Ramsay Health Care UK Operations Limited

West Midlands Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- Staff did not all have training in key skills or were not trained to the required level. Development needs and poor performance were not consistently identified as not all staff had received annual appraisals.
- Records of care were incomplete with psychological assessment of patients undergoing cosmetic surgery procedures not being routinely completed. First stage consent was not always readily available to surgeons before procedures.
- Equipment maintenance systems were not robust. Facilities were not all appropriate.
- Substances hazardous to health were not stored appropriately.
- Governance systems were not all embedded
- Sharing of information with staff was not consistent due to the lack of team meetings in some areas and no standard agenda for meetings that were held with staff.

However:

- Staff assessed risks to patients, controlled infection risk well and managed medicines well.
- Staff provided good care to patients based on evidence and achieved good outcomes. Staff treated patients kindly and with compassion and gave patients enough to eat and drink and pain relief when they needed it.
- There was a positive culture within the workforce. Staff worked well together and treated each other with respect. Staff felt well supported by leaders. There was a strong focus on personal learning and development

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement . See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to West Midlands Hospital

West Midlands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1988. It is a private hospital in Halesowen, West Midlands. The hospital primarily serves these communities and the surrounding areas. It also accepts patient referrals from outside this area. The hospital offers both privately funded and NHS activity across a range of specialities. The hospital provides surgery, endoscopy, outpatients and diagnostic imaging.

Patients can access a range of surgical procedures, outpatient appointments and a physiotherapy service. Medical treatment and surgical procedures are delivered under specialities such as general surgery, orthopaedics, gynaecology, urology, and cosmetic surgery.

The service only treats adults and does not treat anyone under the age of 18 years.

The hospital has 34 beds with en-suite facilities. Facilities include two operating theatres and an endoscopy room, and a three bay recovery area. Outpatient and diagnostic services are available including six consulting rooms and x-ray. MRI and CT scans are provided by Ramsay Diagnostics UK. An offsite hydrotherapy pool is available for patients requiring this as part of the physiotherapy services.

All day case surgery procedures, including ophthalmology procedures, and pre-operative assessments take place at a local sister hospital also run by the provider.

The hospital is registered to provide the following regulated activities:

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

The hospital has a registered manager who has been in post since January 2021. The registered manager is also the Hospital Director.

We have previously inspected this location in March 2014, June 2016 and August 2018. In our last inspection in 2018 we found a breach of Regulation 17 (2)c HSCA 2008 (Regulated Activities) Regulations 2014: Good governance. The location was issued with Requirement Notice for this breach. We do not have evidence that the location has returned to full compliance.

The main service provided by this hospital was surgery. This was the only service inspected at this location during this inspection, although the location also provides medical care (endoscopy), outpatients and diagnostic imaging core services.

How we carried out this inspection

We undertook this inspection on 26 April 2022 as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach. The inspection was unannounced- the provider did not know we were coming.

Summary of this inspection

We visited the ward and theatre areas and spoke with 15 staff, including nurses, consultants, healthcare assistants and managers. We spoke with

five patients and reviewed 16 records. We also reviewed policies, incidents, complaints and meeting minutes.

You can find more information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that records relating to the care and treatment of each person using the service are complete and available. Specifically, there must be evidence of psychological assessment for all patients undergoing cosmetic surgery, in line with national guidance. Records of the first stage consent process must be available to surgeons before operating (Regulation 17 (2)(c): Good Governance)
- The service must ensure that their governance systems are effective in order to monitor and improve the quality and safety of the services provided (Regulation 17 (2)(f): Good Governance)
- The service must ensure that all staff have completed training in all key skills (Regulation 18 (2)(a): Staffing)
- The service must ensure safe management of substances that are hazardous to health (Regulation 15 (1) (a): Premises and equipment)
- The service must ensure that adequate systems are in place for testing equipment so that equipment is in date and safe for use (Regulation 15(1) (e): Premises and equipment)

Action the service SHOULD take to improve:

- The service should ensure that all staff have completed the required level of safeguarding training.
- The service should ensure that all staff have received annual appraisals.
- The service should ensure that first stage consent documentation is available to surgeons before patient's surgical procedures.
- The service should consider any opportunity to improve the estates facility so that there is more available space in theatres and clinical handwash sinks are available to staff at the point of care.
- The service should consider implementing a process for staff to follow the checklist for safer surgery more consistently.
- The service should consider whether there is a need to monitor delays to theatre start times in order to investigate reasons and improve efficiency.
- The service should consider if it is necessary to devise a process to evidence that reusable cold packs have been cleaned between each patient.
- The service should have information leaflets available to patients in different languages.
- The service should develop systems to understand wait times for surgical procedures so that they know whether the waits are attributable to the service or NHS pathways.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Surgery

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

Are Surgery safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service did not provide mandatory training in key skills to all staff or make sure that everyone completed it.

Staff did not all receive and keep up-to-date with all their mandatory training. Data provided by the service for non-medical staff showed that the service met its target for compliance with some mandatory training sessions, but for basic life support and immediate life support there were not clear records of whether staff had completed this. The database provided by the service had gaps for percentage completion of these sessions for all members of staff. Some staff were showing as being out of date for life support training whilst other staff had no date identified for when they had last completed the training. It was unclear if this was a training compliance issue or a recording issue, but it meant that managers could not demonstrate compliance with life support training. Mandatory training for consultants was provided in their NHS roles and compliance was monitored through the practising privileges process.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were required to complete mandatory training in a range of topics including equality and diversity, conflict resolution, fire safety, data protection, health and safety, moving and handling, and infection prevention and control.

Clinical staff had not all completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. There was no requirement for staff to complete separate training in mental health needs, autism or learning disabilities. Managers told us that these training topics were covered within the Mental Capacity Act and safeguarding training sessions. Staff were required to complete training in dementia awareness but 14 out of 77 staff (18%) had not completed this training. However, staff were not routinely required to care for patients living with dementia

Managers told us they monitored mandatory training and alerted staff when they needed to update their training. There was an e-learning system which automatically alerted staff when they were due to update any non face to face training. Heads of department (HODs) kept an electronic database to monitor compliance with all staff mandatory training requirements. Managers said HODs would email staff who were due to update face to face learning to prompt them to

book onto training sessions. However, although there were systems to monitor training compliance, these were not always effective for ensuring training was up to date. The record of basic and immediate life support training was incomplete with 72% of ward and theatre staff showing as having no record of completing the appropriate level of life support training or being out of date with this training. 32% of theatre staff were not up to date with informed consent training. We were not assured that managers had full oversight of compliance with all mandatory training. Managers told us there had been a change to several departmental managers and that the new staff in post were in the process of reviewing the training compliance and establishing where focus was required. There was a training and development officer post which had been vacant due to sickness but had recently been recruited to. The postholder was due to start in post in May 2022 and would have responsibility for oversight of all staff mandatory training compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had not all completed the appropriate level of training on how to recognise and report abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to describe when they would raise safeguarding concerns. There was a national safeguarding lead for Ramsay Health Care UK who provided advice and support to staff. An information board gave details of named safeguarding contacts at the local authority who staff worked with if they identified any safeguarding concerns.

Most ward and theatre staff had received training specific for their role on how to recognise and report abuse. Compliance with level three safeguarding adults training was 88% compliance for staff across wards and theatres.

Medical staff received training specific for their role on how to recognise and report abuse as part of their role working in the NHS. Compliance with consultant's safeguarding training was monitored through the practising privileges process.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding policy and information boards which detailed the process to report concerns.

Cleanliness, infection control and hygiene

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

Ward areas appeared visibly clean and had suitable furnishings which were well-maintained. There was a process to fully clean all rooms before new patients were admitted into them. Cleaning staff had a daily work sheet to identify which rooms required cleaning and what time they were required for. 'I am clean' stickers were used to identify the date and time of last cleaning. Communal areas of the ward, such as corridors, the nursing station and store rooms were cleaned in accordance with work sheets. All completed work sheets were kept in a folder at the nurses station. Managers told us that the completed sheets were reviewed but the process for routine audit of these had lapsed due to recent staff changes. There was a new housekeeping lead due to start in post and managers said there was a plan for them to introduce a system of routine audit to review compliance with completeness of the worksheets.

Standards of cleanliness and hygiene were maintained in theatres in line with NICE guideline NG125 (August 2020) Surgical site infections: prevention and treatment. The service had a service level agreement with an external provider for sterilisation of surgical equipment.

Requires Improvement

Surgery

The service generally performed well for cleanliness. Cleaning audits of the environment were completed six-monthly. The last three available departmental cleaning audit results showed that there was between 88% and 100% compliance with audit standards. Patients told us that they found their rooms to be spotlessly clean.

Staff screened patients for some infections before they were admitted for surgical procedures. There was a policy for testing patients for COVID-19 in advance of planned admission. Patients also completed lateral flow device tests on the day of admission. They were required to have proof of negative results before they were admitted onto the ward. The service had a risk based approach for screening for any other infections such as MRSA or Clostridium difficile *(C. diff)*. Surgical care pathways required staff to check patient's MRSA, *C. diff*, and Carbapenemase producing Enterobacteriaceae (CPE) status which was done through completion of patient health questionnaires prior to admission for surgical procedures.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbow and wore PPE appropriately. There were supplies of gloves and aprons all along the ward corridor. Fluid resistant surgical face masks were kept at the nurses' station and all staff and visitors were required to wear these throughout clinical areas. Hand gel stations were widely available throughout the ward corridor. However, there were no clinical handwash sinks at the point of care or in the ward corridor. Staff were told to use sinks in patient's bathrooms or the clinical handwash sink in the treatment room. We observed that staff decontaminated their hands using the sinks or gel stations in accordance with guidance.

Monthly audits of hand hygiene were completed. Results of the last three hand hygiene audits showed 100% compliance with standards in all three audits.

Staff cleaned equipment after patient contact but did not always label equipment to show when it was last cleaned. All shared patient equipment, such as wheelchairs and hoists, was cleaned after patient use and dated 'I am clean' stickers were used to evidence this. There was a freezer on the ward containing re-usable cold packs for patient use for pain relief following surgery. Staff told us these were wiped with antibacterial wipes between use, but there was no system to evidence that cleaning had taken place.

Staff worked effectively to prevent, identify and treat surgical site infections. From April 2021 to March 2022, the service had 23 surgical site infections (SSIs). They did not report any hip or knee surgical site infections. The service reviewed the SSIs and found that the same staff member had been involved in several of the incidents. They put an action plan in place to address this in order to prevent future SSIs.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The theatre environments were very small with limited storage space. However, staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We saw that patients had call bells next to them when in bed or sitting out in a chair. Patients said that staff answered the bell quickly when they were required to provide support and assistance. A digital display of which room's call bell was ringing was in sight of the nurses station which helped staff to respond to call bells promptly.

The design of the ward environment did not follow all national guidance. Staff did not have easy access to clinical handwash sinks. The control of substances hazardous to health (COSHH) cupboard was found to be empty and unlocked

during our inspection. The cupboard was in an unlocked room which was accessible to anyone on the ward. Substances that should have been stored in the COSHH cupboard were stored in an unlocked cupboard in this unlocked room. We raised this with staff during our inspection who agreed to rectify the storage of COSHH. The hazardous substances were removed from the unlocked cupboard and disposed of during our visit.

Patient bedrooms were all single ensuite rooms which provided privacy and dignity and avoided any mixed sex accommodation. Rooms contained all required equipment for patients to be cared for safely and to be comfortable. There were designated areas on the ward for storage of clinical supplies, clean linen storage, dirty utility area and preparation of drinks and snacks.

The theatre environments were small with limited storage space. The hospital was not a purpose-built unit meaning that the size of the estate was limited. The limited available space in theatres resulted in reduced storage capacity and a cluttered treatment space. Following the inspection in 2018 which identified that theatre space was an issue, the area had undergone a refurbishment and had been decluttered. Additional storage space had been made available. Staff had organised the storage of equipment well, but the available working area was still cramped and overcrowded. There was some decorative damage to doors and walls but managers told us there was a regular programme of maintenance and repair to manage this. However, there were appropriate facilities and equipment in the scrub, anaesthetic and recovery areas of theatres.

Staff carried out daily safety checks of specialist equipment. The resuscitation trolley had regular safety checks. Items on the top of the trolley (suction unit, oxygen cylinder, defibrillator) were cleaned and checked daily. The numbered tag which sealed access to the emergency equipment in the trolley was broken weekly and all items, including emergency medicines were date checked. The trolley was stocked correctly, and all check lists were completed without omissions or errors. There was a temperature data logger to monitor the temperature of the emergency medicines which was checked twice daily.

The maintenance of medical devices and electrical equipment was not in line with requirements. Several items of both medical and electrical equipment were found to be either out of date for testing or did not have a sticker to identify when they were last tested. Equipment included wall mounted suction units, fans and digital thermometers. We raised this with managers who agreed that not all equipment had been tested in line with policy requirements. The provider had a contract with an external company to test medical devices and electrical equipment. The external company kept an electronic log of equipment testing which was available to facilities staff in the service. We asked for a copy of the testing log so that we could understand the scale of the issue, but this was not provided. Managers explained that the company responsible for monitoring equipment testing compliance would contact the service when equipment was due for testing. However, the service did not have oversight of the equipment testing compliance. The monitoring system was not robust as not all equipment had been tested in line with process and policy. When concerns about the testing process were raised with the service, managers told us they would review the processes to ensure they could be assured that all equipment due for testing was compliant.

The service also had additional specialist equipment items such as hoists and wheelchairs which had separate testing processes. Hoists were tested in line with the Health and Safety Executive (HSE) Lifting Operations and Lifting Equipment Regulations (LOLER). Wheelchairs for transporting patients were checked weekly by engineers who kept a checklist to evidence this had been completed.

Requires Improvement

Surgery

The service had enough suitable equipment to help them to safely care for patients. Staff told us that they had enough equipment to do their job properly. We were also told that any replacements were ordered and delivered promptly. In addition, all equipment such as beds and theatre tables were able to accommodate patients with a body mass index of up to 40, in accordance with the NHS contract.

Staff disposed of clinical waste safely. There were orange bags for disposal of clinical waste which were emptied daily and disposed of in line with policy and guidance. All clinical waste sharps bins were used, stored and disposed of in accordance with national guidance. There were coloured coded bags for dirty linen. Any linen soiled with bodily fluids was placed in red bags so that it could be laundered separately from other used linen.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, there were some inconsistencies in how the surgical safety checklist was used.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients at risk of deterioration were monitored using the National Early Warning Scores (NEWS) tool. Staff described the process of escalating any patients who became acutely unwell by use of an emergency buzzer. In this situation patients would be assessed by the Resident Medical Officer (RMO) who would seek support from the consultant as appropriate. Where patients did not require urgent treatment, they were closely monitored by staff recording observations on NEWS charts at 15-minute intervals until they returned to within normal ranges. At the time of our inspection no patients required the completion of NEWS tools. There was a dedicated patient room opposite the nurses' station that was kept available for use by any patient who deteriorated and needed closer observations. The NEWS charts provided guidance on actions for staff to take in relation to patient's scores. In addition, information boards displayed 'track and trigger guidance' for staff to use alongside the NEWS tool.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed assessments for the risk of pressure area damage, falls, malnutrition and venous thromboembolism (VTE). The risk assessment process was started during the pre-operative assessment so that care needs, based on risk, could be identified before surgical procedures. Risk assessments were repeated when anything had changed with a patient.

Staff knew about and dealt with any specific risk issues. Nursing staff were aware of the risk of sepsis, although explained that the incidence of sepsis cases was low. They explained that patients undergoing joint replacement surgery were given prophylactic antibiotics in theatre to reduce the risk of infection. Post-operative wounds were closely monitored by staff for any signs of infection. There were education boards on the ward which provided information on VTE (reducing the risk of clots) and recognition and management of sepsis.

In the event of a post-operative complication where patients required a return to theatre, there were on call rotas for theatre staff. This included operating department practitioners who could perform anaesthetics and recovery, scrub practitioners and health care assistants. In addition, consultants and anaesthetists had systems in place to provide 24 hour cover for advice, and to review the patient return them back to theatre if necessary.

Requires Improvement

Surgery

The ward held a blood fridge which stored cross-matched blood for use in the event of patient blood loss during or following surgery. An anaesthetics operating department practitioner was identified as a blood transfusion trainer and managed the blood products in the fridge. The fridge was locked and there were documents to complete when blood products were removed. The service had emergency access to blood products within 40 minutes in the event of a major haemorrhage.

The service did not have any access to face to face specialist mental health support (if staff were concerned about a patient's mental health). However, managers told us that there was a policy for staff to follow if patients experienced a deterioration in their mental health. This listed a range of support services available that staff could seek support and guidance from. The policy provided contact details of support organisations staff could signpost patients to if they were concerned about their mental health.

Staff shared key information to keep patients safe when handing over their care to others. All staff starting their shift attended a handover meeting with staff from the previous shift. Information about patients who had stayed overnight, and new patients being admitted was shared.

Shift changes and handovers included all necessary key information to keep patients safe. Any patients who had deteriorated were discussed and written handover information sheets were produced from the records system and shared with staff. All patients were allocated to a named staff member at handover, so it was clear which nurse had responsibility for each individual.

Patients requiring anaesthesia who had a high body mass index received a documented risk assessment by the consultant prior to surgery. The risk assessment included consideration of if the unit had facilities to deal with any likely complication which may arise. Any patients that were considered to be too high risk were referred back to the NHS for care.

Staff used National Safety Standards for Invasive Procedures (NatSSIPS) to provide safer care and reduce patient safety incidents. However, we observed that the World Health Organisation (WHO) surgical safety checklist was not always fully followed. Different staff completed the sign-in in different orders and did not always follow the standard order. We observed that not all staff were fully engaged in the time out process of the checklist and continued to prepare the patient for surgery during the time out.

Nurse staffing

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

The service mostly had enough nursing and support staff to keep patients safe. There was no set planned number of staff on each shift as staffing levels depended on what surgical procedures were planned and the expected dependency levels of patients following surgery. However, there was always a minimum of two Registered Nurses on the ward each shift.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers used an electronic rostering system which they aimed to complete eight weeks ahead. Heads of department managed any gaps or changes in the rotas once they had been approved by the head of clinical services. The electronic system analysed and identified any unfilled shifts so these could be filled in advance. In theatres, staffing followed the Association for Perioperative Practice (AFPP)

guidance. If theatres were short staffed on the day and shifts could not be filled, surgical procedure lists would be reduced or cancelled to ensure patient safety. Numbers of theatre staff could be flexed down if not all staff were required. There was a system to monitor any hours owed or overworked by theatre staff to ensure the correct balance. Ward staff who were rostered on but not required would complete elearning or audits.

Managers could adjust staffing levels daily according to the needs of patients. Although the number of theatre procedures was constant, the types of procedures being performed varied with each list. If there were additional staff that were not required to deliver safe patient care, these staff could work at the local Ramsay sister hospital where daycase procedures were performed. Staff routinely worked across both locations to maintain flexibility of service delivery and staff competence.

The number of nurses and healthcare assistants on shift did not always match the planned numbers. On the day of our inspection, the actual number of staff met the planned number. Data provided by the service for March 2022 showed that actual staff hours worked almost met budgeted hours. However, staffing data from 11 April 2022 to 8 May 2022 showed that planned numbers of registered nursing staff did not meet actual numbers on any shift on the ward. Bank and agency staff were used to increase staffing numbers of registered nurses but planned staffing levels were still not always met. The service did ensure that they always met the minimum requirement of two registered nurses on each shift.

The service had low vacancy rates. There were four whole time equivalent (WTE) registered nurse vacancies on the ward and two WTE vacancies in theatres.

The service had high but reducing sickness rates. Sickness rates were at 18% across departments for all staff types. Consultant sickness rates were not monitored. There had been a reduction in staff sickness rates of 2% since the last month. Managers told us the majority of sickness was COVID-19 related.

The service regularly used bank and agency nurses. The agency staff that worked on the ward and in theatres were regular staff who had long term arrangements with the service to provide cover. The limited use of bank and agency staff meant that staff were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

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

The service had enough medical staff to keep patients safe. The service employed two Resident Medical Officers (RMO) through a recruitment agency. The RMOs worked opposite each other on a one week on and one week off shift pattern.

Consultant staff were not employed by the service but there were 110 consultants operating at the service under the practising privileges systems. There was a robust system in place for the appointment of consultants working under practising privileges in the service. There was a process of checks and approval which were recorded on an electronic database. All required checks were completed prior to approval of practising privileges.

Managers could access locums when they needed additional medical staff. A locum agency provided cover for RMO holiday and sickness absence.

Requires Improvement

Surgery

The service always had medical staff support available. The RMO was resident in the hospital overnight and provided cover 24 hours a day, seven days a week. Consultants and anaesthetists were available for telephone advice out of operating hours. If required, they would attend the hospital to review patients. Practising privileges arrangements required them to live within less than one hours travel time of the hospital. Consultant staff operated a buddy system so if the primary consultant who had performed the procedure was uncontactable, their buddy (who was another consultant highlighted during the team brief) could be contacted. The anaesthetist was on call for 24 hours post operatively for advice, to review the patient and to return the patient back to theatre if required. If a return to theatre was required outside of the 24-hour period, and the primary anaesthetist was not available another anaesthetist working at that time would provide cover.

Records

Staff kept detailed records of patients' care and treatment, but these were not always comprehensive or easily available to all staff providing care. There was not always evidence that psychological assessments had been carried out for all patients who underwent cosmetic surgery procedures. However, records were clear, up-to-date, and stored securely.

Patient notes were not always comprehensive. During our inspection in 2018 the service was served with a requirement notice for a breach of Regulation 17; the service did not ensure that a full psychological assessment had been undertaken for all patients undergoing cosmetic surgery. The action plan produced by the service set out four actions which were marked as completed. Actions included signing up to a national psychological screening tool which was implemented at consultation and regular auditing of medical records to ensure compliance with the expected standard. However, results of a medical records audit by the service in October 2021 showed that only 50% of patients undergoing cosmetic surgery had a psychological assessment documented as completed. The service told us that all patients undergoing cosmetic surgery were initially seen by the consultant surgeon for consultation. Before this appointment, patients should be given a cosmetic surgery questionnaire to independently complete. This brief psychological screening tool should then be reviewed and discussed in the consultation appointment. The service provided a copy of the questionnaire and we retrospectively reviewed 10 sets of records for evidence of this for patients who had undergone cosmetic surgery procedures. We saw that five out of the 10 records had evidence of completion of the questionnaire. We did not see any evidence of discussion of the questionnaire between the patient and consultant in any of these records. Managers told us that treatment would be re arranged to allow the time for further assessment by a psychologist if any concerns were identified. However, the service was unable to evidence a clear, robust process for identifying psychologically vulnerable patients who may need referral on to a psychologist. This meant that the service was still in breach of Regulation 17: Good governance.

There was a specific process for patients going through gender reassignment requiring a letter for referral from a private gender psychologist and a letter of support from their GP prior to consultation for surgery. During our inspection we reviewed the record of one patient who had undergone gender reassignment surgery and saw that the required psychological assessment had been completed.

Records were kept on an electronic system which all staff could access easily. Records were contemporaneous and provided the required information for staff to provide safe post surgical procedure care to patients. Records were stored securely as there was password protected access to the electronic records system. However, records for patient's pre-operative care were completed as paper records at the local sister hospital. These should be scanned into the electronic system or transferred over to the West Midlands hospital before patients were admitted for surgical procedures. During our inspection we saw an example of when a patient's pre-operative records were not available to the surgeon. Since the surgeon did not have access to the record of first stage consent, they were unable to start the procedure until this was confirmed. This resulted in a delay to the start of the patient's surgery.

Requires Improvement

Surgery

When patients transferred to a new team, there were no delays in staff accessing their records. Patient discharge summary letters were sent to their GP electronically, so they were received without delay.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. There was a service level agreement with a local NHS trust to provide pharmacy support to the hospital. The pharmacist provided a range of support to the service including advice, review of medicines charts, stock control and carrying out medicines audits.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. Patients had their medicines explained to them on discharge and their discharge medicines were available in a timely manner.

Staff completed medicines records accurately and kept them up-to-date. Medicine charts we reviewed were complete and without omissions or errors. Six-monthly audits of medicines reconciliation and prescribing were carried out and showed there was good compliance with the audit standards. In the last audit in March 2022, the service achieved 100% compliance with the pharmacy governance audit standards and 97% with the safe and secure medicines audit standards.

Staff stored and managed all medicines and prescribing documents safely. The pharmacist visited three times a week to do stock checks of medicines and was responsible for the ordering of additional medicines stock. Safe and secure medicines audits were carried out by the pharmacist three-monthly and showed good compliance with required standards. Controlled drugs (medicines with specific storage requirements) were stored securely and checked in line with policy and guidance. Controlled drugs audits were carried out monthly and showed good compliance with required standards. Private prescription pads were stored and managed in accordance with local policy by the outpatients department.

Staff followed national practice to check patients had the correct medicines. Medicines reconciliation (checking of medicines prescription charts) was carried out three times a week by the visiting pharmacist.

Incidents

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

Staff knew what incidents to report and how to report them. The service used an electronic system for reporting incidents which all staff had access to. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. There was a Ramsay Health Care UK corporate incident reporting policy which set out staff responsibilities for reporting incidents. From December 2021 to May 2022, the service had reported 96 incidents. Managers told us no themes had been identified in these incidents, but that any themes recognised across the Ramsay Health Care UK group would be discussed and actioned locally with appropriate teams.

The service had no never events since the last inspection.

Requires Improvement

Surgery

There had not been any serious incidents in the last 12 months. However, managers told us that staff knew how to report serious incidents and would do so in line with policy. There was a monthly report of all serious incidents reported across Ramsay Health Care UK which was discussed at the group clinical governance meeting. Any trends or themes were identified and a lessons learned document was shared across all Ramsay hospitals by the central clinical team.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff described an open and honest culture where they were supported to apologise to patients if things had gone wrong. Managers followed duty of candour requirements in line with the organisation's 'being open' policy.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where possible. Heads of department investigated all incidents reported and identified any initial actions required to be taken. All completed incidents were reviewed by the head of clinical services and the clinical quality partner. Patients were spoken with to gather information to inform the investigation process where the incident was patient related.

Staff received feedback from investigation of incidents, both internal and external to the service. Individual staff members involved in incidents were updated with the outcome of incident investigations. Incidents were routinely discussed at team meetings so that any learning or required actions identified could be shared. Staff also received shared learning about incidents that had happened in other hospitals within their Ramsay Health Care UK cluster.

There was evidence that changes had been made as a result of feedback. Managers described how a consent checklist process had been changed following a recent incident with the two-stage consent process not being signed. The change in process had improved consistency.

Are Surgery effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service used corporate Ramsay Health Care UK policies to inform their practice. Policies were based on relevant national guidance and guidelines from professional bodies. Staff followed professional standards and guidelines, and used recognised tools, to assess and plan treatment. Relevant guidelines for surgical procedures were displayed on the wall in the anaesthetic room and theatres.

Due to the service's admission and exclusion criteria, it would be unlikely that patients under restrictions of the Mental Health Act 1983 would be treated by the service. Staff told us that the pre-assessment process would identify that their needs would best be met at the local NHS trust.

At handover meetings, staff referred to the psychological and emotional needs of patients. For example, staff would highlight if patients were particularly anxious or worried about planned surgical procedures.

Requires Improvement

Surgery

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients were offered a range of hot and cold food and drinks following their surgical procedure.

Staff were not required to use special feeding and hydration techniques. Due to the admission criteria, it was unlikely that patients requiring this level of care would be treated by the service.

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

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The Malnutrition Universal Screening Tool (MUST) was routinely used to assess all patients pre-operatively.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff followed a standard operating procedure for pre-operative fasting to avoid unnecessarily long periods of fasting and reduce the risk of dehydration, discomfort and possible delay in patient's recovery.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff asked patients to score their level of pain using a visual analogue pain scale chart.

Patients received pain relief soon after requesting it. Patients told us that staff regularly checked on their pain levels and administered pain relieving medicines when required. When patients needed to use the call buzzer to request pain relief, this was responded to quickly.

Staff prescribed, administered and recorded pain relief accurately. Medicines charts showed that patients were prescribed regular prophylactic pain relief and additional PRN (as needed) pain relief following surgical procedures. When pain relieving medication was administered this was recorded accurately.

Patient outcomes

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

The service participated in relevant national clinical audits. The service participated in the National Joint Registry (NJR). The service collected and reported data to the NJR for hips and knees. In addition, they participated in the British Spinal Registry for spinal implants and to NHS Digital for the Breast Implant Registry.

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. The service collected Patient Reported Outcome Measures (PROMs) on private hip, private knee, shoulder, carpal tunnel, ENT septoplasty, breast augmentation, and mammoplasty. The service benchmarked its performance for key clinical performance indicators against other hospitals in the Ramsay Health Care UK group. The service performed similar or better for all indicators apart from 'other infection (excluding hip and knee)' where it was an outlier.

Requires Improvement

Surgery

The service had low numbers of patients requiring a return to theatre. Two patients during the last 12 months had needed to return to theatre following complications. A further 11 patients had required to be transferred out to the local acute hospital in the same period, to receive appropriate care.

Managers and staff used the results to improve patients' outcomes. Managers told us the possible causes for the outcome outlier were considered and actions were put in place to address this and improve performance. The service was waiting for the latest data relating to this outcome.

The service performed well for readmission rates compared to other hospitals in the Ramsay Health Care UK group. From April 2021 to March 2022, less than 1% of patients required readmission.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a clinical audit schedule set out by Ramsay Health Care UK which identified required audits, their frequency and ownership for completion. Audits included Infection Prevention and Control (IPC), medical records and consent, care bundle, pharmacy and NatSSIPS audits.

Managers used information from the audits to improve care and treatment. Results from audits were reported as a dashboard of audit performance across the Ramsay Health Care UK group. The dashboard was reviewed and discussed by senior managers and the clinical quality partner to identify any areas of performance requiring improvement. Action plans were produced to implement improvements.

Managers shared and made sure staff understood information from the audits. Audit results were discussed at team meetings and any required improvements to performance were identified.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance. However, supervision meetings were available to staff to provide support and development.

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

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

Managers did not support all staff to develop through yearly, constructive appraisals of their work. Data provided by the service at the time of inspection showed that 55% of staff across the ward and theatre departments had received an appraisal in the last 12 months. However, updated data was provided following our inspection as managers told us that the original data had included staff on sick leave, maternity leave, and in their probation period. This new data showed that 76% of eligible staff had received an appraisal within the last 12 months. Managers told us that compliance with appraisals was a focus for improvement for the new ward manager and ward sister who had recently started in post.

Medical staff working under practising privileges completed appraisals as part of their NHS roles. They were required to provide copies of their appraisals when they were completed.

Requires Improvement

Surgery

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. There was a Ramsay Health Care UK clinical supervision policy which set out clinical supervision principles. The location, time and frequency of supervision was agreed between the supervisor and supervisee as part of a supervision contract. Although clinical supervision must be offered there was no requirement for staff uptake of this. Data for participation in clinical supervision was not available but staff reported that they had received clinical supervision.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Face to face team meetings had been suspended during the pandemic but managers had tried to continue virtual staff meetings. Due to the change in ward management this had not always happened routinely but had been more consistent in theatres. All team meetings followed a set agenda and minutes of meetings were produced and distributed to all staff.

Managers could not always identify any training needs their staff had as low numbers of staff had received appraisals which was the process through which training and development needs would be identified. This meant that the service was unable to provide evidence that staff had the opportunity to discuss training needs with their line manager.

However, managers told us how staff were supported to develop their skills and knowledge. There was a talent mapping process where staff could discuss what skills they required to do their job and any training required for progression within their role. Managers stated there was a lot of investment in staff development and described different staff development opportunities that had been supported. Staff had access to the Ramsay academy and could request training sessions with the approval of managers.

Managers made sure staff received any specialist training for their role. In addition to mandatory training requirements, registered nurses were required to complete and update a range of clinical training sessions.

Managers could not always identify poor staff performance promptly or support staff to improve. As low numbers of staff had received appraisals, which was the process through which poor performance would be identified, the service could not evidence that there was a process to identify and address poor performance. However, consultant performance was managed through the practising privileges process.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Theatre staff met monthly to review and discuss the requirements for theatre preparations for patients on the operating list for the following month. Action lists were produced to ensure all the required equipment and most appropriate staff were available.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was a pooled resources approach for staffing across the West Midlands Hospital and the local sister hospital. Staff routinely worked across both locations in order to provide flexibility and ensure the most appropriate skill mix of staff was available to meet patient's needs. Medical staff, nursing staff and therapy staff worked alongside each other to provide holistic care.

Seven-day services

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

Requires Improvement

Surgery

Consultants led daily ward rounds, including at weekends, to review patients following their surgical procedure. Patients were reviewed by consultants depending on the care pathway.

Planned surgeries took place over six or seven days a week; theatres operated Monday to Saturday every week and on Sundays twice a month. Theatres were also available for any patient needing to return to theatre following a complication, 24 hours a day, seven days a week.

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week. The Resident Medical Officer was always onsite and was available to review any patients staff were concerned about. Diagnostic tests, such as x-rays could be requested and completed at any time, including out of hours. Out-of-hours pharmacy advice was available from the local NHS hospital and medicines could be couriered from the local NHS hospital if required out of hours under a service level agreement. Physiotherapists worked Monday to Saturday 8:30am until 8:00pm and an on call physiotherapy service was also available if physiotherapy was required out of their standard working hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. For example, there were information boards and leaflets providing information on smoking cessation, physical activity and alcohol consumption.

Staff assessed each patient's health before they were admitted and provided support for any individual needs to live a healthier lifestyle. During consultation and pre-assessment, health risk factors such as alcohol consumption, weight and smoking history were discussed with patients and advice was given to patients with any identified health risk factors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions. However, compliance with Mental Capacity Act and informed consent training was low. Consent was not always clearly recorded in patient records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Due to the admission and exclusion criteria, any patient who was deemed to lack capacity and who would not be able to consent to treatment, would have arrangements made to treat them at the local NHS trust.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff followed a two-stage consent process. We observed the second stage consent process in theatres and saw this was robust.

Staff made sure patients consented to treatment based on all the information available. First stage consent was completed at the pre-operative assessment appointment which was completed at the local sister hospital. Risks and benefits of surgical procedures were discussed with patients at these appointments.

Staff did not always clearly record consent in the patients' records. One of the surgical procedures we observed was delayed in starting due to there being no record of the first stage consent in the patient's electronic record. The surgeon and patient confirmed verbally that first stage consent had occurred in the clinic setting but no record of this could be found. The surgeon explained that this would have been written on a paper record and not in the electronic records

system. Patient's paper records were made available to surgeons before procedures. Consent audits were completed six monthly and the latest audit result for May 2022 were reviewed. These showed 76.3% compliance with the overall audit standards. The standard requiring the original copy of the consent form to be filed in the notes or scanned into the electronic patient record showed 90% compliance.

Staff had not all received up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff should complete training in the Mental Capacity Act as part of their safeguarding training. Since not all staff had completed the appropriate level of safeguarding training, this meant not all staff had completed training in the Mental Capacity Act.

Staff may not all have understood the relevant consent and decision-making requirements of legislation and guidance. Data provided for compliance with informed consent training showed that 27% of staff across the ward and theatres had not completed or updated informed consent training.

Are Surgery caring?

Good

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

Compassionate care

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

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

Patients said staff treated them well and with kindness and that staff were friendly.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. When patients were admitted for surgical procedures, nurses asked them about individual needs, including those related to religious or cultural beliefs.

Emotional support

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

Staff gave patients and those close to them help, emotional support when they needed it. Staff recognised when patients were anxious about their procedure and provided appropriate support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Requires Improvement

Surgery

Understanding and involvement of patients and those close to them

Staff supported patients to understand their condition and make decisions about their care and treatment. There was limited involvement of families and carers as patients were encouraged to attend the hospital alone to limit the risk of infection.

Staff made sure patients understood their care and treatment and to make informed decisions about their care. Staff explained processes and procedures with patients and gave them opportunity to ask questions. Staff were not aware of any communication aids that were available to support conversations.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. At the point of discharge from the ward, staff discussed patient's satisfaction with their care with them. Staff hoped to resolve any issues raised locally before patient's were discharged home. Following discharge all patients were sent a feedback survey to complete about their experience. The hospital had a website which encouraged patients to leave feedback and enabled patients to request contact from the service to discuss any issues of concern. All feedback was collated in a database which was reviewed by the head of clinical services. Patient feedback data from November 2021 to April 2022 showed that the service received positive feedback and scored the same or better than other Ramsay Health Care UK hospitals in satisfaction surveys.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. Managers worked with the local acute trusts and commissioners to support NHS waiting lists for surgical procedures. From March 2021 to April 2022 the service had completed a total of 6287 surgical procedures, 4551 (73%) of which were for NHS patients. The service was able to offer a range of surgical procedures for different specialties.

Staff knew about and understood the standards for mixed sex accommodation. Since all patient rooms were single ensuite rooms there was no potential for mixed sex breaches.

Facilities and premises were not all appropriate for the services being delivered. The hospital was not purpose built resulting in space limitations, particularly in theatres. However, the service worked closely with the newly purpose built sister hospital to deliver pre-operative care and day case surgery. The use of these nearby facilities reduced some of the pressures on available space at the West Midlands Hospital.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital had acceptance criteria set out in the Ramsay access policy and local CCG NHS standard acute contract. These identified exclusions where patients required specialist care and support that could not safely be provided; these patients would be seen by the local NHS acute trust.

Requires Improvement

Surgery

Managers at the local sister hospital monitored and took action to minimise missed pre-operative appointments and ensured that patients who did not attend appointments were contacted. From April 2021 to April 2022, 989 patients at the West Midlands Hospital who were booked in for planned surgical procedures had these cancelled. Reasons for cancellation were wide ranging including surgeon and patient illness, holidays, unsuitability for procedure and personal circumstances. 104 procedures were cancelled on the planned day of surgery with the rest being cancelled with between one and 39 days notice.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff had the resources available to make reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were aware that patients living with dementia may have additional care needs and had access to a resource box to support those patients. However, wards were not specifically designed to meet the needs of patients living with dementia.

Patients with acute mental health problems would routinely receive their care at the local NHS acute trusts due to the service exclusion criteria.

Staff were aware of a range of support services and helplines they could signpost patients to. Any patient experiencing an acute mental ill health crisis during their admission would be transferred to the local trust for acute crisis management.

Staff were not routinely required to apply the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had access to information leaflets available in languages spoken by the patients and local community. Staff could access an electronic system to download and print information leaflets in other languages and in Braille. Hearing loops were available for those patients with hearing difficulties.

Managers made sure staff, and patient's loved ones and carers could get help from interpreters or signers when needed. Staff could request support from language line for translation services and from interpreters from an external agency when required. British Sign Language Interpreters were also available to support patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences. All patients had a choice of menu options. Catering staff were able to provide appropriate meals on request to meet the religious and cultural dietary needs of patients.

Staff did not have access to communication aids to help patients become partners in their care and treatment but told us these were not generally required for the population the service was provided to.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Referral to treatment time targets had been difficult to meet during

COVID-19 pandemic but were improving. The latest available data for February 2022 showed that 46.5% of patients of patients on incomplete pathways were treated within the target 18 weeks of referral. The median (average) waiting time for surgical procedures was 19.3 weeks. There were, however, 99 patients who had been waiting over 52 weeks for treatment. There was a process for monthly review of all patients waiting over 52 weeks to ensure they had not suffered harm whilst waiting. There was an action plan in place to reduce the number of people waiting over 52 weeks. However, it was not clear if patients were transferred onto the hospital waiting list for treatment with existing waits from the point of NHS referral or if the waits were a result of West Midlands hospital processes. Managers told us the data was not able to be analysed to identify if the wait times were attributable to Inter Provider Transfer (IPT NHS) or Ramsay (NHS).

Theatre operating lists did not always start on time. During our inspection we observed delays to starting operating lists for multifactorial reasons. Staff told us delays were common place. We asked managers if delays to theatre times were routinely monitored and they told us they were not. Managers said that staff reported any significant delays through the incident system and that these would be investigated. However, there was no system of consistently recording start times to theatre lists to monitor the frequency of any delays.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients were supported to return home the same day or following day of their surgery where possible. Expected length of stay was discussed with patients at consultation and confirmed at the point of admission.

Staff supported patients when they were referred or transferred between services. All patients had discharge summaries sent to their GP which detailed the care they had received. Nurses spoke with patients before they left the ward to ensure they understood all their post-operative care arrangements.

Managers monitored patient transfers and followed national standards. Managers monitored the numbers of patients transferred out to the local acute hospital following any complications after surgery or sudden deterioration in their condition. They reported that 11 patients had been transferred out from March 2021 to April 2022. This was in line with the number of transfers out for other hospitals in the Ramsay Health Care UK group.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service had leaflets available to provide information to patients about how to make a complaint

The service did not currently display information about how to raise a concern in patient areas. This was since many of the display boards had been removed during the COVID-19 pandemic to reduce infection risk. There was a plan to reintroduce complaints process posters on the ward.

Staff understood the policy on complaints and knew how to handle them. The complaints policy set out the reporting and investigation process for complaints including timelines for responses to patients. Managers kept a complaints tracker to monitor progress of complaints which detailed response due dates and any actions taken. From April 2021 to March 2022 there had been 12 new complaints about the service.

Managers investigated complaints and identified themes. Complaints investigations were managed by heads of department and once completed were reviewed by the hospital director. The complaints tracker was used to monitor for any themes with complaints.

Requires Improvement

Surgery

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers acknowledged receipt of complaints and provided copies of complaint investigation reports to patients in line with policy. Managers routinely met with patients to discuss complaint responses if this was requested.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers said they would discuss complaints with individual staff concerned. However, there was no standing agenda item in team meetings for managers to discuss complaints investigations widely with all staff.

Staff could give examples of how they used patient feedback to improve daily practice. Managers gave an example of how staff had been reminded about the process for removing or taping jewellery before surgical procedures in response to a complaint about a lost wedding ring.

Are Surgery well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

The hospital had a hospital director who had been in post since 2018. The director provided support to the head of clinical services and heads of departments. Theatre managers were experienced and provided effective leadership. However, there had been some recent changes with the ward management structure and leaders at this level were new to the role and still developing their skills and experience.

Staff described managers at all levels as visible, approachable and supportive. Staff spoke highly of them. Staff described having confidence in hospital managers and described heads of department as competent and responsive.

There was a focus on developing staff, including through leadership training programmes which were available through the Ramsay Academy.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

There was a Ramsay Health Care UK wide five-year strategy. This set out a vision to:

'establish strategic partnerships with local, national and global stakeholders to be the trusted provider of choice to deliver excellent, affordable care to all patients with the best team in the sector'.

There were five pillars which informed the strategic plan and objectives were identified to support achievement of the strategy.

Requires Improvement

Surgery

The West Midlands Hospital had a three year vision based on the Ramsay Health Care UK strategy and had set priorities for this. The hospital was working with GPs and local NHS trusts to meet local healthcare demands.

Culture

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

We observed a positive culture within the service during our inspection. Theatre staff spoke of working in a great team with strong working relationships between staff at all levels. We observed respectful relationships between medical and nursing staff.

Staff told us that they had not experienced any racist or bullying behaviour in their roles.

Staff worked in accordance with the corporate values known as 'the Ramsay way'. These values incorporated the importance of constructive relationships and respect.

Staff were supported to develop by taking opportunities available through the Ramsay Academy. There was a talent mapping process where staff could discuss any training required for progression within their role. Managers stated there was a lot of investment in staff development and gave examples of how staff had been supported to complete nurse associate training, a master's degree and management courses.

Staff said that there was a no blame culture and they felt confident to raise issues and concerns without fear of retribution. There was a Ramsay 'speaking up for safety' agenda which supported to staff to speak up using the safety code. Staff were trained in this to give them confidence to raise concerns and prevent unintended patient harm.

All staff were aware of their responsibilities under duty of candour. Staff could give examples of when duty of candour had been applied.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff did not all have regular opportunities to meet, discuss and learn from the performance of the service.

We found that governance systems and processes were not always followed. For example, there was a failure to store substances hazardous to health in line with policy and there was a lack of oversight of equipment testing processes. Although there were appropriate processes for consent and psychological assessment of patients before surgical procedures, these were not consistently followed. The service was still not compliant with the breach of Regulation 17 (good governance) identified at the last inspection in 2018. We were therefore not assured that they effectively used findings from audit or fully embedded action plans where poor performance and learning was identified.

However, there were many governance systems and processes in place which were overseen by the regional clinical quality partner (CQP). The CQP had a remit to support the head of clinical services (HOC) with governance oversight and audits. There were monthly meetings between the CQP and heads of clinical service they supported. The HOC met with other HOCs nationally to ensure consistency of governance management across Ramsay Health Care UK. We did not find evidence that these governance systems were fully embedded across the service.

Clinical governance reports were produced by the HOC and updated monthly. These were reported at a corporate level, meaning there was national oversight of the hospital's governance and performance. Heads of department attended monthly clinical governance meetings which fed into the integrated governance meetings that were held between the heads of department and senior leadership team. We asked for minutes of these meetings, but they were not provided. This meant we could not be sure what format these meetings took or what issues were discussed

We were told that staff had regular meetings at department level, and that a standing agenda had recently been implemented for all team meetings. However, we saw minutes of theatre meetings held between the theatre manager and theatre staff which did not show that these meetings had followed a set agenda and did not cover all aspects of service performance. The service was not able to provide any minutes for meetings held at ward level. Staff and managers told us that ward meetings were currently not routine but there was a plan to reinstate regular meetings by the new ward managers. Minutes of any meetings held were sent out to all staff electronically.

There was some information sharing at daily huddle meetings between the leadership team and heads of department. Corporate messages were shared at these meetings and then shared with staff by the heads of department. These included, for example, lessons learned from incidents and complaints. However, there was no formal or consistent process for the sharing of learning with all staff.

The clinical director for Ramsay Health Care UK sent 'flash messages' about current relevant guidance (e.g. NICE guidelines) or issues of concerns to all staff by email. There was also a monthly clinical update newsletter issued monthly which detailed audit performance across the Ramsay Health Care UK group.

Management of risk, issues and performance

Leaders and teams did not always use available systems to manage performance effectively. However, they identified and escalated relevant risks and issues and identified actions to reduce their impact.

There were systems to monitor the service's performance. The hospital director and head of clinical services met with heads of department bimonthly to review all aspects of service performance. This included review of achievement of clinical indicators, audit performance, compliance with training requirements and any incidents and complaints. Performance for clinical key performance indicators was reported at a corporate level and funnel charts were produced which monitored performance of each hospital in the Ramsay Health Care UK group. Any outliers for performance were reviewed and appropriate actions were put in place to improve performance. Although audit performance was reviewed, we did not see evidence that learning from poor performance in audits was consistently embedded in the service.

Any poor performance concerns within the consultant body were addressed at the Medical Advisory Committee. Practising privileges were granted, reviewed and withdrawn through this process.

Each department held a local risk register which recorded risks and provided a system to monitor a reduction in risk. Local risks were reviewed at monthly heads of department meetings; we saw evidence of this process.

Any risks scoring nine or above (where a maximum score was 20), were escalated and added to the hospital risk register. All hospital wide risks were reviewed by the clinical quality partner. Any risks that had potential national relevance or impact were escalated to the Ramsay corporate risk register.

Requires Improvement

Surgery

Information Management

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

Data was routinely collected and analysed to understand performance and identify areas for improvement. Data was shared across the Ramsay Health Care UK group and used to produce charts to enable services to benchmark their own performance against that of their colleagues in other hospitals

The information system was largely computer based with access limited to staff with individual password protection. A new electronic record programme had recently been introduced across the hospital. Any paper records were scanned into the electronic system at the point of patient discharge. This meant that medical records were stored securely.

All data and notifications were submitted to external organisations appropriately. The service submitted data to the National Joint Registry. Statutory Notifications were submitted in line with policy. There was a process for review of incidents that may meet the reporting threshold to decide if a notification was required.

Engagement

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

Staff had a conversation with each patient at the point of discharge to see if they had been satisfied with the care they had received. Feedback forms were sent out to all patients following discharge. The hospital website encouraged patients and the public to get in touch with any feedback to help staff and managers improve the service.

We were told that a patient forum was in the process of being set up to enable more engagement with patients. The first meeting of the forum was planned for 8 June 2022.

The hospital engaged with staff through regular staff surveys which identified how engaged and enabled staff who worked for the organisation felt. Results of the survey were shared with all staff and opportunities for improvement were identified. A staff working group was created to generate ideas for an action plan based on the results. The hospital director had just set up a staff engagement group where any staff issues could be raised, and staff suggestions could be discussed. An employee of the month award, nominated by staff, had just been introduced.

The hospital worked with local acute NHS hospitals and commissioners to manage waiting lists for elective surgical procedures.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged staff development. However, managers were unable to provide examples of improvement through innovation.

There was investment in staff to support them to professionally develop. Staff were keen to learn and develop new knowledge and skills in order to improve care to patients. Managers gave examples of how staff had been supported to complete nurse associate training, a master's degree and management courses

'Lunch and Learn' sessions were held with staff as drop in sessions to learn about current issues and updates within the hospital.

Requires Improvement

Surgery

The service did not provide any examples of quality improvement initiatives when asked for evidence of this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The service must ensure safe management of substances that are hazardous to health (Regulation 15 (1) (a): Premises and equipment) • The service must ensure that adequate systems are in place for testing equipment so that equipment is in date and safe for use (Regulation 15(1) (e): Premises and equipment)

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that records relating to the care and treatment of each person using the service are complete and available. Specifically, there must be evidence of psychological assessment for all patients undergoing cosmetic surgery, in line with national guidance. Records of the first stage consent process must be available to surgeons before operating (Regulation 17 (2)(c): Good Governance) • The service must ensure that their governance systems are effective in order to monitor and improve the quality and safety of the services provided (Regulation 17 (2)(f): Good Governance)

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

- The service must ensure that all staff have completed training in all key skills (Regulation 18 (2)(a): Staffing)