lead for safeguarding adults. Staff could name the safeguarding lead and were aware of safeguarding principles and practices.
- The hospital's safeguarding policies and procedures were readily available. Staff were aware of their responsibilities to protect vulnerable adults and the actions required to do so.
- Mandatory e-learning for all staff included safeguarding vulnerable adults, levels one and two Information we received from the hospital showed that they met their

target of 85% compliance of staff that had completed training modules for the period July 2014 to June 2015. Safeguarding Adults level three was completed by a matron and two other members of the clinical team with 100% compliance rates.

Mandatory training

- The hospital used electronic learning to provide much of their mandatory training, plus face to face elements where necessary, for example the practical elements of manual handling and basic life support.
- For the period July 2014 to June 2015, mandatory training completion across all staff groups was 85%, this was in line with the hospital's target of 85%.
- Mandatory training covered: manual handling, equality and diversity, basic life support, health and safety, hand hygiene, fire training, information security, adult and children safeguarding levels one and two and risk management. An action plan was in place that linked completion of mandatory training to pay scale progression. This had improved mandatory training rates to nearly 100% by the time of inspection.
- All resident medical officers were qualified in advanced life support, which was a mandatory requirement for the role.
- Staff we spoke with said managers reminded them to complete mandatory training when it was due.

Assessing and responding to patient risk

- Nursing staff assessed risks to patients at pre-admission appointments, which took place for all patients. If any concerns were identified surgery did not take place. These operations were rescheduled or referred back to the NHS. This assessment incorporated the Association of Anaesthetists of Great Britain & Ireland guideline for day surgery and short stay surgery. Staff gave all patients detailed verbal and written information on their procedure.
- The hospital used an early warning score. An early warning score is a guide used by clinicians to determine the degree of illness of a patient quickly and assist staff to identify any deterioration in patients. We looked at 13 patients' records and found that early warning scores were regularly reviewed and accurately reflected the patients' conditions.
- The hospital had a policy in place covering the process to be followed should a patient need to return to theatre unexpectedly out of hours. A theatre team was on call, supported by senior nursing staff, radiologists and physiotherapists.
- There had been three cases of unplanned transfers of an inpatient to other hospitals in the reporting period July 2014 to June 2015. We assessed the proportion of unplanned transfers to be 'similar to expected' compared to the other independent acute hospitals (per 100 inpatient discharges) over the same period.
- There was a formal agreement and protocol in place for patients to be transferred to the local NHS acute hospital if they required high dependency or critical care (level two or three).
- Staff told us and we saw that a 'morning brief' took place daily before each theatre session. We saw that each planned procedure was discussed and notes made. These notes were stored for future reference, should any issues be raised about planning and procedure.
- The World Health Organisation (WHO) surgical safety checklist is a process that involves a number of safety checks before, during and after surgery to avoid errors. The National Patient Safety Agency recommends that it is used for every patient undergoing a surgical procedure. Ramsay Health Care's Theatre Operational Policy included this recommendation. Staff told us that this guidance was followed and we saw the 5 steps to safer surgery, WHO surgical checklist being used in practice.
- There was a Surgical Safety Checklist for with has been specified for cataract surgery and endoscopy.
- We saw compliance with the WHO checklist in 13 records we viewed. However, there was no regular audit in place to monitor completion of the checklist despite this being in the hospital's policy. This meant that hospital managers did not know their staff's compliance with this safety check.
- The resident medical officer (RMO) was always on site and provided an immediate first response in an emergency situation. Due to the size of the hospital the RMO was able to attend incidents usually within five minutes or sooner when required.
- The hospital had a clear admission policy setting out safe and agreed criteria for admission of people using the service.

Requires improvement

Surgery

- There was an appropriate 24-hour telephone contact arrangement in place following discharge for all patients. We saw this information being given and explained to patients on discharge.
- Emergency surgery was not conducted at this hospital.
- Radiologists operated an on-call rota in case imaging services were required out-of-hours.
- All patients considering a cosmetic procedure underwent appropriate and relevant psychiatric history assessments and discussions with a specialist cosmetic nurse to ensure they had been prepared physically and psychologically for their surgery.
- The hospital had a risk register. This identified 10 risks at the time of our inspection. Two of these risks related to surgery, one for theatre staffing and one for theatre capacity to accommodate level of action. This meant that a patient may not be able to have an operation on the day they request. Plans were in place to action these risks involving use of agency nurses to cover staffing shortfalls and use of theatres at the weekend to accommodate capacity.

Nursing staffing

- Ramsay Health Care introduced a new rota management system in 2015. This system allowed heads of departments to manage staff rotas, skill mix, and staff requirements including senior cover requirement. It also provided good visibility of safety and effectiveness indicators for staffing levels and allowed heads of departments to manage sickness and annual leave absences.
- Patient activity levels and acuity were reviewed daily to enable staff numbers to be flexed in clinical areas. This meant that the hospital could ensure staffing levels met National Institute for Health and Care Excellence (NICE) guidelines.
- Actual staffing levels closely met planned levels due to a flexible staff bank. Last minute sickness or increased patient acuity was covered by regular bank staff. This arrangement meant staff were familiar with the hospital and protected people from avoidable harm.
- Arrangements for using bank, agency and locum staff ensured the correct number of staff with appropriate skills and induction to the hospital were available. Only regular bank and agency staff were used to ensure they were familiar with the environment, staff and patients.
- Hospital managers checked for agency staff's competencies. Certain duties were restricted until safety had been assured, for example agency staff did not administer medicines to patients until they had undergone a medication competency assessment.
- Handovers were structured and clearly communicated appropriate patient information. The ward team managed handovers in a way that left staff available to respond to patients' needs.
- On the ward, we saw staffing levels of one nurse to six patients. This was better than the national average (NHS) of one nurse to eight patients and we saw staffing levels at the hospital met the needs of the patients.
- The hospital only undertook elective surgery which meant the number of nursing and care staff hours needed on any particular day could be calculated and booked in advance. Employed staff worked their contracted hours flexibly to cover the rota and any gaps were filled by bank or agency nursing staff or overtime. This is in line with NICE guideline- Safe staffing for nursing in adult inpatient wards in acute hospitals 2014.
- For the reporting period July 2014 to June 2015, the use of agency nurses in theatre had increased from 20% to 39%. The theatre manager told us they used regular agency nurses who were familiar with the hospital, patients and other staff. The same level of agency staff was present at the time of inspection to fill the two whole time equivalent theatre nurse staff vacancies.
- Recruitment was ongoing to address the need to use agency staff although managers told us that this remained a challenge.

Surgical and medical staffing

- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. They also arranged alternative cover from another consultant with practising privileges at the hospital, in the event that they were not available. Hospital staff were given details of consultant appointed to cover the patient's care, however, the on call arrangements were not recorded in any formal way. We were told and we saw that details were communicated at handover times and notes were left on the reception desk. This could lead to confusion or miscommunication of information. We raised this issue

with the hospital's senior managers during our inspection and on our unannounced follow-up inspection we saw that a diary system had been set up to record these arrangements.

- We saw there were no formal arrangements for anaesthetist 'on call' cover. Surgeons would contact their own anaesthetist if required for return to theatre. No incident had ever occurred where an anaesthetist could not be acquired. However, with no formal arrangement there was a risk that cover may not be found.
- The hospital policy required that consultants were available on site within 45 minutes or have suitable cover in place when patients they had treated were on the hospital ward. Therefore, each patient had 24 hours a day, seven days a week consultant cover available.
- Surgical consultants' and anaesthetists' workload varied dependent on patient demand and theatre sessions were scheduled accordingly. A wide range of surgical staff were available, including suitably skilled nurses and operation department practitioners.
- The hospital had a resident medical officer (RMO) who provided cover on site 24 hours a day.
- Staff told us that the RMOs were responsive and would attend to assess patients immediately when requested.
- West Midlands Hospital had a Medical Advisory Committee (MAC) whose role included ensuring that new consultant were only granted practicing privileges at the hospital for procedures they were deemed competent and safe to undertake.
- The role of the MAC also included periodically reviewing existing consultants' practicing privileges and advising the hospital on their continuation. The MAC chair gave an example where practicing privileges had been suspended as a result of concerns raised. An investigation was undertaken and only when the MAC and Senior management team were satisfied with the results of the investigation, the suspension of the consultant's practising privileges lifted. This demonstrated that the MAC was an effective body for monitoring the competence of the consultants practising at the hospital.

Major incident awareness and training

- The hospital had a major incident plan that told staff the actions they should take in the event of emergencies such as fire or power failure. Staff told us that in the event of a power failure any operations in progress would continue with the hospital emergency generator but no other operations would be undertaken until power had been restored. Theatre staff recalled generator testing within the last 12 months.
- Fire safety training was included in the hospital's mandatory training package. Staff could describe the actions they would take in the event of a fire.
- The staff we spoke to could not recollect any fire drills within the last year.

Are surgery services effective?

Requires improvement

We have rated this service as "requires improvement" for effective. This is because:

- Multi-disciplinary team arrangements with local NHS acute trusts were not coordinated to provide effective care for some patients, particularly those being treated for cancer.
- There were shortfalls in management and support arrangements for staff, such as completing staff appraisals and carrying out nursing competency assessments. There was no formal competency framework to support ward nurses with clinical practice and no management oversight of nurses' skills.
- 57% of nursing staff had not received recent performance appraisal.
- The competency register for medical devices and equipment to ensure that staff had the competency to use equipment was out of date and did not include the night staff.
- The outcomes of people's care and treatment was not always monitored regularly or robustly.
- Participation in external audits and benchmarking was limited. The results of monitoring were not always used effectively to improve quality.
- Staff did not carry out MUST care plans for patients who were obese or had experienced recent weight loss.

However we also saw:

- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- When patients received care from a range of different staff, teams or services within the hospital, this was

coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of patient's needs.
- The endoscopy unit had participated in and achieved accreditation from the Joint Advisory Group (JAG) in GI endoscopy.

Evidence-based care and treatment

- We saw that the hospital had systems in place to provide care and treatment in line with best practice guidelines such as the National Institute for Health and Care Excellence (NICE) guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. For example: an early warning score system was used to alert staff should a patient's condition start to deteriorate. This followed the Ramsay Health Care 'Recognition and Management of the Deteriorating Patient' policy.
- Surgical specialties managed the treatment and care of patients in accordance with guidance from NICE and the Royal College of Surgeons (RCS).
- We saw that the RCS Good Surgical Practice guide 2014 was followed. Consultants demonstrated safety, skill and knowledge of the operations to be performed.
- We saw that cosmetic surgery was performed in line with RCS Professional Standards for Cosmetic Practice and the Independent Healthcare Advisor Service guideline for Good Medical Practice in Cosmetic Surgery. This included assessment of patient suitability and reasons for cosmetic surgery, ensuring a detailed discussion with the patient regarding financial implications, a detailed discussion with a specialist nurse, a two week cooling off period for the patient to consider their options and the use of a register for all implants.
- The endoscopy unit had achieved Joint Advisory Group (JAG) accreditation in 2014. This demonstrated that the unit delivered care and treatment in line with national endoscopy standards.
- We observed that patients were encouraged to mobilise as soon as possible after surgery with the support of staff and urinary catheters were removed promptly to reduce the risk of infection in line with NICE guidelines.

Pain relief

- Patients were prescribed and given appropriate pain relief following surgery. We spoke with 12 patients who told us that their pain was well managed with prescribed painkillers.
- We saw that five out of 21 nursing staff had been on a recent pain management training day (October 2015) which had been very helpful and informative in order to keep up to date with the latest practice.
- Staff told us and we saw records showing that pain management was discussed with patients at their pre-assessment appointments and again on admission to the ward. While in theatre, recovery staff were supported by anaesthetists and discussed requirements with patients to ensure they were given appropriate pain relief.
- Records showed that patients were prescribed regular pain relief and additional 'as required' pain relief which was administered in a timely fashion.
- Pain levels were recorded on an early warning score chart. We saw these records were thoroughly completed and pain relief was administered when required.

Nutrition and hydration

- West Midlands Hospital had received a Dudley Food for Health award for offering healthy food choices to patients.This helped to contribute to improving patients' diets and health.
- Records relating to nutrition and hydration were well completed and provided an audit trail of decisions and actions completed. Fluid balance charts were consistently completed and we saw that patients had access to drinks and snacks at all times.
- Staff discussed the management of 'nil by mouth' prior to surgery at patients' pre-admission assessments. Protocols were in place to ensure that food and fluids were taken in line with consultant advice to ensure patients' safety.
- All patients told us that they had been given instructions not to have anything to eat from midnight and no fluids from two hours prior to their admission to hospital in case they were early on the operating list. Theatre staff told us that they discussed the list and informed the ward of the time until which the patient could continue to drink if they were not early on the operating list.
- We saw appropriate prescription and administration of anti-sickness medicines following surgery.
- We saw that malnutrition universal screening tool (MUST) care plans were completed for patients who had

a body mass index under 20. Staff did not carry out MUST care plans for patients who were obese or had experienced recent weight loss. Patients in these categories may be at risk of malnutrition or other dietary problems and should undergo dietary screening according to NICE guideline- Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition.

Patient outcomes

- The infection control nurse contacted patients 30 days after surgery to follow up on their wellbeing.
- Patient Reported Outcome Measures (PROMs) are standardised validated question sets designed to measure patients' perception of health and functional status and their health-related quality of life. The hospital invited all patients (private and NHS) who had undergone hip, or knee and hip replacement surgery to complete a PROMs questionnaire. PROMs data for knee replacements for the year 2014-2015 showed that West Midlands Hospital's patients had a slightly above average expected health gain for these procedures.
- The Oxford Hip and Knee Score is a patient reported outcome questionnaire that was developed to specifically assess the patient's perspective of outcome following total knee arthroplasty. Arthroplasty is a surgical procedure to restore the integrity and function of a joint. The hospital scored a slightly higher improved patient health gain compared to the rest of England for both hip and knee surgery.
- Participation in other audits and benchmarking was limited.
- Information provided by the hospital showed that there had been three cases of unplanned returns to theatre between 1 April 2014 and 31 March 2015. For the time period July to September 2014 there had been two cases of unplanned return. We assessed the proportion of unplanned returns to be 'similar to expected' compared to the other independent acute hospitals for which we hold this type of data.
- There had been seven unexpected readmissions to the hospital within 31 days of discharge between 1 July 2014 and 31 June 2015. CQC has assessed the proportion of unplanned readmissions to be 'similar to expected' compared to the other independent acute hospitals for which we hold this type of data.

Competent staff

- The hospital provided opportunities for induction, learning and development for all staff.
- New staff had a supernumerary period of two weeks to ensure they were familiar with the hospital, policies and procedures before they were in charge of patient care. This period could be extended if required. Agency staff were orientated to the hospital on their first shift. Agency staff who were block booked for several shifts received medication competency assessments, such as Intravenous therapy administration, to ensure patients were protected from risks. However there was no formal competency framework to support ward nurses with clinical practice. Training certificates were issued and retained in nurses' personal files, however it was unclear what nurses were competent at, without asking them directly. The senior ward manager advised us this was an area for improvement. Numerous nurses had worked at the hospital for many years and senior management told us they now needed a competency framework to record competency skills and practice. The senior ward manager was confident in the abilities of the nurses who worked at the hospital.
- When new policies were introduced managers had a 'read and sign' sheet which ensured the new information was disseminated to all relevant staff. The level of embedded learning was not monitored.
- The competency register for medical devices and equipment to ensure that staff were safe to use equipment was out of date and did not include the night staff. This meant there was a risk that staff may use equipment that they have not been trained appropriately to use.
- In 2014, 89% of surgical staff had had an appraisal. However we saw eight out of 14 (57%) ward nurses had not received an appraisal within the last 12 months. Ongoing clinical supervision was not seen as a priority, we were told by the senior management team that clinical supervision was completed with staff but not recorded.
- Staff who delivered training within the hospital were supported by their managers and team leaders with protected time to ensure this part of their role was fulfilled.
- There was a process in place for checking General Medical Council and Nursing and Midwifery Council registrations, as well as other professional registrations.
- Consultants working at the hospital were utilised under practising privileges (authority granted to a physician or

dentist by a hospital governing board to provide patient care in the hospital) and consultant competencies were assured through their NHS annual appraisals and the General Medical Council (GMC) revalidation process.

- All consultants must have had an annual appraisal by an approved appraiser to maintain practising privileges at West Midlands Hospital. We looked at a selection of consultants' NHS appraisals and we were satisfied that these requirements were met.
- Consultant competencies were also assured through the clinical review process. This formed part of the review and included reviews of the clinicians' whole practice appraisal and untoward incidents, for example: increased new patient ratio to follow up, overbooking of outpatients department appointments, behavioural concerns and complaint data. However, reviews at West Midlands Hospital did not take place every two years, but every five years. We were not confident that a five yearly check was frequent enough to review consultants' performance and practice. Senior managers explained this was part of the corporate policy, however this would be escalated to the corporate team.
- Information we saw identified that 100% of consultants had an in-date NHS appraisal (based on 15 months' expiry) and had supplied in-date evidence of indemnity.
- The role of the Medical Advisory Committee (MAC) included ensuring that consultants were skilled, experienced and competent to perform the treatments they undertook. The MAC representative told us any concerns identified with a consultant's competence would be managed swiftly to protect patients.

Multidisciplinary working (MDT)

- There were no MDT arrangements in place with a local trust for patients' cancer care and treatment. The National Institute for Health and Care Excellence (NICE) recommends that patients with cancer should be managed by a multidisciplinary team. The local NHS trust had declined to include patients from West Midlands Hospital in their MDT discussions which meant that patients may experience disjointed and delayed care. We saw examples of patient referral to the NHS but no pathway for shared care.
- MDT working was evident within the hospital. This ensured that patients' needs could be met across a range of treatments and therapies. We observed medical staff, nursing staff, therapists and pharmacists working together as a team on the ward. Records of care and outcomes were maintained by the whole multidisciplinary team. Ward rounds took place daily, although this mainly included only doctors and nurses.
- Discharge letters were sent to patients' GPs with details of procedures carried out, follow up arrangements and any medication prescribed.
- Physiotherapy was available on the ward and following discharge when needed.
- A dietician and speech and language therapist with practising privileges could be called upon if required.
- We saw effective communication, partnership and teamwork among theatre staff from several disciplines.

Seven-day services

- Theatres were available 8am to 8pm Monday to Friday, 8am to 6pm on Saturdays and 8am to 4pm on Sundays.
- Theatres were also available for any patient needing to return to theatre 24 hours a day, seven days a week when the need arose. There was an on call rota which included scrub staff (specially trained staff who directly assist surgeons in the operating room). Staff were available within 30 minutes if required. Staff worked variable hours to accommodate surgeons' requests.
- Out-of-hours pharmacy advice was available from the local NHS hospital, but there was no on-site pharmacy. Medicines could be couriered from the local NHS hospital if required out of hours under a service level agreement.

Access to information

- For some patients, referral notes from the GP were available with comprehensive patient information prior to their initial consultation, for example NHS e-referral patients. This ensured the hospital had all the information required to make informed judgements about patient care.
- Prior to surgery, patients were required to attend an assessment clinic run by a qualified nurse. The booking form and NHS letter were available at the clinic for NHS patients. For private patients the nurse obtained the information at the clinic.
- Any electrocardiographs (ECGs) that were required for patients were read by the resident medical officer (RMO) and any concerns raised with an anaesthetist.

Requires improvement

Surgery

- Further information was gathered during the assessment to judge whether a patient was suitable for surgery, for example height, weight and blood pressure. Appropriate blood tests were also undertaken.
- There were paper based records for each patient. All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- Observation records were kept in each patient's room and were accessible to patients and staff.
- Staff told us they had access to policies and procedures and felt they were kept informed by the management team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were clear about their responsibilities in relation to gaining consent, including how to assess and make best interests decisions on behalf of people who lacked capacity to consent to their care and treatment.
- Deprivation of Liberty Safeguards training was included in mandatory training and had an 85% compliance for all staff. This met the hospitals target.
- Consent forms complied with current Department of Health guidance. Consent forms identified the procedure to be undertaken, its associated risks and documented the health care professional responsible for consulting the patient. They also recorded signatures from patients indicating that they were providing consent to undergo the proposed procedure.
- We looked at forms recording consent for those patients undergoing surgery at the time of our inspection and found they were fully completed
- Completed Mental Capacity Act training was 85% for all staff.
- Staff told us that Deprivation of Liberty Safeguards (DoLS) meant stopping patients leaving or restraining them against their will. Staff had an understanding of DoLS. The hospital had not made any Deprivation of Liberty Safeguards applications for the current year to date.

Are surgery services caring?

Good

We have rated this service as good for caring. This is because:

- Feedback from people who use the service and those who are close to them was positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. People felt supported and told us staff cared about them.
- People were involved and encouraged to be partners in their care and in making decisions, with any support they needed. People understood their care, treatment and condition.
- Staff helped people and those close to them to cope emotionally with their care and treatment. People's social needs were understood. People who were vulnerable or who had complex care needs were enabled to manage their own health and care when they could, and to maintain independence.

Compassionate care

- Patients spoke in complimentary terms about the staff and the care they received. One person said they had received "really good care and thorough treatment". Another person said "all the staff have been so kind and caring, nothing is too much trouble".
- We observed all staff knocking on doors to patients' rooms and waiting for a response before entering.
- We saw genuine, caring, compassionate interactions between staff and patients during our planned inspection and our unannounced follow-up visit.
- The 2015 PLACE audit scored the hospital 89.3% for privacy and dignity.
- For inpatient services 99% of 73 patients who responded said they would recommend this hospital.

Understanding and involvement of patients and those close to them

- Patients told us that they had received sufficient information prior to their planned surgery. Patients were

provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. They told us that they had any risks explained to them.
- Patient said they had a named nurse at the start of the shift and the same nurse usually looked after them the next day if they were on duty. This provided continuity of care.
- Staff gave an example of when they had supported a patients carer to stay overnight as this was what the patient requested to reduce the anxiety of a hospital stay.

Emotional support

- Patients had access to support from clinical nurse specialists, for example, colorectal and stoma nurse specialists.
- Patients has their holistic wellbeing assessed regularly whist in hospital and patient concerns or request were addressed promptly.
- All cosmetic surgery patients were assessed on two separate occasions by their consultant prior to confirmation of surgery. All cosmetic procedures were subject to a 14 day 'cooling off period' after the initial consultation where the patient could reflect on their decision to ensure it was right for them.
- A specialist nurse for cosmetic surgery assessed and supported patients' psychological wellbeing. All patients undergoing cosmetic surgery had an appointment with the specialist nurse.

Are surgery services responsive?

Good

We have rated this service as good for responsive. This is because

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- People could access the right care at the right time. Waiting times, delays and cancellations were minimal and managed appropriately.
- Care planning for patients with complex needs, such as patients living with dementia or a learning disability, was effective.
- Complaints and concerns were always taken seriously, responded to in a timely way and listened to and improvements were made to the quality of care as a result of complaints and concerns.

Service planning and delivery to meet the needs of local people

- The hospital provided both privately funded care and had a contract to provide identified procedures under the NHS. The admissions mix was 72% NHS, 17% insured and 11% self-pay.
- There had been an increased patient volume of 35% over the last three years, mostly due to a growth in NHS business.
- The hospital did not provide emergency care and all admissions were planned and arranged in advance**.**
- Patients and staff all told us that parking was a problem as there were not enough spaces to accommodate everyone working at or visiting the hospital. Staff told us they believed the planned relocation of outpatients and diagnostic imaging to a new building would improve the situation.

Access and flow

- The admission process and care provided was the same for private patients and NHS patients.
- Patient admissions for theatre were staggered throughout the day to ensure patients did not experience extended waiting times and sufficient time was allowed for the theatre to be cleared and prepared for the next patient.
- A theatre recovery area was available with dedicated staff who had received appropriate training. If a patient's condition deteriorated while they were being cared for by recovery staff, additional help was available from theatre staff.
- Discharge only took place at appropriate times of the day. Discharge arrangements were discussed with patients at pre-assessment to ensure there was support in place following a procedure.
- The referral to treatment waiting time targets for NHS patients between 1 July 2014 and 31 June 2015 were 100% for all areas.

Requires improvement

Surgery

- Patients were seen by the resident medical officer and consultant before discharge and all treatment was communicated to patients' GPs.
- In the six months preceding our inspection the hospital had cancelled only 27 out of 2,852 operations due to non-clinical reasons such as insufficient theatre space as a previous operation had taken longer than expected, or no anaesthetist available. This equated to less than 1% of all scheduled procedures. All cancelled operations were risk assessed and rescheduled within seven days or at the patients convenience.

Meeting people's individual needs

- All patients had a single room with en-suite toilet and shower facilities. All rooms were accessible to wheelchair users.
- Care planning for patients with complex needs, such as patients living with dementia or a learning disability, was effective and commenced at pre-operative assessment and a multi-disciplinary planning meeting was held. Staff showed us an example of the arrangements which had been planned for one patient several months before their planned admission. Dementia training was included in the staff mandatory training package.
- The hospital had an interpretation service available for patients and their families who did not have English as their first language.
- We saw clear signage detailing the patient chaperone policy.
- The hospital sent pre-operative information to patients before they attended for their surgery. The information included details about fasting times, admission instructions and a procedure-specific information leaflet. This information was only available in English.
- Staff gave patients written information on discharge (including a discharge brochure, procedure-specific information, wound care, medicines information and a copy of the discharge summary). They were also given telephone numbers to call, 24 hours a day, in the event of problems following discharge.
- Surgery for both NHS funded patient and privately funded patients was based on clinical need and not according to funding method.
- The hospital's 2015 Patient Led Assessment of the Care Environment (PLACE) audit scored 96.1% for food served in the hospital ward. Patients we spoke with were happy with the food they had received.

Learning from complaints and concerns

- The hospital had received 44 complaints in 2014. Information we saw showed that managers had investigated the complaints in accordance with their hospital's policy and timescales. When needed, actions were undertaken. For example, staff told us that because of one complaint they now spoke to patients every hour prior to their operation. This helped to reduce patient anxiety and kept them updated on the progress of the theatre list and possible time of their operation.
- We saw information in the hospital about how to raise concerns using a feedback form. This form could be completed either while the patient was in the hospital or it could be returned to the hospital after discharge. Staff were encouraged to respond to complaints at the time the concern was raised. We saw contact details for the Independent Healthcare Ombudsman on one of the leaflets available was incorrect; we highlighted this to the management team who told us they would address the issue.
- Staff told us about learning shared following recent complaints. We were given an example where a patient had complained that their regular medication had not been administered on one day of their stay at the hospital due to it not being prescribed. Staff now ensured that all regular medications were prescribed by the resident medical officer. The ward sister monitored this process to ensure it was carried out.
- Complaints were reviewed at the monthly heads of departments meetings, governance meetings and Medical Advisory Committee (MAC) meetings where outcomes, lessons learnt and improvements in practice were discussed. We saw minutes from meetings where these had been discussed.

Are surgery services well-led?

Requires improvement

We have rated this service as required improvement for well-led. This is because:

- The arrangements for governance and performance management did not always operate effectively or consistently.

- Information and analysis of incidents were not used proactively by the senior management team to identify opportunities to reduce risks and drive improvements in care.
- The senior management team did not have robust governance and oversight of risks for the safe use and handling of medicines.
- Senior management did not ensure staff were not supported with up to date annual appraisals and did not have a robust plan to complete the outstanding appraisals.

However we also saw:

- Staff in all areas knew and understood the hospital's vision, values and strategic goals.
- The hospital proactively engaged and involved all staff and ensured that the voices of all staff were heard and acted on. The leadership actively promoted staff empowerment to drive improvement and a culture where the benefit of raising concerns was valued.
- Management encouraged staff to attend training session's specific to their job roles and protected time was given to staff to further their progression.

Vision, strategy, innovation and sustainability for this core service

- Staff were aware of and understood the hospital's and Ramsay Health Care's vision and values, known as the 'Ramsay Way', and how their role and behaviour would achieve these values. Staff felt they had ownership over the vision and felt proud of their organisation.
- Independent health services were dependent on demand for their services. Information we saw showed that demand for services at West Midlands Hospital had increased by 35% over the last three years.
- Managers supported and encouraged a positive culture of staff development and empowerment.

Governance, risk management and quality measurement for this core service

- The clinical governance meeting where incidents were discussed was linked into the heads of departments (HODs), senior management and the Medical Advisory Committee (MAC) meetings. This provided both senior managers and clinicians opportunities to review risk and take appropriate actions to address and reduce highlighted risks. However, there was no governance arrangements in place to routinely discuss non-clinical issues for example, appraisal rates for staff.
- Consultant surgeons and anaesthetists were represented at the MAC. We were told that incidents and complaints were presented and discussed at the MAC. However, we saw that the root cause analysis (RCA) and lessons learnt from an adverse incident involving labelling and transportation of tissue samples had not been shared with consultants. During our inspection, several consultants told us this was the first time they had heard of this incident. We were not reassured there were effective systems in place to ensure that all incidents were discussed at the MAC.
- Managers carried out RCA's for individual incidents and we saw action plans were in place with appropriate timescales for review. However, potential themes and trends were not analysed. For example, the hospital had six surgical site infections (SSI's) relating to abdominal wounds. There was no RCA to identify any potential common links and this had not been discussed at the MAC meeting. We saw this as a missed opportunity for the hospital to look at patterns and learn from SSI's.
- The consultants' biennial review included a clinical review which looked at specific areas of their activity, for example: an increase in new patient ratio to follow up, increased rates of outpatients appointments and behavioural concerns would be reviewed and highlighted for further investigation. These reviews usually take place every two years, however, we saw reviews of consultants at West Midlands Hospital were carried out every five years. We were not confident a five yearly check was frequent enough to review consultants' performance and practice. Senior managers told us this frequency was a directive from Ramsay Health Care UK, this was being reviewed.
- The hospital had introduced Quality Improvement Lead in September 2015. We saw the role involved following up incidents, complaints and compliment actions, dissemination of lessons learned to each department and monitoring of ongoing actions. Staff and senior management told us that the role had made a significant improvement to quality and risk issues and that actions and lessons learned from incidents and complaints was more robust and had started to embed in routine practice. For example, we saw how a complaint relating to treatment overcharging had been

addressed promptly, remedial actions had been put in place and the quality improvement lead had ensured all relevant departments were aware of the complaint and actions implemented.

- We saw infection control audits that revealed areas for improvement within the theatre department. The infection control lead had addressed these issues by providing a study day for staff on aseptic no touch technique. After the study day individual practise was observed to ensure improvement.
- The surgical team were not up to date with 5 steps to safer surgery, WHO surgical checklist audits because they had been in post for three months but there was a plan in place to ensure this audit was completed in a timely fashion.
- The hospital risk register we reviewed during our inspection recorded 10 identified risks. Two of these risks related to surgery. One risk referred to recruitment of theatre staff which was rated high and one to a lack of theatre sessions available to accommodate patients. The theatre manager discussed with us the action plan to manage the risks and they discussed the recruitment plan along with timescales in which they were expected to be completed. Other risks that we identified during our inspection such as the storage of equipment in theatre corridor's was not on the risk register.

Leadership/culture of service related to this core service

- There were no MDT arrangements in place with a local trust for patients' cancer care and treatment. The local NHS trust had declined to include patients from WMH in their MDT discussions which meant patients may experience disjointed and delayed care. We saw the hospital management team were aware of this issue but had not had not addressed it with the NHS trust or the Clinical Commissioning Group and this was not identified on the risk register.
- We saw eight out of 14 ward nurses (57%) had not received an appraisal within the last 12 months, two out of four Heads of department were out of date with their annual appraisal and a senior manager had not received an appraisal within the last 18 months. We were told one to one meetings were regularly held between senior management and heads of department, and clinical supervision was carried out for ward staff, however these meetings were not documented.
- The hospital director led the hospital supported by the matron. Leadership within surgical services was provided by the theatre manager who managed theatre activity and a clinical services manager who managed nursing staff on the ward. A clinical governance and improvement lead reviewed clinical governance both within surgery and throughout the hospital.
- The ward and theatre staff told us they had good leadership from both local and senior management and they found the ward and theatre manager approachable. The theatre manager has been in post for three months following a period where the department was without management.
- We saw the infection control lead was supported to attend annual conferences on infection control and they liaised with their colleagues in similar roles in other Ramsay Health Care hospitals.
- Staff told us that both the hospital director and heads of departments were visible and supportive and they could approach them with any concerns and they were receptive to extra staffing requests to ensure patient safety.
- Staff and managers told us that poor behaviour or performance was challenged and appropriately addressed. We saw an example of poor compliance with aseptic no touch technique in theatre, appropriate training and challenge was put in place to support the individuals.
- All staff told us that the hospital was a friendly place and they liked coming to work. They told us that they would recommend the hospital to their friends and family for care and treatment.
- There was an increase in incident reporting from March 2015 to June 2015 from one per 100 patients discharged to three per 100 patients discharged. Managers told us this was due to a positive reporting culture and that staff felt empowered to report incidents as they were confident action would be taken to improve services for patients.
- Staff told us they had faith in the management team to drive improvements in care.

Patient and Staff engagement

- Staff were not fully aware of what Duty of Candour meant in practice, training had not been effective to ensure understanding.
- The staff we spoke with felt valued and that senior managers engaged with them.

Requires improvement

Surgery

- Staff received an annual salary review only if all mandatory training had been completed.
- Each bedroom on the ward had a notice board that had important information displayed from fire escape routes, food choices and patient feedback methods.
- We saw staff notice boards by the dining room displaying information about upcoming development courses, clinical effectiveness and infection audit results.
- The hospital held a daily meeting attended by representatives from each department. Attendees rotated round all staff members to ensure that everyone was aware of and involved in the process
- All staff had a confidential support line provided by Ramsay as an independent confidential service. This was a 24-hours a day, seven days a week service, and could be used by staff for emotional support or to raise concerns.
- Staff told us that they all received a newsletter and information on their pay slip which updated them about events and incidents at the hospital.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

West Midlands Hospital provides services to patients referred from the NHS, those who are funded by private health insurance and those who are paying for their own treatment. Between July 2014 and July 2015, 71.7% of patients seen in its outpatients and diagnostic imaging departments were NHS funded; the remaining 28.3% were insured or self-pay patients.

The outpatients department has six consulting rooms and two nurse pre-assessment rooms. It offers cosmetic, surgery pre-assessment, cardiology, dermatology, endocrinology, ear, nose and throat, gastroenterology, general medicine, gynaecology, oncology, ophthalmology, oral surgery, orthopaedic, plastic surgery, spinal surgery urology and vascular surgery clinics. It also provides physiotherapy for a range of conditions including back injuries, women's health, sports injuries, musculoskeletal assessments and treatment and post-operative therapy.

The diagnostic imaging department (also known as radiology) provides x-ray, ultrasound and mammography services. Computerised tomography (CT) and magnetic resonance imaging (MRI) services were provided by visits from a mobile scanner unit supplied by another company in the Ramsay Health Care group.

During our inspection we spoke with six patients and relatives and 11 staff, and looked at 13 sets of patient records.

Summary of findings

Overall we rated outpatients and diagnostic imaging services as 'requires improvement' We rated 'safe' and 'well led' as 'requires improvement', however, we rated caring' and 'responsive' as 'good'.

- The hospital had an unsatisfactory patient record management system and informal process for dealing with consultant absences.
- Interventional radiology was not completed in a consistent manner.
- Patients and relatives told us they were well cared for by friendly, compassionate staff; services were planned and delivered to meet the needs of patients using the hospital
- There was a positive management culture and effective staff and public engagement.

We report on 'outpatients and diagnostic imaging services' but do not give a rating for 'effective'.

- In the 12 months leading up to our inspection 75% of outpatients staff and 66.7% of physiotherapy staff had had an appraisal, however no appraisals had been recorded for radiology staff.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated outpatients and diagnostic imaging as 'requires improvement' for safety because:

- The hospital did not always hold records of patients who had been seen in the outpatient clinics, which is a legal requirement.
- The WHO safety checklists for interventional radiology were not completed consistently or audited at regular intervals and needed more effective systems in place to ensure the proper process was followed.

However we also saw:

- With the exception of carpeted floors in consulting rooms, which pose an increased risk of infection, infection prevention and control practices and procedures were effective.
- Incident reporting was consistent and staff had confidence in the system. Learning from incidents was regularly shared among all staff.
- Medicines were stored securely and safely.
- Sufficient numbers of suitably qualified staff were available to meet patient's needs.
- Completion of mandatory training was good and appropriate levels of safeguarding training had been completed.

Incidents

- Incidents were recorded on an electronic system, and that feedback and lessons learnt were shared at the department's staff meetings. Staff in outpatients and diagnostic imaging told us that the incident reporting system was accessible, that there was a 'super user' on site who assisted with any queries together with guidance documents at most work areas.
- Staff in both departments told us they always received an acknowledgment of incidents they reported, often accompanied by requests for extra details or information to assist with investigations. Lessons learnt were compiled by the hospital's quality improvement manager and fed back at heads of department meetings. Department heads then passed feedback on to individual staff members or at team meetings as appropriate. Staff told us managers had a proactive approach to any issues they reported.
- The radiology manager told us they could automatically refer incidents on the reporting system to the hospital's radiation protection advisors. Radiation protection advisors hold qualifications certified by organisations recognised by the Health and Safety Executive. They assess and advise on compliance with the Ionising Radiation Regulations 1999.

Duty of Candour

- The outpatients and radiology managers demonstrated a good understanding of the hospital's duty of candour obligations should an incident result in harm to a patient.
- They described the process as being open and honest, apologising if the hospital was to blame and keeping an open dialogue with the patient or their representatives during an investigation.
- They told us it was about a "responsibility to report problems in order to protect patients".

Cleanliness, infection control and hygiene

- All staff and managers we saw in the outpatients' and diagnostic imaging departments were observing 'bare below the elbow' guidance. This meant that patients, visitors and staff were protected from the risk of infections from micro-organisms carried on clothing and jewellery.
- Posters detailing the World Health Organisation's 'five moments for hand hygiene' were displayed throughout the outpatients and diagnostic imaging departments.
- Consulting rooms were carpeted throughout. The outpatients' department manager told us that this was not considered to be a problem because the rooms were only used for consultations rather than treatment, and the department had spill kits available to deal with any fluids that were spilled on the floor. They told us they had never had to use the kits as those rooms were mainly used for consultations and invasive procedures rarely took place. The carpets were visibly clean, without any staining. Department of Health guidance for 'all providers of NHS care' states "if carpets are to be considered for non-clinical areas (for example, interview rooms, counselling suites, consulting rooms), it is essential that a documented local risk assessment is

carried out with IPC involvement and a clearly defined pre-planned preventative maintenance and cleaning programme is put in place." We saw the hospital had carried out an IPC risk assessment for the carpeted areas.

- Flooring in the diagnostic imaging rooms was wipe-clean, and spill kits were available.
- All of the consulting and imaging rooms we inspected had hand-washing facilities, antibacterial hand gel and cleaning wipes available. Hand hygiene posters were displayed.
- No incidences of MRSA, MSSA or C. difficile infections had been reported in the hospital between July 2014 and June 2015.
- The outpatients manager told us that any needle-stick injuries suffered by patients, visitors or staff were reported to the hospital's infection prevention and control (IPC) link nurse. The injury was managed using a 'sharps injury pack' which was held in the department. We were shown the sharps injury pack and saw that it contained a cover sheet giving immediate actions (bleed, wash irrigate, cover and report), an information sheet for affected staff, a blood-borne virus risk assessment tool, an exposure pathway flowchart, a template for completion of a blood sample analysis request and the process for recording needle-stick injuries on the hospital's electronic incident reporting system.
- The IPC link nurse carried out regular environment and hand-washing audits in outpatients and radiology. We were given copies of the audit results from July to November 2015. Radiology scored 88% in its environment audit, and outpatients scored an average of 92%. Hand hygiene scored 100% in July 2015 and 94% in December 2015.
- In the outpatients department sluice, we saw a cleaning matrix detailing when various items of equipment should be cleaned and whose responsibility each was. This ensured that equipment was regularly cleaned and protected patients from infection.
- We saw 'I am clean' stickers on several items of equipment in the department. This meant that staff could be confident that equipment they were using had been cleaned prior to use.
- Used linen bags in the outpatients department sluice were not over-full and notices were displayed stating when and how they should be changed.
- Radiology had not had any reportable radiation incidents in the year leading up to our inspection.

Environment and equipment

- Outpatients had six consulting rooms and two pre-assessment rooms. The pre-assessment rooms were used by nurses who carried out initial checks with patients before they were seen by consultants who held practising privileges at the hospital.
- Conversations at the outpatients reception desk could not be overheard from the seats in the waiting area.
- The sound of conversations could be heard from outside consulting room doors, but soundproofing was sufficient that the words being spoken were not audible.
- We saw that qualified nurses carried out daily and weekly checks on the resuscitation trolley in the outpatients department. The checks were recorded on a form kept with the trolley, and we saw that none had been missed during the three months preceding our inspection. We found that the defibrillator was in working order and the oxygen cylinder was full. We inspected a selection of consumable items and medicines in the trolley and found they were all properly stored in intact packaging and were in date.
- The physiotherapy department had a non-slip floor surface and all of the equipment we inspected was in a good state of repair.
- We looked at service records for all of the x-ray equipment in the hospital and found they were all up to date.
- The PAT dates on the medicines refrigerator and humidifier in outpatients were overdue having expired in 2013 and 2014 respectively. We told the OPD manager about this while we were on site and they immediately contacted their estates department to arrange for testing to be carried out. This request identified the in date (2015) testing record was located on the plug and had not been seen at the time of inspection. The hospital agreed a review of the process was necessary for updating equipment PAT testing notices/stickers to avoid confusion and lack of clarity re correct identification
- We were given a copy of the most recent radiation protection advisor audit of the hospital's diagnostic imaging department. The audit was carried out in June 2015 and overall the department was rated as "nearly fully compliant with only a few minor improvements

necessary". The improvements mainly related to new documentation and none had any impact on safety for patients or staff. At the time of our visit we saw the department was compliant.
- Radiation warning signs were clearly displayed outside all appropriate rooms in the diagnostic imaging department.

Medicines

- Prescription forms were kept secure in locked cabinets and individual forms were issued to consultants when required. The number of the prescription form issued was recorded in a log book along with details of the patient for whom it was used.
- Radiologists prescribed any medicines, including enemas and contrast media, which were required by patients undergoing diagnostic imaging. No controlled drugs were stored in either the outpatients or radiology departments.
- We looked at a selection of medicines in the outpatients department's resuscitation trolley and found they were all properly stored in intact packaging and were in date. Records showed the medicines were checked by a pharmacist from a local NHS trust.
- The outpatients department medicines cabinet had a thermometer on its door, which recorded minimum and maximum temperatures. We were shown the hospital's policy for monitoring and recording these temperatures. We saw records of temperature checks for the last three months, which were recorded daily without any omissions. We were also shown the policy for dealing with abnormal temperature readings.
- We checked a sample of 15 medicines stored in outpatients and found they were all in date, had intact packaging and were stored tidily in a clean environment.
- Contrast media, a type of medicine used during diagnostic imaging procedures, was kept in a locked cabinet in the radiology department, and only suitably qualified staff had access to the key.

Records

- The hospital kept records for anyone who was treated as an inpatient, however they did not hold records of consultations for everyone seen in the outpatients department, which is a legal requirement.
- We looked at records for a random sample of 15 patients out of 150 who had attended outpatients one a day in November 2015. The hospital did not hold any records for five of these patients, which was 33% of the sample.
- The outpatients manager told us that the hospital was moving from paper patient records to an electronic system in May 2016, and that that system would ensure that they held records of all patients seen in outpatients as well as those treated as inpatients.
- Quarterly audits were carried out on radiology request forms. The audits checked that patient details were fully and correctly completed, that sufficient information was given about the procedure requested, that procedures were carried out correctly and that images were of a high enough quality and were stored and shared appropriately. We were shown copies of the audits completed between February and October 2015. The department had achieved scored of 98% or higher in every audit, with two being scored at 100%.
- The outpatients receptionist's computer screen had a privacy filter which meant that nothing displayed could be read by patients or relatives.
- If a patient used the chaperoning service while being examined by a consultant a rubber stamp was used in the patient's records, which read 'Chaperoned by' followed by space for the name of the chaperone.
- Diagnostic imaging used a national standard image sharing service to send images for radiologists' opinions and to provide results to services that had referred patients.

Safeguarding

- The outpatients manager was trained to level two vulnerable adults safeguarding and that the matron was trained to level three. They told us they had never had to make a safeguarding referral but felt confident they would be able to do so if necessary with support from senior managers and by referring to a safeguarding flow chart which was available to all staff. We saw a copy of the flow chart displayed on the outpatients manager's office wall.
- The outpatients manager told us that all staff completed vulnerable adults training as part of their mandatory courses, and that the hospital had a policy about vulnerable adults. We were shown a copy of the Ramsay Healthcare 'Safeguarding Adults at risk of Abuse or Neglect' policy and saw that it provided

comprehensive information on the definitions and types of abuse and what action should be taken by staff who suspect that a patient or other vulnerable adult had been subject to abuse.
- Mandatory e-learning for all staff included safeguarding vulnerable adults, levels one and two.
- We saw leaflets promoting awareness of female genital mutilation displayed and available for staff, patients and visitors.

Mandatory training

- Mandatory training records for outpatients staff showed that all staff had completed their training day, which covered all compulsory subjects, apart from one staff member. The remaining member of staff was booked in for training the week after our inspection. This meant with the exception of one staff member the department scored 100% for mandatory training.
- Staff told us their mandatory e-learning included safeguarding and dementia awareness, and that other subjects such as basic life support, infection prevention and control and blood sample handling were delivered face-to-face.
- Mandatory training records showed the following subjects were included:
- Basic life support
- Customer service
- Data protection
- Fire and personal safety
- Equality, human rights and workplace diversity
- Health and safety
- Infection control
- Information security
- Manual handling
- Safeguarding adults levels one and two
- Safeguarding children levels one and two, and level three for some staff
- Sharps and blood-borne viruses

Staff were encouraged to complete their mandatory training It was linked to pay progression.

Assessing and responding to patient risk

- We saw the radiology department were inconsistent when completing the WHO safety checklist for Interventional Radiology. Staff told us they were only a small team, knew each other's clinical practice well and did not feel they needed to complete the checklists. We fed this back to the senior management team who assured us this would be addressed as a priority.
- Nursing staff were available in or close to the outpatients waiting room. Reception staff told us they would call a nurse if a patient or relative became unwell. The outpatients manager described one occasion when a member of the public had walked in to outpatients complaining of chest pains. Although the hospital does not have an emergency department staff looked after them, dialled 999 for an ambulance and performed an electrocardiogram (ECG) which is test which measures the electrical activity of your heart to show whether or not it is working normally.
- A resuscitation trolley was kept in outpatients to allow staff to care for patients or carers in the event they became seriously unwell.
- Radiology staff used a six-point check before carrying out any investigation, to ensure that the correct procedure was being carried out for the correct patient.
- A mobile magnetic resonance imaging (MRI) scanner from another company in the same group visited the site weekly. When it was on site a telephone connection to the hospital's network was installed to allow staff in the MRI unit to call for help if a patient became unwell. The hospital had carried out timed trials to ensure that outpatients staff were able to respond to calls from the MRI unit, with their resuscitation trolley, in a timely manner.
- Resuscitation bleeps were held by the resident medical officer, matron and mangers in outpatients, theatres and the ward.

Nursing and radiology staffing

- Outpatients had one 30-hour nurse vacancy, which had recently arisen when two part-time staff had moved from permanent contracts to work on the hospital's bank. The outpatients manager told us that a number of applications had been received for the vacancy and that interviews were in progress.
- During the period July 2014 to June 2015 outpatients had not used any agency nursing staff. We saw there was an agency induction programme available if and when required. Shortfalls were covered by bank staff, who were familiar with the hospital processes and outpatients team.

Requires improvement

Outpatients and diagnostic imaging

- During the period July 2014 to June 2015 radiology had not used any agency staff. We were given figures for bank staff usage for the same period, which averaged 18% of shifts per month.
- The outpatients manager, who was a qualified nurse, acted as an occupational health link nurse, taking bloods and giving vaccinations to staff as required and liaising with the Ramsay group occupational health service.
- Nurse staffing rotas were held electronically on a roster management system that was used throughout Ramsay Health Care facilities. The system allowed heads of departments to manage rotas, skill mix, and staff requirements including senior cover and to manage sickness and annual leave absences. Hard copies of rotas were printed out and kept in the manager's office for access by staff.
- The radiology department had had one vacancy but that had been filled shortly before our inspection. However, due to a member of staff going on maternity leave, the radiology manager had to spend all of their contracted hours on clinical work and then work overtime to complete their management tasks.
- Radiologists operated an on-call rota in case imaging services were required out-of-hours.

Medical staffing

- Consultants with practising privileges were not directly employed by the hospital, however as part of the application for practicing privileges process they had to confirm they were willing to be contacted if the need arose out of hours to support any patient who may require it. This situation was unlikely to occur in outpatients as patients only attended for prearranged appointments with consultants.
- Radiologist cover was provided during daytime and evenings, Monday to Friday. Radiologists arranged their own cover when they were unavailable for any reason.

Major incident awareness and training

- The hospital had a service major incident plan that informed staff of the actions they should take in the event of emergencies such as fire or power failure.
- Staff were able to tell us about the plan and what action they would take in the event of an emergency.
- We were told and we saw the plan was easy to follow and informative.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

- Care and treatment was provided in line with national guidelines and best practice. Information about outcomes of people's care was collected and monitored, and used to improve services for patients.
- Staff were suitably qualified and further training was made available for those who wanted to develop. However staff in radiology had not had regular appraisals and ongoing supervision. Staff were able to access policies and procedures needed during their work.
- Some departments had less than optimal space available to provide their services, however plans were in place to move these to new premises with more room.
- Staff in different departments worked well together to provide an effective service for patients, and flexed their working hours to make services accessible when patients needed them.
- Staff had training and guidance on consent, Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

Evidence-based care and treatment

- The physiotherapy department used a number of evidence-based, nationally recognised assessment tools such as 'VISA-A' for Achilles tendonopathy, 'STarT Back' for back pain, the foot and ankle disability index, the Tegner Lysholm knee scoring scale and the Modified Cincinnati Rating System for knee pain.
- In accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) the diagnostic imaging department checked their diagnostic reference levels (DRLs) yearly against national levels. DRLs are contained in guidance published periodically and recommend the doses of radiation to be used for each different procedure.
- All corporate policies were available on the hospital's intranet. We asked five members of staff, separately, to show us where policies could be found and they were all able to do so quickly and easily.

Pain relief

Requires improvement

Outpatients and diagnostic imaging

- Patients in the outpatients and diagnostic imaging departments did not normally require pain relief. On the rare occasions it was needed, the hospital's resident medical officer would attend and prescribe pain relief.

Patient outcomes

- Outpatients and diagnostic imaging offered consultation services only, and did not provide any treatment to patients. Because of this, there were no patient outcomes to be measured.

Competent staff

- Outpatients staff were provided with training in venepuncture (gaining access to a vein to give medicines or take blood samples) by an NHS trust and training on decontamination of specialist equipment by the equipment manufacturer. All qualified nursing staff had completed venepuncture training. Competencies were verified during annual appraisals for outpatients staff..
- We were given records which showed that all staff in the outpatients and diagnostic imaging department had had an appraisal with their manager in 2014 year. In the 12 months leading up to our inspection 75% of outpatients staff and 66.7% of physiotherapy staff had had an appraisal, however no appraisals had been recorded for radiology staff.
- The hospital's parent company ran regular training courses on a range of subjects, for which funding and time was made available to staff. We were given details of the courses provided for staff, which included areas such as sterile services regulation, endoscopy decontamination, control of substances harmful to health, heads of departments training, and communication and presentation skills.
- Department managers attended a five day management training course provided by Ramsay Healthcare. The outpatients manager told us this course assisted greatly with their development.
- Physiotherapy staff had training sessions once a week, on a variety of subjects connected to their practice. We saw a training plan detailing names of staff attending sessions on a number of complementary therapies such as pilates and acupuncture.
- Records of radiographers' registration with the Health and Care Professions Council and of their continuing professional development were held by the hospital's human resources department.
- The radiology manager was qualified as a radiation protection supervisor (RPS). An RPS is a person appointed to monitor the hospital's compliance with the Ionising Radiation (Medical Exposure) Regulations 2000. The radiology manager undertook a three-day refresher training course every five years to maintain their qualification.

Equipment

- Systems were in place to ensure equipment such as blood pressure machines and scales was appropriately serviced and calibrated (where required).
- Diagnostic imaging staff were able to use a portable x-ray machine as backup in the event of their main equipment developing a fault. This meant that appointments would not have to be cancelled.
- All diagnostics and imaging equipment had routine quality assurance and calibration checks in place to ensure the equipment was working effectively.

Facilities

- The x-ray room had an en-suite toilet with a separate exit to the main department, for patients to use after procedures involving barium enemas.
- Physiotherapy staff told us that their department was too small and that they were looking forward to the planned move to new premises with more space. Physiotherapy staff had been involved in planning the new premises.
- The physiotherapy department had three treatment couches and one separate room. During our inspection two patients were being treated in adjacent curtained-off areas and we were able to overhear conversations from both.
- Physiotherapists were able to refer patients to an off-site hydrotherapy service, following a patient-centred risk assessment carried out in the hospital.

Multidisciplinary working (related to this core service)

- We saw seamless multidisciplinary working between outpatients, diagnostic imaging and the physiotherapy department. Staff in all departments supported the others to ensure services were provided when patients needed them.
- Details of assessments and treatments carried out were communicated to patients GPs on their discharge from the hospital.

Requires improvement

Outpatients and diagnostic imaging

- The hospital had a formal transfer agreement with a local NHS acute hospital which allowed emergency transfer of patients who required a level of care which the hospital could not deliver.

Seven-day services

- The outpatients department was usually open from 8.30am to 8pm, Monday to Saturday. Staff told us they sometimes stayed open later or on Sundays if patient demand meant this was needed.
- Permanent and bank physiotherapy staff provided a service six days a week, including weekday evenings.
- Radiology operated seven days a week and services were provided on an on-call basis outside normal working hours.

Access to information

- Two staff nurses in outpatients told us they have time during their shifts to keep up to date with information on notice boards and in the department's communication folder.
- Radiology had policy and procedure folders on 'justification and technique' and 'protocols for x-ray procedures' and operating manuals for their equipment, all located in the control room used by radiologists. 'Justification' is a process carried out by radiographers which balances the benefits of carrying out a procedure against the risks of exposure to ionising radiation, for the patient. Radiographers have a professional obligation to ensure that any imaging they carry out is justified.
- All corporate policies were available on the hospital's intranet. We asked five members of staff, separately, to show us where policies could be found and they were all able to do so quickly and easily.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were given copies of Ramsay Health Care's corporate policies on consent to treatment, Deprivation of Liberty Safeguards and mental capacity, all of which provided clear, detailed guidance for staff.
- Staff were aware of these policies and were able to locate them on the hospital's intranet when we asked them. We were assured staff understood the principles of each subject.
- We looked at 15 patient records and saw consent forms were completed appropriately.
- Training on Deprivation of Liberty Safeguards and Mental Capacity Act assessments formed part of the hospital's mandatory e-learning.
- The radiology manager told us the hospital's human resources staff sent them regular reports on their staff members' progress with this training and its completion was linked to performance related pay reviews.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging as "good" for caring because:

- We saw compassionate, caring interactions between staff, patients and relatives.
- Patients and relatives were treated with dignity and respect and were consistently complimentary about the quality of care they received within the outpatients department.
- People were involved as partners in their care and were encouraged to take part in decisions, with support.
- Patients were given sufficient information before, during and following their consultation.

Compassionate care

- NHS and private patients all described staff as polite, friendly, caring and "always smiling". They told us that they received an individualised service tailored to meet their needs and staff provided care with compassion.
- We saw staff interacting with patients in a consistently friendly and caring manner, for example we saw one nurse sitting with an older patient, explaining the admission process thoroughly and took time to answer the patient's questions.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us they had been kept informed about what would be happening at each stage of their assessment and treatment.
- Patients told us they felt involved in decisions about their care and had enough information about available options to allow them to make informed decisions.

Requires improvement

Outpatients and diagnostic imaging

- We saw a person centred approach was used to ensure patients were involved as partners in their care.
- The outpatient's manager told us that all positive feedback and NHS 'Friends and Family Test' results they received were printed off and put in a communication folder for staff to see.

Emotional support

- Nurses or healthcare assistants acted as chaperones for any patients who requested the service and chaperones were of the same sex as the patient. The chaperoning facility was advertised on posters in all of the outpatients consulting rooms, we saw the chaperone process being followed in practice and patients were made to feel at ease and supported throughout their procedure.
- We saw staff throughout OPD made time to support patients. We were told how patient was invited into a side room to discuss their procedure as the patient was worried. The nurse reassured them about their procedure, answered their questions and alleviated their anxiety.
- Chaperone facilities were also available in radiology.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatients and diagnostic imaging as "good" for responsiveness because:

- Services were planned and provided in ways that met the needs of patients and staff were willing to change their working hours to accommodate patients' needs.
- Patients told us they found it easy to make appointments, that appointments were at most within three weeks of the request and when they arrived at the hospital they were seen within a few minutes of their appointment time.
- Patients with a learning disability or patients living with dementia were supported from pre admission to post discharge.
- Staff had access to printed information in languages other than English, and an interpretation service was available for staff to use if patients preferred to use a different language.
- Learning from incidents and complaints was shared among all staff.

However, we also saw:

- There was not enough parking space at the hospital to cater for patients which mainly impacted on patients attending for an outpatient appointment; however plans were in place to move part of the hospital's services to a new building with additional parking.

Service planning and delivery to meet the needs of local people

- A consultant radiologist told us that reports following diagnostic imaging were always completed by local radiologists rather than being outsourced, and that they were never left longer than a day. This ensured that results of investigations were available promptly and patients were not kept waiting if treatment was needed.
- Patients and staff all told us that parking was a problem as there were not enough spaces to accommodate everyone working at or visiting the hospital, and they often had to park in surrounding residential streets. Staff told us they believed the planned relocation of outpatients and diagnostic imaging to a new building would improve the situation.
- Four patients and two patients' relatives told us that had been provided with plenty of information before attending the hospital and felt well prepared.

Access and flow

- Appointment waiting times in outpatients varied depending on individual consultants. A whiteboard behind the reception desk was used to display information about any consultants who were running late, to keep patients informed about likely delays.
- We spoke with four NHS patients, two relatives of NHS patients and one private patient, all of whom had had appointment dates within three weeks of their initial referral.
- Parking at the hospital was a problem sometimes patients had to park off site in surrounding streets due to lack of space.
- A consultant radiologist told us the waiting time for ultrasound scans was one to two weeks, and that GPs were able to refer NHS patients direct to the hospital.
- At busy times the outpatients waiting area could become full and some patients, relatives or carers had to stand. There were plans in place to relocate the

Requires improvement

Outpatients and diagnostic imaging

outpatients department to a new building about a mile away from the hospital. Plans for the new building included a larger waiting area to accommodate larger numbers of patents, relatives and carers.

Meeting people's individual needs

- Patients with a learning disability and patients living with dementia were supported from pre admission to post discharge. Prior to the admission of a vulnerable patient staff contacted their carer/family member at home, they were supported by staff throughout their stay and family members were encouraged to remain with them throughout their care and treatment where possible. We saw one patient who was living with dementia was given a bedroom close to the nursing station and we saw staff took turns to make regular checks on them and their spouse to offer reassurance and answer questions.
- A disabled toilet was available on the ground floor of the hospital, and was shared between outpatients and radiology. We saw that it was fitted with a high level seat, hand rails, a chair rest, low hand basin and an emergency pull cord.
- The corridors in the outpatients and diagnostic imaging departments were not wide enough to allow wheelchairs to turn around. There was room for wheelchairs to manoeuvre into and out of consulting and imaging rooms without any difficulty.
- Changing rooms in radiology were unisex, and patients waited in the changing rooms until they were called in for their procedure. This involved a short walk through a corridor where other staff, patients or relatives may have been present. Patients walking through this area were provided with suitable garments to maintain their dignity. If this conflicted with patients' religious beliefs they were offered the option to get changed in the x-ray room.
- All of the hospital's information leaflets could be printed off in a range of foreign languages to cater for patients whose first language was not English.
- Outpatients and diagnostic imaging staff had access to interpreter service. Staff we spoke with were all aware of the service and knew how to access it.
- The outpatients waiting area was comfortably furnished with a range of seats of different heights, with and without arms. Staff told us they sometimes had more people in the waiting area than seats, and on those occasions extra chairs had to be brought from other areas in the hospital.

Learning from complaints and concerns

- The outpatients manager told us they rarely received complaints in that department, but that when they did learning outcomes were shared at their team meetings.
- We saw minutes of heads of department and clinical governance committee meetings detailing discussions about complaints received and learning from investigations.
- We saw complaints were managed as per the Hospital Complaints Policy and response times were within the recommended time frame.
- We were told how learning from complaints were used to improve practice. For example one patient had been overcharged for an OPD consultation as staff had used incorrect costing data. Following the investigation all costing data had been checked and up to date information had been shared with staff to reduce the repeat of a similar error. The patient had been reimbursed, sent a letter of apology and reassured of actions taken by the OPD for future practice.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated outpatients and diagnostic imaging as "required improvement" for 'well led' because:

- We were not assured the hospital had a robust process in place or the senior management team were fully aware of issues relating to the legal requirement to keep a complete and contemporaneous set of patient's records on site.
- Senior managers had not ensured the process underpinning the WHO check list for interventional radiology was completed in a consistent manner or audited.
- Senior managers had not ensured there was a formal process in place to manage patients when consultants needed to cancel clinics at short notice.

Requires improvement

Outpatients and diagnostic imaging

- The Risk Register did not provide an accurate comprehensive reflection of the key risks across the OPD and senior managers did not have clear oversight of what risks should be included on the register.

However we also saw:

- Staff were aware of and felt a connection with the hospital's vision and values.
- Senior managers, heads of departments and members of the medical advisory committee met and communicated regularly and effectively.
- A culture of prioritising safe, high quality, compassionate care, of openness and candour and of mutual respect between staff of all levels was evident.
- Staff told us managers at all levels were approachable and supportive.

Vision and strategy for this this core service

- Staff in outpatients told us that the hospital's vision of 'people caring for people' resonated with them as it was simple and exemplified what they did for patients every day.
- Some staff were aware there were five main values of the organisation and although they were unable to articulate all five, we were told they were aware of the values as they were simple and were part of their everyday care. The values related to: integrity, caring, pride, relationship and valuing other people.
- The outpatients manager also told us that it applied to the management team caring for staff as well as all the staff caring for patients and relatives.

Governance, risk management and quality measurement for this core service

- We were not assured the hospital had a robust process in place to ensure there was a complete and contemporaneous set of patient's records on site, which is a legal requirement. The hospital provided a medical secretary service and records of patients whose consultants used that facility were held on site. However, only 22.3% of consultants with practising privileges used the four on-site secretaries, the remainder used their own private staff. Records of patients seen by consultants with private secretaries were not held at the hospital. This meant that the hospital did not maintain records of all patients seen in the outpatients' department. If patients who had attended the hospital for a consultation returned unannounced in an emergency the hospital may not have had details of what had been done during their consultation, and this could affect any treatment given.
- Monthly meetings were held for all of the hospital's heads of departments. We were given copies of the minutes of meetings held between June and September 2015. Matters discussed included finance, patient activity, staffing matters, risk registers, audits and training. These meetings ensured that all of the heads of departments were kept up to date with matters that may affect their units and meant that the hospital's senior managers were able to monitor issues across their areas.
- The hospital's electronic appointment booking system held real-time records of consultants who had practising privileges, and would not allow appointments or rooms to be booked for consultants who were not on the system. This meant that managers and staff were assured that all consultants using the hospital's facilities had undergone proper checks and held current practising privileges.
- The hospital had agreements with Medical Directors of all the NHS trusts at which consultants with practising privileges normally worked. These agreements involved using a standard template to share information from personal development reviews and communicating if issues were identified at either location.
- We were given copies of the minutes of quarterly clinical governance committee meetings held between October 2014 and September 2015. The meetings were attended by senior managers from the hospital and members of the medical advisory committee (MAC). They discussed clinical incidents, complaints, infection prevention and control, results of clinical tests and clinical practice development. A senior manager explained medicine issues were not usually discussed at this meeting, however the corporate pharmacy group met and forwarded minutes to staff across the Ramsay group.

Leadership / culture of service

- The Risk Register did not provide an accurate comprehensive reflection of the key risks across the OPD and there was a lack of robust oversight and ownership of the key risks. For example, the risk register did not

include the risks associated with patient's notes not retained on site for all patients. There was no record on the risk register relating to the inconsistent completion of the WHO check list for interventional radiology.

- The outpatients' department, physiotherapy and radiology managers told us they felt well supported by their own teams and by the hospital's senior managers. They told us the senior managers had an 'open door' policy in spirit and practice, and that the staff in all the hospital's departments felt like an extended family.
- Two medical secretaries told us they felt included in the hospital team and that managers were approachable and when issues arose they tried to resolve them without apportioning blame.
- The outpatients manager told us they would be happy to undergo treatment at the hospital, or for a member of their family to do so. They told us that a number of members of staff had undergone procedures there.
- A reception manager told us they felt valued and a part of the hospital team, and enjoyed coming to work.
- The hospital held a daily meeting known locally as 'a huddle' attended by representatives from each department. Attendees rotated round all staff members to ensure that everyone was aware of and involved in the process.

Public and staff engagement

- Regular meetings were held for outpatients' department staff. These were open to all nurses and healthcare assistants, and the department manager told us some team members chose to attend the meetings even when they were not on duty.
- We saw the hospital's patient survey, 'We value your opinion', prominently publicised throughout the reception, outpatients and radiology departments.
- The radiology and outpatients managers told us they were involved in planning for their department's move to a new building with better facilities. They told us they had shared plans for the new layout with their team and asked for their input. We spoke with members of the radiology team separately and they confirmed this had happened and that they felt included in the planning process.

Outstanding practice and areas for improvement

Outstanding practice

West Midlands Hospital had received a Dudley Food for Health award in 2014 for offering healthy food choices to patients. This helped to contribute to improving patients' diets and health.

Areas for improvement

Action the provider MUST take to improve

- Ensure that hospital staff have access to all necessary information, including maintaining an accurate, complete and contemporaneous record on the hospital site in respect of each patient.
- Ensure all medicines are handled and stored safely.
- Ensure all medication errors including 'missed doses' are reported appropriately.
- Ensure all medicines for general use are ordered and kept separately from individual patient medicines
  - Ensure the WHO check list for interventional radiology is competed appropriately for each procedure carried out and audited at regular intervals.
  - Improve external multidisciplinary team management of patients with cancer in accordance with NICE guidance.
  - Review the frequency of 'Biennial reviews' which the hospital is currently undertaking every five years.
  - Formalise the nursing competency assessment process.
  - Update the equipment register and include all staff who use equipment.

Action the provider SHOULD take to improve

- Ensure the completed 5 steps to safer surgery, (WHO) surgical checklist is promptly included within patient's records.
- Ensure Complaints leaflets contain correct information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good Governance - Regulation 17, 2 (c) The Provider did not ensure that hospital staff had access to all necessary information, including maintaining an accurate, complete and contemporaneous record in respect of each patient and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance - Regulation 17 2 (b) The provider did not have a robust governance process in place and oversight of risks for the safe use and handling of medicines.