West Midlands Hospital

Quality Report

Colman Hill
Halesowen
West Midlands
B63 2AH
Tel: 01384 560123
www.ramsayhealth.co.uk

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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

Summary of findings

Letter from the Chief Inspector of Hospitals

West Midlands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 34 beds with en-suite facilities. Facilities include two operating theatres and an endoscopy room, and a three bay recovery area. One theatre had laminar flow ventilation system. Outpatient and diagnostic services were available including six consulting rooms and x-ray. MRI and CT scans were provided by Ramsay Diagnostics UK and therefore these facilities were not inspected. An offsite hydrotherapy pool is available for patients requiring this as part of the physiotherapy services.

The hospital provides surgery, and outpatients and diagnostic imaging. We inspected both core services.

We inspected this service using our focussed inspection methodology which meant we followed up on issues and concerns raised at the last inspection. We carried out the inspection on 31 May 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

This inspection was conducted as a follow up inspection to identify changes made after the previous inspection completed in 2015. During the previous inspection we found the following concerns:

- Outpatient records were removed from site resulting in hospital staff not having access to contemporaneous notes.
- Medicines were not consistently stored and managed as per national guidelines. In addition, some medicine errors were not reported appropriately.
- The World Health Organisation (WHO) safer surgery checklist was not consistently completed for interventional radiology; and there was no regular audit to monitor the completion of WHO checklists within theatres.
- The external multi-disciplinary approach to managing patients with cancer required improvement.
- Consultants held practising privileges which were reviewed by the hospital every five years rather than every two years.
- The nurse competency assessment process was informal and required improvement.
- The equipment register did not include all staff who used this.

Following this inspection, we rated this hospital as good overall.

- We found that medicines were managed and stored appropriately. The hospital had improved the amount of pharmacy support provided by the local trust since the previous inspection. We found a pharmacist attended West Midlands Hospital three times per week to check medicine stock and management; and held a weekly meeting with the resident medical officer (RMO) to review medicine requirements.
- We found the World Health Organisation (WHO) checklist was consistently completed; and was audited to ensure compliance. In particular, the imaging service had introduced a modified World Health Organisation (WHO) safer surgery checklist for patients undergoing specific procedures, for example ultrasound guided injections.
- We saw consultants' practising privileges were reviewed yearly at Medical Advisory Committee meetings.
- The management of patients with cancer through external multidisciplinary team meetings had been formalised with the local NHS trust.
- We found that patient records were kept securely on site.
- During our inspection we found that staff competencies, including nurses, were well recorded and up to date.
- Medical and non-medical equipment was well maintained and serviced in line with manufactures requirements. This was well managed by the operations and facilities department.

Summary of findings

However, we found that record keeping required improvement. Improvements were needed to ensure medical staff maintained accurate and up to date records about patient care.

- Medical records for outpatient clinics were incomplete and lacked detail. We found three out of 14 records looked at had no outpatient documentation within them.
- We found psychological assessments on patients undergoing cosmetic surgery were not documented fully within patient records. Therefore, we could not gain assurance consultants completed these fully.
- We looked at an inpatient record for a patient who had deteriorated post-surgery and required an additional night at the hospital. We found that consultant updates; and a review by the resident medical officer had not been documented within the patient record. The management team took immediate action in response to this during our inspection and both the consultant and the RMO were made aware that, on that occasion, there was a lack of documentation.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Surgical specialties at the hospital also included orthopaedics, gynaecology, ear, nose and throat, ophthalmology, general surgery and urological procedures. The hospital undertook cosmetic surgery including breast enlargements, abdominoplasty, liposuction and facial surgery.
Outpatients and diagnostic imaging	Good 	A range of specialist consultants undertook consultations on an outpatient basis. Outpatient facilities also included a physiotherapy department who provided post surgery rehabilitation in addition to sports injury clinics, pain management clinics and acupuncture. An offsite hydrotherapy pool was available for patient use. The diagnostic facilities included an x-Ray department offering a range of screening and x-Ray procedures, including: on site plain x-ray and ultrasound. A mobile magnetic resonance imaging (MRI) scanner and a computerised tomography (CT) scanner also came to the hospital; however these were offered under a different provider therefore were not included within this inspection.

Summary of findings

Contents

Good

West Midlands Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging

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

The hospital has had a registered manager in post since 2011; however the current general manager has worked as the general manager for 12 years in total.

Our inspection team

The team that inspected the service comprised four CQC inspectors, and two specialist advisors with expertise in theatres and outpatients respectively. The inspection team was overseen by Mark Heath, Inspection Manager.

Information about West Midlands Hospital

The hospital is registered to provide the following regulated activities:

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

During the inspection, we visited the theatres, endoscopy room, the inpatient ward, the outpatients department and the diagnostic imaging area. We spoke with 26 members of staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with seven patients and three relatives. During our inspection, we reviewed 14 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected three times, and the most recent inspection took place in December 2015. At the previous inspection the hospital was rated requires improvement overall. This inspection was conducted to follow up on the main findings of the previous inspection and to assess improvements.

Activity (June 2017 to May 2018)

- In the reporting period, there were 5908 inpatient and day case episodes of care recorded at The Hospital; of these 4614 were NHS-funded and 1294 other funded.
- 19% of all NHS-funded patients and 41% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 64247 outpatient total attendances in the reporting period; of these 14072 were other funded and 50175 were NHS-funded.

Eighty-one consultants and 25 anaesthetists worked at the hospital under practising privileges. Regular resident medical officers (RMO) worked on a one week on; two

Summary of this inspection

week off rota. West Midlands Hospital employed 28 registered nurses, 12 health care assistants and eight receptionists. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety for the time period May 2017 to May 2018

- 0 Never events
- Two serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- 25 complaints between May 2017 and May 2018
- 163 incidents reported from November 2017 to April 2018

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Laundry
- Maintenance of medical equipment
- Resident Medical Officer provision
- Pharmacy services
- Pathology and histology services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Are services safe?

We rated safe as requires improvement because:

- As reported within the overall summary, we found patient records did not consistently contain accurate and up to date medical entries. However, we saw entries made by nurses and allied health professionals were to a satisfactory standard.
- We found infection control risks across outpatients and diagnostic imaging. Carpeted flooring was in place in rooms used to change dressings and perform internal ultrasounds. We requested the cleaning policy which indicated for bodily fluid spillages; clinical staff should follow the infection and prevention control policy for cleaning this. Housekeeping staff could complete their normal clean following this. Therefore, the infection control risks were mitigated. The hospital was undergoing extensive re-decoration and plans were in place to replace the carpeted flooring post inspection.
- Incident reporting and sharing of learning was not consistent across outpatients. We found examples where staff had not reported incidents and learning had not been shared. However, we found that within the surgery department including theatres and the ward; incidents were reported and investigated; with lessons learnt consistently disseminated to staff.

However, we also found:

- Mandatory training compliance within outpatients and surgery met targets.
- Safeguarding knowledge and training was good. Systems were in place to ensure patients were protected from abuse.
- Staffing across the hospital met the needs of the service, including nursing, medical and allied health professionals (such as radiographers and physiotherapists).
- Medicine management throughout the hospital was good. This was an improvement from the previous CQC inspection in 2015.

Are services effective?

Good

We rated effective as good because:

- The imaging service had introduced a modified World Health Organisation (WHO) safer surgery checklist for patients undergoing specific procedures, for example ultrasound guided injections.

Summary of this inspection

- Fasting guidelines given to patients due to undergo surgery adhered to National Institute for Health and Care Excellence (NICE) guidelines.
- We saw staff were assessed as competent to undertake their roles within the hospital.
- We found staff had knowledge around capacity and the Mental Capacity Act 2005. Staff asked were aware of their requirements to raise concerns around capacity and the ability to consent for treatment.
- Multidisciplinary work was evident across the hospital; staff worked with different teams and liaised with each other in order to achieve a high standard of care for patients.

However, we also found:

- Appraisal rates across theatres required improvement. At the time of the inspection, 83% of staff had received an appraisal. However, it was noted that appraisal rates for ward staff were much higher than the rates for theatre staff.

Are services caring?

Good

Are services caring?

We rated caring as good because:

- All patients undertaking intimate examinations were accompanied by a chaperone to ensure their privacy and dignity needs were met. Staff were respectful of patients and knocked on doors prior to entering patient rooms.
- Staff involved family members in consultations and decisions where the patient wished this to happen. Staff answered patients' questions about their care and treatment. Patients told us that they were given time to consider their choice to undertake treatment prior to consenting for this.
- We observed a caring approach from staff who sought to ensure the patient was comfortable at all times throughout appointments and procedures.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned with the needs of the local population in mind. The hospital opened six days per week and flexibility around appointment days and times was offered.

Summary of this inspection

- Staff could access information leaflets in multiple languages, and print these directly from their internal intranet. Staff told us that they could access interpreters for both spoken and signed languages. Interpreters could be accessed via telephone and in person depending on the needs of the patients.
- Patient complaints and concerns were dealt with appropriately; and improvements were made following these.

However, we also saw areas in which the hospital could improve:

- Storage within the physiotherapy department was limited. The physiotherapy room was small and contained a lot of equipment. Staff told us they felt this hindered their ability to undertake full physiotherapy sessions. In addition, physiotherapy patients had no specific waiting room. Instead; chairs were set out along a corridor.

Are services well-led?

Good

We rated well-led as good because:

- During our inspection, we observed a culture of openness, transparency and support. Staff were encouraged to report incidents, raise new ideas and initiatives and to work towards continued professional development.
- Staff reported that heads of department and senior leadership were visible and supportive.
- Risks to each core service were noted on departmental risk registers; these were assessed and where required escalated to a hospital risk register which was reviewed through clinical governance meetings.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as **good.**

Summary

At our last inspection, this domain was rated as requires improvement. This was because:

- Effective systems were not in place to ensure medicines were consistently managed in a safe manner.
- Lessons from incidents were not always shared amongst all staff to reduce the risk of further incidents from occurring.
- 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 'five steps to safer surgery' checklist despite this being on the hospital's policy.

At this inspection, we found that these improvements had been made and we have now rated this domain as good because;

- Effective systems were now in place to support the safe management of medicines.
- Incidents were reported, investigated and managed effectively and lessons learned were shared across all staff groups.
- The environment and equipment were safe and appropriate.
- Staff completed mandatory training to enable them to provide safe care and treatment.
- Systems were in place to ensure patients and their visitors were protected from the risk of abuse.
- The risks of infection were reduced because effective infection control and prevention procedures were in place and followed.
- Risks to patient's health and wellbeing were effectively assessed and managed.
- Staffing levels and skill mix were appropriate and safe.
- Nursing and allied health care professional records were maintained to an appropriate standard.

However;

- Improvements were needed to ensure medical staff maintained accurate and up to date records about patient care.

Mandatory training

- Staff told us that computer based learning was used to provide the majority of their mandatory training. However, face to face training was also used where necessary to provide the practical elements of subjects such as, manual handling and basic life support.
- 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. We saw that staff applied the skills acquired through this training programme to ensure patient safety. For example, we saw theatre staff use safe moving and handling methods.
- At the time of our inspection, average mandatory training completion rates were 98% for ward staff and 96% for theatre staff.
- All resident medical officers were qualified in advanced life support, which was a mandatory requirement for the role. Nursing and theatre staff completed basic life

support and immediate life support. Provider records showed that at the time of our inspection training compliance rates for immediate life support were 79% for ward nursing staff and 77% for theatre staff. Staff who required updates in this training had been booked onto the next available training courses.

Safeguarding

- Staff completed level one and two safeguarding training on a regular basis to ensure their knowledge and skills within this area remained current. This training covered children and adults safeguarding. The hospital did not treat children, however staff completed children's safeguarding training to ensure they were equipped to identify and act upon any children's safeguarding concerns they may witness whilst treating the adults under their care. Training records showed 100% of ward and theatre staff had completed safeguarding awareness levels one and two.
- The provider had an identified member of staff who was the safeguarding lead. This person had completed enhanced safeguarding training for adults and children. All the staff we spoke with named the safeguarding lead and described how they would recognise and report any potential safeguarding concerns. For example, two members of staff told us how they had recognised and acted upon a recent safeguarding concern that resulted in a referral to the local authorities safeguarding team for investigation.
- Staff told us where they could access the hospital's safeguarding policy and we saw that the agreed local reporting procedures were displayed in clinical areas for staff to refer to when required.

Cleanliness, infection control and hygiene

- The hospital had appropriate accessible policies and procedures in place to manage infection prevention and control (IPC). Staff demonstrated that they were aware of and understood these policies and procedures. For example, staff told us they removed cannula's and catheters as soon as it was safe and appropriate to do so in order to reduce the risk of infections.
- Infection control training formed part of the hospital's mandatory training programme. Compliance rates for this training were 91% at the time of our inspection.
- Before being admitted to the hospital for their surgery, patients were assessed and screened for potential infections such as Methicillin-resistant Staphylococcus aureus (MRSA). In accordance with national guidance, patients were only admitted for surgery if no infection was identified and any patients with infections were offered suitable treatment and reassessment.
- We observed staff following safe IPC procedures in pre-assessment areas, theatres and on the ward. This included following the 'bare below elbows' policy and safe handwashing between patients and before and following interventions. Theatre staff followed the National Institute for Health and Care Excellence (NICE) guidance for surgical hand antisepsis 2017. The provider undertook hand hygiene audits, which included observation of staff hand washing. Records showed 100% compliance for correct hand washing from November 2017 to April 2018.
- Personal protective equipment was readily available, correctly stored, and worn by staff in accordance with the hospital's policy. All staff adhered to national dress requirements to minimise the risk of health care acquired infections. This included the use of scrubs and suitable footwear in theatres to minimise the risk of cross contamination and infection. A new system had been recently introduced that meant different coloured footwear was used on wards and theatres by staff to reduce the risk of cross contamination and infection. We saw that staff followed this new procedure.
- The hospital did not have a sterile services department on site. Arrangements were in place for sterile services to be accessed at another healthcare site owned by the provider. 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.
- Information provided by the provider identified that from 1 May 2017 to 30 April 2018 there had been no cases of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile, Escherichia coli or methicillin-susceptible staphylococcus aureus (MSSA) infections had been reported during this same period. These are all potential serious infections that could cause harm to patients.
- Provider data showed that from 1 May 2017 to 30 April 2018, 23 post-operative wound infections had been reported during this time. Two of these infections had been classified as causing severe harm. We saw that full root cause analysis' had been completed to identify if the hospital were accountable for the infections. There

was no evidence to show that these infections were directly caused by the staff at the hospital, but areas had been identified to improve practice and this learning had been shared amongst all staff.
- Regular infection control audits were completed on the ward, theatres and recovery. Action plans were in place to address any identified shortfalls.
- The hospital's 2017 Patient Led Assessment of the Care Environment (PLACE) audit identified a score of 93.60% for cleanliness. This was lower than the national average of 98.38%. The management team had devised an action plan to make improvements following feedback from the PLACE audit. A review of this action plan showed some improvements had been made and some were in progress.
- Patients told us and we saw that clinical areas and patient's rooms were visibly clean. All equipment was stored neatly and ready to use with 'I am clean' stickers attached. These evidenced when the equipment had been cleaned. 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 these were addressed.

Environment and equipment

- We saw that improvements had been made and sustained with regards to the theatre environment. There were ongoing challenges with storage and space and long-term plans were in place to address this. However, the theatre environment had been decluttered.
- Patient-led assessments of the environment took place each year. In 2017, the hospital scored 82.98% for the condition, appearance and maintenance of their premises compared to a national average of 94.02%. All the actions on the associated action plan relating to this assessment had been completed to make the required improvements.
- Emergency resuscitation equipment, oxygen and suction equipment was available in the pre- assessment area, on the ward and in theatres. Records showed that this equipment and other medical equipment was routinely checked to ensure it was fit for purpose and ready for immediate use.
- We saw records that showed anaesthetic equipment was checked in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. This ensured equipment used for anaesthetic purposes was safe to use.
- 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.
- Equipment, implants and instruments were compliant with the Medicines and Healthcare Products Regulatory Agency (MHRA) requirements. We saw that when prosthesis or implants were used, an appropriate record was made which detailed the batch number and identification number for future reference.
- We saw that swabs, blades and sutures were counted and recorded on the 'count board' as appropriate and in line with safe practice. At the end of the procedures swabs, instruments and other equipment were checked and confirmed to be correct.
- The management of waste was appropriate with designated areas for the appropriate segregation, storage and disposal of waste.

Assessing and responding to patient risk

- Nursing staff assessed risks to patients at pre-assessment appointments, which took place face to face or by phone dependent upon patient need. This process allowed staff to identify if patients were high risk for surgery and refer to other providers as the hospital did not have critical care facilities.
- We saw that care records contained risk scores for risks that included; the development of pressure ulcers and blood clots and the risk of falls and malnutrition. However, fully completed individual assessments were not recorded in care records which meant staff would be unable to identify the specific areas where risk may have changed and managers could not check that these assessments were being completed correctly. For example, the staff used the Waterlow Score to assess and monitor the risk of developing pressure ulcers. The Waterlow Score card advises users to ring individual scores on the assessment card. However, staff told us and we saw that they were not doing this as they were only recording the overall score. We fed this back to the provider who told us they would make improvements to this process.

Good

Surgery

- We saw that where risks; such as the development of blood clots or pressure ulcers had been identified appropriate action was taken to mitigate these risks. For example, specialist equipment in the form of compression stockings and/or mechanical aids were used to mitigate the risk of the development of blood clots in patients' legs.
- The staff used the National Early Warning Score (NEWS). The NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. The patient records we reviewed demonstrated that the NEWS was used in accordance with best practice guidance and any significant changes in patients' NEWS were reported and escalated appropriately.
- Guidance and information relating to the identification and treatment of suspected sepsis was accessible in clinical areas and staff demonstrated they understood how to respond if sepsis was suspected. Staff told us they followed the 'Sepsis Six' approach which is a national approach used to facilitate the early identification and treatment of sepsis.
- 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, radiographers, radiologists and physiotherapists. A service level agreement was also in place with the local acute NHS trust to ensure patients could be transferred in the event of a medical emergency. Staff demonstrated a sound awareness of this agreement and the protocols in place.
- Hospital records showed that from 1 May 2017 to 30 April 2018 there had been four cases of appropriate unplanned transfers of in-patients who had become acutely unwell post-surgery. These patients were transferred to the local NHS hospital as per service level agreement. We assessed the proportion of unplanned transfers to be 'similar to expected' compared to the other independent acute hospitals over the same period.
- Staff told us and we saw that a team 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.
- We observed that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was completed in a variable manner in the theatres we visited. This process should be used for every patient undergoing a surgical procedure. The process involves specific safety checks before, during and after surgery. Patient records showed that the checklist was completed and recorded, but we saw that it was not always completed in an interactive manner in accordance with WHO guidance. For example, the checklist states the pre-surgery 'before' check should be read out loud in full. However, during one of the two surgeries we observed we saw one staff member completed the 'before' check without verbally consulting with other staff. After sharing this feedback with the management team, they assured us that this was an isolated incident and action was taken to ensure all staff adhered to WHO guidance.
- The completion of the WHO safety checklist was monitored as part of the hospital's audit programme. This included auditing through observing compliance in theatres and reviewing patient records. Completed audits contained action plans where necessary to drive any improvements with the compliance and completion of the WHO checklist. We saw that action taken in response to these audits was effective. For example, a theatre audit for March 2018 showed that a surgical pause prior to starting surgery was not always completed. During our inspection, we observed improved compliance with this element of the WHO checklist and a surgical pause was completed for the two surgeries we observed.
- A handover system was in place to enable any relevant surgical information to be passed onto the ward staff. This included a verbal handover and written notes reflecting the patients journey through theatre and recovery.
- Systems were in place to respond to any changes in risk post discharge from the ward. Patients were given the details needed to enable them to access telephone advice and support 24 hours a day. Nursing and medical advice could be sought via this phone line in the event of any changes to a patient's health and/or wellbeing.

Good

Surgery

Nursing and support staffing

- Patients and staff told us they felt that the staffing levels and skills mix were sufficient. For example, one patient told us how competent staff which included; nurses, doctors and a radiographer had responded urgently when their health deteriorated.
- An effective rota system was in place that enabled heads of departments to manage staff rotas, skill mix, and staff requirements including senior cover requirement.
- 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. In addition to this pre-planning, 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. The ward manager told us that the ward was staffed with one nurse to every six to seven patients and the staff rotas we viewed confirmed this.
- Information about peoples predicted in-patient needs were identified at pre-assessment and communicated to the ward. This enabled the ward to ensure appropriate staffing numbers were available to support any additional needs. For example, the ward manager told us that a patient that was due to be admitted to the hospital required one to one care during their admission, so this had been planned for on the nursing rota.
- Systems were in place that ensured sickness, other leave or increased patient acuity was covered by regular bank staff. This arrangement meant staff were familiar with the hospital policies and procedures which reduced the risk of harm to patients. Having an effective bank staff pool in place meant the use of agency staff was low with 10% of the total staffing hours supplied on the ward and in theatres from November 2017 to April 2018 being supplied by agency staff.
- We saw that on call systems were effective in ensuring people's needs were met. For example, a patient and staff told us a radiographer had been called into the hospital out of hours on the evening before our inspection to complete an urgent diagnostic test. The patient told us the radiographer completed this test within approximately 20 minutes of being called.
- Handovers were completed in a safe manner. This included the handover of patient information between departments, such as theatre to ward and the handovers that occurred between staff shifts. Important information about patients' needs was clearly communicated to ensure that patients' individual needs were met.

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 cover from another consultant with practising privileges at the hospital, in the event that they were not available. We spoke with staff on the ward who told us there were no issues with cover and when it was arranged it was clearly communicated and recorded.
- A resident medical officer (RMO) was on the hospital site 24 hours a day, seven days a week. This ensured that a doctor was always available to promote patient safety. Staff told us that the RMOs were responsive and would attend to assess patients immediately when requested.
- Effective handover systems were in place to ensure safe medical handover. This included communication between consultants and the RMO and handovers between individual RMO's.
- The hospital had a Medical Advisory Committee (MAC) that provided oversight and review of practicing privileges prior to the approval of the Ramsay Medical Director in accordance with the provider's policies and procedures. The role of the MAC included ensuring that new consultants 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 reviewing existing consultants' practicing privileges and advising the hospital on their continuation.

Records

- The staff used a paper based records system to record patients' care. Care pathway documents were used which covered the patient's journey from pre-assessment, surgery and discharge. Different care pathways were available for the different types of surgery undertaken at the hospital, for example gynaecology, and hip and knee replacement.
- We looked at the care records of 14 patients who had undergone surgery at the hospital. Two of these patients were inpatients at the time of our inspection. We found that theatre, nursing and allied healthcare professional

records were generally of a satisfactory standard. However, we found that patient records that reflected patient's initial medical consultations and post-operative medical care were not always sufficiently detailed to reflect the assessments and interventions that had been requested or completed.

- Staff told us that an inpatient had become unwell on the evening before our inspection and had required assessment from the RMO who had requested an out of hours diagnostic test. There was no record of the RMO's consultation with this patient in their medical records, to reflect their findings or rationale behind requesting the test. This meant that although the patient got the medical support they needed, when they needed it, their records did not reflect that. There was a risk that if the patient required an emergency transfer to the local NHS trust important information about their care may not have been handed over. The management team took immediate action in response to this during our inspection and both the consultant and the RMO were made aware that, on that occasion, there was a lack of documentation. We were advised that an audit of this specific consultant's record keeping would be conducted to ensure ongoing compliance.
- Four of the records we viewed were for patients who had received cosmetic surgery. All four records contained no recorded evidence to show that their psychological wellbeing or psychiatric history had been considered or assessed in accordance with the Professional Standards for Cosmetic Surgery 2016. This meant that we could not be assured that patients' psychological wellbeing was being considered as recommended.
- We also found that best practice guidance with regards to record keeping was not always followed. A Clinician's Guide to Record Standards – Part 2: 2008 states, 'The name and designation of the person making the entry should be legibly printed against their signature'. We found that this guidance was not being followed as nine of the 14 records contained consultants' signatures, but no name or designation were printed by the signature, meaning we could not always identify who had made clinical entries into the records. Following our inspection, the management team informed us that they recognised that this was not in line with best practice, but they did have systems in place to identify staff members signatures.
- We saw that summaries of the patients care and treatment were recorded and sent to patient's individual GP's. This meant the GP's had access to the information they needed to support people post discharge.
- All patient records were stored securely and in locations where confidentially could be assured.

Medicines

- There was no onsite pharmacy at West Midlands Hospital, however pharmaceutical services were provided by a local NHS trust. This pharmacist support included regular visits to the hospital three times a week to complete checks of prescription charts, medicines supplies and to audit compliance with medicines management. 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.
- Hospital records showed that there were effective communication systems in place to ensure the service provided by the pharmacists was reviewed on a regular basis. We saw that a meeting had been held in April 2018 reviewing the safety and effectiveness of the service provided and an action plan was in place that addressed the issues raised during the meeting so that the service and support could continue to be provided in a safe and effective manner.
- We found that medicines were stored safely. This included controlled drugs, temperature sensitive medicines and cytotoxic medicines which are classed as hazardous substances. Staff told us how these medicines needed to be stored to promote safety and we saw that the systems in place to do this were followed. For example, controlled drugs were stored in a separate secure, locked cupboard and robust recording procedures were followed that ensured the stock levels of these medicines were regularly monitored to reduce the risk of medicines misuse.
- We found that safe systems were in place to ensure medicines were administered safely. Allergies were clearly recorded and patients wore red wrist bands to alert staff of any medicines allergies. Medicine administration records were clear about medicines that had been prescribed and administered. Staff told us and records showed that medicines related competency assessments were also completed on an annual basis to

ensure staff were suitably skilled in the safe administration of medicines. For example, records showed that nursing staff completed competencies in drug calculations and intravenous medicines.

- We saw evidence that the hospital received and responded to safety alerts about medicines from relevant agencies including the Medicines and Healthcare Products Regulatory Agency (MHRA). For example, we saw appropriate action had been taken in response to safety advice relating to the substances used during skin preparation prior to surgery.
- The Ramsay Group's chief pharmacist was the named Medicine Safety Officer (MSO) for the hospital. An MSO has the responsibility to oversee medication error incident reporting and be the named contact for the MHRA and NHS England. Hospital records showed that medicines related incidents were reported, investigated and monitored in accordance with best practice.
- Staff told us that the provider's chief pharmacist visited West Midlands Hospital once a year to inspect the hospital for quality and safety. Staff told us that the latest chief pharmacist visit was completed in April 2018. Hospital managers were waiting to receive formal written feedback from this visit, but were keen to share that verbal feedback from the chief pharmacist had been positive. Managers told us a formal action plan would be produced to respond to any areas that required improvement as soon as the formal feedback was received.

Incidents

- Staff told us they had received training and felt supported to report clinical incidents and near misses. Incidents were reported by staff electronically and all the staff we spoke with demonstrated an understanding of this reporting system.
- Between 1 November 2017 and 30 April 2018 there had been a total of 163 reported incidents. 139 of these incidents resulted in no harm, 21 were classified as mild harm and three were classified as moderate harm. None were classified as severe harm and/or death. These incidents included patient related incidents such as; cancellations, falls, medicines errors and unplanned overnight stays as well as incidents relating to resources and staff trips and falls. This demonstrated an open reporting culture within the organisation.
- Staff told us and we saw evidence to show that reported incidents were investigated and learning was shared with them individually and in ward meetings.
- Staff told us and we saw that root cause analysis (RCA) investigations were completed following significant incidents. We reviewed three completed RCA's that related to post surgery wound infections. These were detailed and provided staff with action to take to reduce the risk of future incidents from occurring.
- Incidents were monitored by the management team and provider to ensure any patterns or themes were identified.
- There had been one unexpected death between April 2017 and May 2018. This death occurred elsewhere, but within 30 days of surgery at the hospital. We saw that a full investigation into the patient's care at the hospital was completed and although the death was not linked to a specific incident at the hospital, the hospital had taken the opportunity to learn from some of the investigation findings that needed acting upon. For example, the investigation showed that some improvements were needed to ensure patient records were sufficiently detailed at all stages of the patients care. This showed the hospital had effective incident investigation procedures.

Safety Thermometer

- 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 blood clots. West Midlands Hospital reported 100% harm free care during the time period we reviewed between May 2017 and April 2018.
- Contracts for care and treatment delivered at private hospitals but funded by the NHS have a target of 95% completion of venous thromboembolism (VTE) screening (risk of developing a blood clot). During 2017, the hospital achieved an average of 97.75% compliance against this target. This meant the hospital exceeded this target.

Are surgery services effective?

Good

We rated effective as **good.**

Good

Surgery

Summary

At our last inspection, this domain was rated as requires improvement. This was because:

- There were shortfalls in management and support arrangements for staff, such as completing staff appraisals and carrying out nursing competency assessments.
- The outcomes of people's care and treatment was not always monitored regularly or robustly.
- Staff did not complete nutritional risk assessments and care plans for patients who were obese or had experienced recent weight loss.

At this inspection, we found that improvements had been made and we have now rated effective as good because:

- Most staff received an annual appraisal and staff training needs were met.
- Patient outcomes were being monitored to ensure treatment was effective.
- Care and treatment was based on current best practice.
- Patient's nutritional needs were assessed and managed effectively.
- Effective systems were in place to ensure patients pain was managed during their admission.
- Multi-disciplinary team arrangements with local NHS acute trusts were in place to provide effective care for patients, particularly those being treated for cancer.
- The hospital provided a seven day service which included access to all professions out of hours if required.
- Patients were offered health promotion advice when this was indicated.
- Effective systems were in place to ensure the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were met.

However;

- Improvements were needed to ensure that all theatre staff received an annual appraisal.

Evidence-based care and treatment

- We saw that the provider 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 Clinical Guideline 50: 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.
- 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 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.

Nutrition and hydration

- Staff discussed the management of 'nil by mouth' prior to surgery at patients' pre-admission assessments. These discussions were based around best practice guidance.
- All patients told us that they had been given instructions not to have anything to eat from midnight and to drink 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. This ensured patients were kept hydrated if their surgery was not planned until later in the day.
- Medicines administration records showed appropriate prescription and administration of anti-sickness medicines following surgery.
- Patients were assessed with regards to their risk of malnutrition on admission. At the time of our inspection, none of the patients records we viewed showed they were at risk of this. Staff told us that if a risk was identified plans would be out in place to mitigate any risks this posed to patient safety and wellbeing.
- Following surgery fluid input and output records were maintained and the patients' condition monitored until normal urinary functions resumed.
- There was no access to a dietitian at the hospital. Should advice be needed then staff confirmed they would contact a local NHS hospital for guidance and refer appropriately.
- The 2017 results for ward food on the patient-led assessments of the environment (PLACE) scored 80.55% for ward food which was lower than the national

average of 90.19%. These results mostly related to the dining experience rather than the quality of the food. All the actions on the associated action plan relating to this assessment had been completed to make the required improvements to ward food.

Pain relief

- There were systems in place to effectively manage patients' pain control. Patients and staff told us that pain and pain relief was discussed at all stages of their care under the hospital. We saw that people's individual pain relief needs were planned for. For example, we saw one patient at a pre-assessment appointment request to not receive opiate based medicines post-surgery and this was clearly recorded by the nurse so a record of their pain relief preferences was recorded.
- We spoke with five patients who all told us their pain had been regularly assessed and was under control. Pain levels were assessed using a numerical pain scale and the results were recorded on the monitoring tool used to assess for signs of health deterioration. Records we viewed showed that patients pain levels were assessed and recorded each time this tool was used.
- We asked staff if there was an alternative pain assessment system in place that was suitable for people with any cognitive impairments. Staff told us that they used to use a pictorial pain assessment with children and young people, but this was removed from the service as children and young people no longer received care at the hospital. When we fed this back to the management team, they told us they would reintroduce the pictorial pain assessment so that people with cognitive impairments could be supported to discuss their pain management needs.
- Medication administration records (MAR's) clearly recorded people's 'required' and 'as required' pain medicines. Patients confirmed and MAR's showed that patients were able to access their 'as required' pain medicines when they needed these to help manage their pain. For example, one patient told us they had called staff in the night as they were in discomfort and staff had immediately administered their 'as required' pain relief as prescribed.

Patient outcomes

- As an independent hospital West Midlands Hospital did not participate in the majority of national audits undertaken by the NHS. However, the data that was available indicated that the hospital was either similar or better than expected when compared with other hospitals offering a similar service. This included readmission rates, returns to theatre and unplanned transfers to other hospitals. This indicated that patients were achieving positive outcomes for their conditions following intervention by the hospital.
- Provider information showed that there had been two cases of unplanned returns to theatre during in-patient stays between 1 May 2017 and 3 April 2018. These returns to theatre related to post-operative bleeding which was promptly resolved.
- For the same time period provider data showed there had been six readmissions post discharge. These related to circumstances outside of the hospital's control and included; a fall, infections, bleeding and urinary retention and were all managed appropriately during readmission. We assessed the proportion of unplanned returns to theatre and readmissions to be similar to expected compared to the other independent acute hospitals for which we hold this type of data.
- 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 staff invited all patients who had undergone hip or knee replacement surgery to complete a PROMs questionnaire. The PROMs results for the hospital for hip and knee replacements between April 2016 and March 2017 showed a higher improved patient health gain compared to the rest of England for both hip and knee surgery.
- PROMs data was also gathered for groin hernia surgery. The PROMs results for the hospital relating to groin hernia surgery between April 2016 and March 2017 also showed a higher improved patient health gain compared to the rest of England for the same surgery.
- Patients who were booked for joint replacement surgery were asked to consider giving consent for registration on the National Joint Registry (NJR) which monitors the performance of joint replacements. The NJR also collated and monitored PROMs data. They had analysed the hospital's PROM's data to be 'as expected' but also higher than the national average in terms of positive health gains.

Good

Surgery

Competent staff

- Systems were in place that ensured staff received a staff induction, ongoing learning development and appraisal. There was a formal induction process supplemented by mandatory training and other training and updates as required. All the staff we spoke with told us they received training and support to enable them to complete their work roles effectively and safely.
- Agency staff also completed a short induction on their first shift to orientate them to the hospital environment and its policies and procedures.
- A 'Lunch & Learn' initiative had been launched in 2018. Two sessions had been held to date which all staff were invited to attend. Plans were in place to ensure each session was based on a learning topic was identified around any serious incidents, audit results or any identified training needs e.g. difficult airways, pharmacy topics. This gave staff the opportunity to attend additional training sessions to ensure they were kept up to date with best practice.
- Staff files showed that annual competencies were completed with staff to ensure they were skilled in specific elements of care and treatment. This included; drug calculations, safeguarding children, gaining consent and pain management. This system ensured staff had understood their training and were equipped with the necessary skills to provide safe and effective care.
- When new policies were introduced managers had a 'read and sign' sheet which ensured the new information was disseminated to all relevant staff.
- The staff we spoke with told us they received annual appraisals. This was confirmed by the records we saw. Records dated 18 May 2018 showed that 83% of the total number of hospital staff had received an appraisal. However, it was noted that appraisal rates for ward staff were much higher than the rates for theatre staff. Records showed that only 50% of theatre staff had received an appraisal at the time of our inspection. The management team told us appraisals had been scheduled to address this.
- There was a process in place for checking General Medical Council and Nursing and Midwifery Council registrations, as well as other professional registrations. This ensured that staff were appropriately registered to fulfil their roles.
- 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' appraisals and we were satisfied that these requirements were met.
- Consultant competencies were also assured through the annual clinical review process. At our last inspection, we saw that this review process was completed every five years. The provider had improved this process by increasing it to an annual review to ensure consultants competencies were monitored as robustly as other staff groups.

Multidisciplinary working

- In accordance with the National Institute for Health and Care Excellence (NICE) recommendations, there were multidisciplinary working arrangements in place with other local hospitals for patients' cancer care and treatment. This ensured patients received a coordinated MDT approach to their care and treatment.
- Multidisciplinary working was evident within the hospital. This ensured that patients' needs could be met across a range of treatments and therapies. We observed positive interactions and collaborative working between the medical staff, nursing staff, theatre staff, pharmacists and allied health professionals working together as a team.
- Staff from pre-assessment worked closely with ward and theatre staff to ensure important information about people's risks and care needs were handed over and planned for in an effective manner. For example, a nurse in pre-assessment told us they worked closely with the anaesthetists with regards to any risks identified that may influence patient safety and care.
- Discharge letters were sent to patients' GPs with details of procedures carried out, follow up arrangements and any medication prescribed. This ensured GP's had access to the information they needed to support patients on discharge.

Good

Surgery

Seven-day services

- Planned surgeries took place between 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.
- There was an on-call rota in place to cover the services provided by the hospital out of hours. This rota ensured suitably skilled staff were always available within 30 minutes if required.
- Diagnostic tests, such as x-rays could be requested and completed at any time, including out of hours. We saw that the systems in place to complete diagnostic tests out of hours were effective as a patient told us and we saw that they had been able to access an x-ray out of hours on the evening before our inspection.
- 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.
- The staff had adopted the use of a 24-hour triage service for the rapid assessment and access to treatment for oncology or haematology patients. This enabled faster access to urgent treatment where necessary and had a clear patient pathway.

Health promotion

- Staff told us that during consultation and pre-assessment health risk factors such as; alcohol consumption, weight and smoking history were discussed with patients. Staff then told us that advice was given to patients with any identified health risk factors. For example, smoking cessation information was given to patients verbally and in a leaflet format so they knew which services they could access to receive this support.
- Patients were also screened for dementia using a nationally recognised screening tool if they showed any signs or symptoms or if they shared any concerns about their memory. Staff told us that patients who displayed signs and symptoms of dementia were referred to their GP for further investigations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All the staff we spoke with told us they had received training in the Mental Capacity Act 2005 and 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.
- A dementia screening tool was used at pre-assessment if a patient or relative showed any signs or symptoms of dementia or if they expressed any concerns about their memory. This enabled staff to identify patients who may lack capacity or struggle with making decisions about their care and treatment.
- All 14 consent forms we viewed complied with best practice guidance and were completed and reviewed throughout the patient's journey from consultation to surgery. 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 had consented to the proposed procedure.
- Staff told us that Deprivation of Liberty Safeguards (DoLS) in the hospital setting could mean preventing patients leaving the site or restraining them against their will. Staff told us that no patients had required a DoLS authorisation at the hospital and records we reviewed for the time period between April 2017 and May 2018 confirmed that no Deprivation of Liberty Safeguards applications had been made.

Are surgery services caring?

Good

We rated caring as **good.**

Summary

The caring domain remains the same since our previous inspection. We have rated caring as good because:

- Patients were supported and treated with dignity and respect and we observed caring and compassionate interactions between staff and their patients.
- Feedback from patients and their relatives was positive about the care and support they had received.

- Staff provided people and their families/carers with emotional support and promoted self-care and independence where possible.

Compassionate care

- We spoke with four in-patients and a patient who attended a pre-assessment appointment. Without exception, all the patients we spoke with spoke positively about the care they had received. Comments included; "The care is exceptional. Everyone is so considerate", I've been treated very well" and "The staff are excellent, they've been very nice".
- People told us and we saw that they were treated with kindness and compassion. For example, one patient told us that staff came quickly to them at night when they had complained of pain. This person said staff administered pain relief and monitored them closely to reassure them during the night. We saw a visibly anxious patient was escorted to surgery with the nurse whom they had developed a rapport with on the ward. This nurse stayed with the patient and held their hand and chatted to them until the patient had been anaesthetised.
- We saw that staff treated patients with dignity and respect. For example, we saw one nurse ask a patient how they would like to be addressed to ensure they addressed them in accordance with their preferences.
- We also saw that people's privacy and dignity was respected and promoted. For example, in theatre patients were covered appropriately to ensure that the only body parts uncovered were the parts that were being operated on. We also saw that staff knocked on people's room doors and waited for a response before entering rooms.
- The 2017 patient led PLACE assessment scored the hospital 60.87% for privacy and dignity. However, the areas requiring improvement appeared to mostly relate to out-patient services rather than surgery. An action plan was in place to ensure improvements were made as a result of the assessment and all actions relating to surgery had been completed.
- The hospital was compliant with the government's requirement to eliminate mixed-sex accommodation. Patients admitted to the hospital were only admitted to single rooms and only shared facilities when clinically necessary such as in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity.
- None of the patients we spoke with reported any cultural or spiritual needs. However, staff told us and we saw that patients were asked prior to admission and on admission if they had any cultural or spiritual needs. Staff said they would plan for these needs as required. For example, one staff member told us meals could be requested to meet people's religious needs when required.
- The provider also used the Family and Friends Test as a means of receiving patient and family feedback from patients whose care was funded by the NHS. Between November 2017 and April 2018 108 patients who had received in-patient care completed this survey. 100% of these patients stated they would recommend the service to their family and friends. For the same time period, 379 patients who received day case surgery returned the survey. 97.63% of these patients stated they would recommend the service to their family and friends. These results exceeded the national target of 90%.
- The provider's own patient satisfaction questionnaires were used to gain feedback from patients who paid for their care privately. Between November 2017 and February 2018 average scores showed that 98.75% of patients who completed the questionnaires would recommend this hospital to their family and friends.

Emotional support

- At pre-assessment appointments staff explained the process of admission, surgery and discharge to the patient. We saw this was an interactive discussion and patients were given the opportunity to ask questions or raise concerns. This ensured patients knew what to expect which helped to alleviate any fears or concerns.
- We spoke with one patient who elected to pay for their care and treatment. They told us they had not been placed under any pressure to consent to their chosen treatment. 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. This ensured people were not pressurised into agreeing to care and treatment at the hospital.
- We found that patients were given information from investigations in a timely manner which eased patients' anxiety around potential diagnoses. One patient told us they had not received the 'best' news immediately following an investigation they had undergone.

However, they told us their diagnosis and next steps in their treatment had been explained to them in a kind and supportive manner. This helped them to process the information.

- We found that the relatives of patients were also supported. One relative told us how staff had reassured them when their relation became unwell and that a flexible approach to visiting hours was taken in response to the situation. This had helped to ease the patient and relative's anxieties.
- Staff told us they had been able to access some training to raise awareness of the physical and emotional needs of people who identified as transgender. One member of staff told us, "It gave me more of an awareness of the issues transgender people face and it was delivered by someone who was transgender so it was good to hear from them what they felt comfortable talking about".
- Staff told us that if any mental health needs were identified during a patient's in-patient stay they would offer immediate support to the patient and discuss these needs with the patient's GP to ensure they could access the professional assessment and support required.

Understanding and involvement of patients and those close to them

- We saw that staff took time to listen to patients' concerns and explained treatment plans using clear, simple language to make sure patients understood what was going to happen. Staff involved family members and carers where appropriate; and provided appropriate information for continued care.
- Patients told us and we saw that verbal information was backed up with written information where needed in the form of leaflets and advice sheets. This ensured people were presented with information about their care and treatment in different formats to help them to understand and retain the information.
- Staff provided support and guidance to patients' and relatives in order to enable them to support self-care. For example, staff supported people to acquire the skills needed to monitor and manage their surgical drain needs if they needed to be discharged.
- Patient's told us they had a named nurse at the start of the shift. This provided continuity of care. It was clear from our observations and conversations between staff and patients/relatives that the staff made an effort to get to know the patients. Staff engaged in conversation; demonstrating knowledge and understanding of the patients' relevant medical needs, and also the patients' personal preferences. This was done in a professional way which showed interest and involvement with patients and relatives.

Are surgery services responsive?

Good

We rated responsive as **good.**

Summary

This domain remains the same since our previous inspection. We have rated responsive as good because:

- Patient's chose to use this service because it could meet their needs.
- Effective systems were in place to ensure patients could access their care and treatment in a prompt manner that met their individual preferences.
- Complaints were managed effectively in order to make improvements to people's care experiences.

Service delivery to meet the needs of local people

- The hospital provided both privately funded care and worked closely with NHS commissioning groups regarding the provision of surgical services for NHS patients. Between November 2017 and April 2018, the admissions mix was 77.5 % NHS, 12.9 %insured and 9.6 % self-pay. All the patients we spoke with told us they had chosen to receive their care and treatment at the service over other choices that were made available to them. Reasons behind this from patients included; prompt access to care and treatment and friendly staff.
- The hospital only provided elective care and treatment, therefore admissions were planned and arranged in advance. Surgery was performed seven days a week, enabling patients to select appropriate treatment times for themselves and their families.
- The structure of care and treatment at West Midlands Hospital meant patients received continuity in care. Patients were seen by the same consultant throughout their care and treatment at the hospital.

Good

Surgery

Meeting people's individual needs

- The hospital was fully accessible to all patients with facilities in place to meet the needs of disabled people. All patients had a single room with en-suite toilet and shower facilities. All rooms were accessible to wheelchair users.
- Staff told us there was no discrimination between NHS and private patients and that patients were treated based on clinical need and not according to funding method. We saw that all patients were treated the same and were admitted to their private bedroom with equal facilities that included TV and Wi-Fi which promoted patient comfort.
- Systems were in place to ensure care plans were put in place for patients with complex or additional needs, such as patients living with dementia. This included the staff from pre-assessment discussing assessed needs with ward staff to ensure any additional needs were met. During our inspection, we saw that care planning was in progress to ensure the needs of an imminent admission of a patient who lived with dementia were planned for. This included the provision of an extra staff member to support this person on a one to one basis to ensure they received safe care and treatment. At the time of our inspection hospital records showed that 100% of ward and theatre staff had completed dementia awareness training.
- We saw that when patients' needs changed during their admission, care plans were adapted to meet these changing needs. For example, a patient who had become unwell during their stay was moved, with their consent to a bedroom that was closer to the nurses station to enable closer monitoring and observations to be completed.
- Staff told us that they worked with the local authority to ensure complex discharges were planned for. One staff member told us how they had requested social care support for a patient whose discharge needs had changed during their admission. This showed that staff were able to work with other agencies to ensure people's individual discharge needs were met.
- Staff could access information leaflets for patients in multiple languages, and print these directly from their internal intranet. Staff also told us that they could access translators for both spoken and signed languages. This ensured people whose first language was not English could still access care and treatment at the service.
- Feedback from the hospital's latest patient led assessment audit had been used to ensure menus were available in braille for people who were visually impaired. This meant the hospital had acted upon feedback to make improvements that ensured the needs of people with visual impairments were met.

Access and flow

- The admission process and care provided was the same for private patients and NHS patients. Following an initial appointment, patients were given a surgery date. Prior to surgery all patients were reviewed at a pre-assessment appointment which was completed either via the phone or face to face, dependent upon patient risk.
- 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 day. For example, out of hours discharges did not occur for patients who did not have appropriate support packages in place. Discharge arrangements were discussed with patients at pre-assessment to ensure there was support in place following a procedure. Where support was not available referrals to the local authority and/or local nursing teams were made.
- Provider data showed that between November 2017 and April 2018, there were 2,842 admissions for surgical procedures. 20 of these procedures were cancelled, with reasons that included; changes in health status and power failure. This equated to less than 1% of all scheduled procedures. Staff told us that all cancelled operations were risk assessed and rescheduled when the patient was fit to undergo surgery and at the patients' convenience.
- We reviewed the referral to treatment (RTT) times for patients between April 2017 and March 2018. NHS

patients should been seen within 18 weeks of a referral being made. We found all except one speciality achieved the 18 weeks RTT target. For example, the average number of patients seen within 18 weeks between April 2017 and March 2018 were: general surgery 99.5%, urology 98.5%, trauma and orthopaedic 98.7% and ear, nose and throat 99.5%.

- The one speciality that did not achieve the RTT 18 week target was ophthalmology, with an average of 75.1% of patients seen within 18 weeks between April 2017 and March 2018. Senior managers told us they were working closely with local commissioners to address waits that exceeded 18 weeks. This included allocating additional theatre slots to the ophthalmology team when these were available.

Learning from complaints and concerns

- We found that there were systems in place to listen and respond to patients concerns and complaints. The provider had a complaints policy that was viable throughout the hospital environment. Feedback forms were readily available to patients and their relatives. These could be completed either while the patient was in the hospital or returned to the hospital after discharge.
- One of the patients and their relative that we spoke with were using the service for a second time. They told us how feedback from concerns raised at their previous surgery about parking had been satisfactory resolved. Staff told us and we saw that the number of parking spaces available had increased in response to complaints.
- Provider records showed that 25 complaints had been received between 1 May 2017 and 31 May 2018. Five of these complaints remained open at the time of our inspection, but all other complaints had been closed with an outcome. Information we saw showed that managers had investigated the complaints in accordance with the hospital's policy and timescales. Records showed that at least 11 of the 23 complaints had been upheld and apologies had been given by the provider which showed the provider was able to identify and apologise for shortfalls in care.
- Complaints were monitored and 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.
- Staff told us that learning from complaints was shared during team meetings and minutes of these meetings confirmed this. This meant action was taken to respond to complaints and prevent similar themes incidents from occurring.

Are surgery services well-led?

Good

We rated well-led as **good.**

Summary

At our last inspection, this domain was rated as requires improvement. This was because:

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

At this inspection, we found that improvements had been made and we have now rated well-led as good because:

- Suitable governance systems were in place to ensure the safety and quality of care was consistently assessed, monitored and improved.
- Suitable leadership structures were in place to provide staff with the support and guidance they required. Staff described their team leaders and managers as approachable and accessible.
- A new provider strategy was due to be launched. Staff had been involved in the development of this.
- We found a positive staff culture where staff felt able to report safety concerns.
- Risks were identified, monitored and managed to promote patient and staff safety.
- Systems were in place to ensure the views of staff were sought and used to monitor and improve quality. Plans were in place to make improvements to the ways that patient engagement was completed.
- We saw evidence of a drive to improve the quality of the care provided. This was from the staff on the ground floor to the senior management team.

Good

Surgery

Leadership

- A new Chief Executive Officer for the provider had been appointed in January 2018. Staff we spoke with were aware of and spoke positively about this change.
- Each department had a head of department who oversaw the delivery of care and management of staff. All the staff we spoke with told us that heads of department were approachable, accessible and supportive.
- We saw that the hospital management team aimed to support staff where possible. For example, we saw examples where staff were provided with additional training and responsibilities to encourage retention.
- Staff development was promoted. We saw many examples where staff were encouraged, and funded, to attend additional training including degrees to support their job role and future career progression. This included succession planning for matron's and general managers.
- Three members of the more senior management had recently undertaken human factors training; which was due to be rolled out across the wider staff group post inspection, starting in July 2018. This meant that the leadership team were working together to embed a culture that promoted safety.

Vision and strategy

- At the time of our inspection; the hospital managers were about to launch a new provider five year strategy. This had been disseminated to the hospital management teams; but had not yet been shared with staff. We were told this strategy was developed with input from location level; via the general manager whom liaised with their senior management team.
- In addition to new strategy, there was a local business plan that aimed to improve local performance over the next two years.
- The clinical strategy was based around the nationally recognised six C's for health and social care. These six C's included; care, compassion, competence, communication, courage and commitment. We saw that information about the six C's was visible throughout the hospital and staff demonstrated an awareness of how they applied these six C's during their day to day care.

Culture

- We saw that a positive patient focussed culture was embedded from the senior management team right down to the staff who worked on the ground floor. Staff demonstrated a positive attitude towards team work and they told us they were proud of their work. Staff described a supportive environment in which team members were aware of each other's strengths and skills.
- Staff told us there was a 'no blame' culture. Staff told us they felt able to raise safety concerns when required. Staff provided examples of how managers had worked with them in a supportive and caring manner in response to adverse incidents that triggered any development needs.
- Staff told us they were able to raise concerns about safety and quality through a number of channels. This included speaking directly with line mangers and senior managers or following the whistleblowing policy and procedure. We saw examples that showed concerns about patient safety were investigated and managed promptly and effectively.
- We saw that the Duty of Candour requirements were followed when required. These requirements are in place to ensure that providers are open and transparent with people who use services in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Records we viewed that related to safety incidents showed that the hospital was meeting these requirements.
- The provider demonstrated compliance with the Workforce Race Equality Standards and the staffing ethnicity mix reflected the local communities.
- We saw that equality and diversity concerns raised by staff were dealt with promptly and appropriately by hospital management; and wider investigations instigated to ensure the Equality Act 2010 was adhered to at all times.

Governance

- Audit cycles were in place that ensured there was continuous assessment and monitoring of quality. This included; WHO checklist observations and audits,

medicines audits and consent audits. When audits had identified areas for improvement, action plans were in place, followed and reviewed to ensure positive steps were taken towards making improvements.

- Governance was monitored through heads of department meetings, clinical governance meetings and medical advisory committee meetings. In addition health and safety, and quality meetings were held. Information was filtered to all staff following head of department meetings; the heads of departments fed back information such as incident learning and trends, complaints, new clinical guidelines and changes and updates to the hospital.
- Provider led visits were completed to assess and monitor safety and quality. We saw that action had been taken by the senior management team in response to the feedback from their latest provider led visit. For example, the management team had received feedback about the flow of staff entering and exiting theatre areas which posed an infection risk. Action had been taken to reduce this risk and we saw that the new procedures put in place to address this were being followed.
- During our inspection, it became apparent that the hospital manager's were already aware of the concerns we identified that related to the medical staffs record keeping. We saw that action had already been taken by them to try and address the concerns. This included writing to consultants to highlight their record keeping responsibilities. Despite this, some consultants had not improved their record keeping practices, therefore the hospital managers were reviewing the options available to them to drive the required improvements. This included the option of removing medical staffs practicing privileges if required.
- Effective systems were in place to ensure staff were suitable to work at the hospital. During the inspection we reviewed eight consultant records to ensure practising privileges were up to date and were regularly reviewed. We saw practising privileges were reviewed yearly. All files showed up to date medical indemnity insurance, disclosure and barring checks, and revalidation and appraisal paperwork. All consultants whose files were checked were noted to be registered as fit to practise on the General Medical Council (GMC) register.

Managing risks, issues and performance

- We reviewed the surgery risk register. This contained all the identified risks associated with the core service and detailed the control measures in place to mitigate the risks, the staff responsible for managing the risk and a review date. Records showed risks were reviewed at departmental level and senior management level on a regular basis.
- We were given examples of effective monitoring of risk. For example, it was identified via clinical governance meetings that no falls had been reported over a set period of time. Therefore, heads of department explored whether this was due to the hospital having no patient falls to report; or if it was due to staff not reporting falls effectively. This meant the senior management team analysed and challenged risk information to ensure monitoring was effective.
- Systems were in place to monitor the hospital's overall performance and productivity as well as the individual performance of the staff. Poor performance and concerns within the consultant body was addressed at the Medical Advisory Committee. Practising privileges were granted, reviewed and withdrawn through this process.
- Staff files showed that concerns and issues such as poor performance, and staff concerns were discussed and dealt with appropriately. Letters to staff members and consultants were clear and outlined expectations.

Managing information

- Systems were in place to ensure information about people was kept safe and secure. We saw that medical records were stored securely and computer screens were locked when not in use.
- Information relating to joint surgery was only passed on to the National Joint Registry with consent from patient's. This meant that patients had control over the sharing of this information.

Engagement

- There was an employee engagement action group at the hospital which ensured staff voice was sought and responded to. A cross section of staff from across the hospital were representatives of this group. Minutes from this group showed that items such as, patient feedback, the staff survey and career progression were discussed.

Good

Surgery

- The latest staff survey was completed by 83% of West Midland Hospital staff. This was in line with the Ramsay Health Care UK group as a whole who recorded an 82% response rate. This showed a high proportion of staff felt able to engage in this process. The results of the most recent survey had not been analysed at the time of our inspection as the survey had been completed very recently. However, we saw staff were updated regarding the progress made to responding to their feedback from the previous staff survey via a 'traffic light' report. This report outlined 10 areas that the provider was committed to address, 10 areas that were work in progress and just one area that they could not proceed with at that time.
- We saw staff notice boards by the dining room displaying information about upcoming development courses, clinical effectiveness and audit results. This ensured all staff had access to this information.
- The hospital managers 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
- A staff feedback box was located within the hospital; this was to encourage staff to contribute ideas, give feedback and communicate with senior management. Senior managers said that staff feedback had led to changes at the hospital. For example, one staff member had suggested that patient compliments should be included in the staff newsletter as traditionally only patient complaints had been shared with staff. This change was made in response to staff feedback.
- Systems were in place to ensure lessons were learnt from compliments as well as complaints. For example, one of the recent themes gained from patient compliments was, 'a smile has a big impact'. This had been communicated to staff via team meetings and staff newsletters. This ensured staff gained feedback about positive care.
- At the time of our inspection. The provider only formally sought feedback from patients through feedback cards. However, plans were in place to launch a new patient engagement group as the senior management team had recognised that alternative methods of engaging with patients were required.
- The general manager and operations manager attended local neighbourhood meetings. This enabled the managers to work through any concerns raised by the public who lived nearby; such as loud early morning deliveries; and parking issues. The forthcoming changes to the hospital were also discussed; enabling agreement to be reached with regards to additional traffic during time of construction.

Learning, continuous improvement and innovation

- 'Lunch and Learn' sessions had recently commenced within the hospital and had been held within the months of March and May 2018. These enabled staff to learn about incidents and updates within the hospital. The general manager was also in the process of setting up 'lunch with the general manager' sessions; whereby specific staff would be invited to a lunch; whereby they would be encouraged to share their opinions and ideas about the hospital. Different staff would be invited each time to ensure staff engagement across the whole hospital.
- A member of the management team had recently undertaken training on 'speak up for safety' which was being rolled out across the hospital. This was a new initiative which encouraged staff to speak up about concerns and to whistle-blow if necessary. The purpose was to improve overall staff culture and promote a transparent approach to identifying concerns and reporting incidents.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

- Staff undertook mandatory training on a yearly basis. Mandatory training included: safeguarding training, basic life support, moving and handling and infection control.
- We found staff within outpatients had completed 93% of mandatory training.
- The outpatient manager had a system in place to monitor the compliance of each member of staff with mandatory training. For example, bank staff could not continue to work at the hospital without updating their mandatory training.
- We found each member of staff had an individual training file held by the department manager. We reviewed three staff training files (two registered nurses and a healthcare assistant) and found that all staff reviewed were up to date with the required level of training.

Safeguarding

- We asked staff about safeguarding. All staff asked showed a good understanding of their responsibilities in relation to safeguarding patients.
- All staff completed adult safeguarding training, which included training on female genital mutilation (FGM) and Prevent (anti-radicalisation) training. All staff within outpatients completed a children and young people safeguarding competency booklet; however, did not complete any formalised training on safeguarding children and young people. The hospital did not treat any patients under the age of 18 years.
- We saw information leaflets within waiting rooms informing patients about safeguarding, abuse and the hospital's responsibility if staff suspected abuse.

Cleanliness, infection control and hygiene

- We found a good level of cleanliness across outpatients. All areas visited were visibly clean and free from surface dust.
- We reviewed hand hygiene audits for November and December 2017 and January, March and April 2018. We found good compliance with hand hygiene across all five months. Within the April 2018 audit a mini immediate action plan was devised which included feeding back information at the next monthly meeting. The April 2018 audit also specifies that an aseptic non-touch technique (ANTT) procedure was observed and undertaken in line with policies and requirements.
- We found hand sanitiser for staff, patient and visitor use readily available across outpatients, physiotherapy and imaging services. We observed staff using hand sanitiser and washing their hands as required and at appropriate times, for example washing hands after changing a patient's dressing.
- Personal protective equipment (PPE), for example gloves and disposable aprons, were readily available in all clinical areas. We observed staff using PPE appropriately, for example during dressing changes and examinations. Staff disposed of PPE in line with hospital policies on the disposal of waste.
- We found cleaning wipes available in all clinical areas. We observed staff cleaning equipment and the

environment following patient contact. For example, we observed staff using disposable bed covers on trolleys within consulting rooms, but also staff cleaning the trolley after each patient had left.

- We found carpeted rooms and corridors throughout the rest of the hospital. All consulting rooms had carpeted flooring within them. We found the ultrasound room within the imaging department had carpeted flooring. This included where internal ultrasounds were taking place. This posed a risk of body fluid spillages on carpeted floors.
- We found carpeted flooring was on the local risk register. We found some mitigations in place to reduce the risk of cross contamination. We found that wherever possible dressing changes and cast removals (for example) were undertaken within the clinical room in outpatients. Senior staff did tell us that dressings were changed within consulting rooms when the department was busy to prevent delays. We asked if these incidents were reported; however, senior staff told us they did not report infection control incidents of this kind. This was supported by incident data supplied by the hospital.
- Independent health care providers must take account of the Department of Health (DoH) Health Building Notes when designing and utilising clinical environments. However, independent providers do not have to comply with the Department of Health requirements. Health Building Note 00-10 design for flooring, walls, ceilings, sanitary ware and windows states carpets should be avoided in clinical areas.
- We requested the cleaning policy for carpeted areas. As above, we saw the housecleaning policy clearly specified that if contaminated waste had been spilt or dropped onto the carpet; a clinical member of staff was to undertake cleaning of this in order to ensure the carpets were appropriately cleaned as per infection control and prevention guidelines.

Environment and equipment

- We found good processes in place for cleaning and decontamination of equipment within imaging and endoscopy. The endoscopy unit had recently had two new sterilising units fitted, with a storage facility to keep instruments sterile following cleaning.
- During the inspection we observed the endoscopy cleaning units undergoing routine servicing and maintenance.
- The diagnostic imaging department had recently purchased a chlorine gas cleaning unit for the internal ultrasound probe. This ensured that between patient use the probe was cleaned effectively. The new machine halved the time taken to clean the probe (now seven minutes), ensuring a smooth running clinic and reducing delays for patients.
- We looked at equipment across outpatients, imaging and endoscopy throughout the inspection and found all equipment looked at had been serviced within the last year.
- For detailed findings on equipment servicing, please see the Safe section in the surgery report.
- We found staff segregated waste correctly, for example using clinical and non-clinical waste bins and disposing of sharps (for example needles) within approved sharps bins. This was in line with hospital policies and procedures on the disposal of waste.
- The hospital used oxygen and nitrous oxide gas as required for patients within the outpatient setting. Nitrous oxide is used as a fast acting pain relief gas. We found both oxygen and nitrous oxide gas cylinders stored safely and in line with best practice, for example storing empty and full cylinders separately.
- We found the endoscopy suite, clinical room, physiotherapy room and x-ray room had laminate type flooring in place, allowing for easy routine cleaning and the removal and cleaning of any bodily fluid spills.

Assessing and responding to patient risk

- We found staff had access to resuscitation equipment across the outpatient areas. The outpatient department, physiotherapy and imaging department had access to a resuscitation trolley on the ground floor of the hospital. The endoscopy suite had an emergency airway tray available within the endoscopy suite, and access to a full resuscitation trolley kept on the surgical ward.
- We checked the resuscitation equipment within the outpatient area and found it to be in date, serviced and visibly clean and tidy.
- Within endoscopy, we found the World Health Organisation (WHO) Five Steps to Safer Surgery check list in use. The radiology department had implemented an adapted version of the WHO checklist to assess the safety of patients undergoing certain procedures, for example internal ultrasounds.

- We found that consultants discussing cosmetic surgery with patients did not routinely document the psychological assessments in detail within the patient's medical records.

Nurse and allied health professionals staffing

- We found a good level of nurse staffing across outpatients. The outpatient department employed 2.8 whole time equivalent (WTE) registered nurses and 1.47 WTE healthcare assistants (HCA). Within pre-assessment clinic, the service employed 2.4 WTE registered nurses. There was also a 0.4 WTE cosmetic nurse to support cosmetic clinics.
- The outpatient department employed three bank registered nurses and two bank HCAs. Bank registered nurses undertook 16% of the total number of shifts within the outpatient department between January and April 2018.
- We found a good level of radiographer cover within diagnostic imaging. The hospital employed three WTE radiographers. The hospital had 2.06 WTE bank radiographers. The imaging department aims to have two radiographers on site Monday to Friday for outpatient appointments. The imaging department employed one WTE HCA to assist within the department.
- Radiographers were available Monday to Saturday, specifically 8:30am to 9pm on Mondays and Thursday, 8:30am to 8pm on Wednesdays and 8:30am to 6pm on Tuesday and Fridays, and Saturday 9am to 2pm.

Medical staffing

- Radiologists were available Monday to Friday from 8:30am to 9pm on Mondays and Thursday, 8pm on Wednesdays and 6pm on Tuesday and Fridays.
- Radiologists from multiple specialities were available throughout the week, for example with an orthopaedic background. Radiologists reviewed any images routinely; however, referred specific concerns or complex images to radiologists with a specialist background.
- Individual consultants undertook their own clinics, with the support of outpatient nursing staff. Within outpatients, 81 consultants had practicing privileges, which includes nine consultant radiologists.
- The radiation protection supervisor (RPS) was the head of department at the hospital. The RPS had access to a radiation protection advisor. The head of department had regular contact with the radiation protection advisor.
- For detailed findings on medical staffing, please see the Safe section in the surgery report.

Records

- We reviewed four nursing records from outpatients, specifically from nurse led dressing change clinics. We found that all four records were completed in full and contained information and assessments relevant to the patient. We found it was clear to identify the nurse that had undertaken the treatment and the follow up needed.
- However, we found that the nursing documentation was put inside the front flap of the records and not filed correctly within the patient's file.
- We found that medical documentation was lacking detail, incomplete and sometimes missing from peoples records entirely. We requested and reviewed 12 records specifically relating to orthopaedic, cosmetic, gynaecology and nurse clinics.
- We found the cosmetic surgery documentation was generally completed, signed and dated.
- We found the cosmetic consultants documented on proformas and the documentation was generally legible and in chronological order.
- However, we found the psychological assessment of patients requesting cosmetic surgery was limited or missing in all three cosmetic records reviewed.
- Within gynaecology and orthopaedic records, we found mixed compliance with record keeping.
- Within the gynaecology (three records) and orthopaedic (five records) records we found these were not in chronological order or filed within the relevant sections of the medical files. We found within three of the five orthopaedic records reviewed the consultants did not document the consultations undertaken.
- In the five gynaecology and orthopaedic records looked at, we did find documentation; however, this was limited and was documented on the back of other sheets of paper, for example on the back of registration forms. We found that the documentation that was present was illegible and not in chronological order.

Good

Outpatients and diagnostic imaging

- We found that none of the gynaecology or orthopaedic records contained the consultants signature, name and GMC number. However, all were signed. We found it difficult to track the consultant involved in the care of the patient.
- The service undertook medical records audits in November 2017 and May 2018. We found that the results in May 2018 had improved. The audit measured seven aspects of records, and looked at the following areas:
- Procedural information given to the patient: May audit score 100%, November audit score 67%. Is the laterality (the correct side of the body) of the procedure written in full on the consent form: May audit score: 90%, November audit score 0%. Has a signed copy of the consent form been given to the patient: May audit score 70%, November audit score 10%.
- The intended benefits of the procedure have been documented: May audit score: 100%, November audit score 67%. Has patient consent been obtained for any unlicensed medicines used: not measured in May, November audit score 0%. Clinical information has been clearly recorded by the consultant where a procedure has taken place in the outpatient department: May audit score: 80%, November audit score 23%. Evidence that contact details for the hospital has been given to patients: May audit score 90%, November audit score 17%.
- The audit had an action plan; however, this was brief, lacked detail and did not specify timescales for actions to be completed.
- On request, the hospital provided an update on the actions identified within the November 2017 records audit. The actions had been reviewed in May 2018 and showed an improvement in all of the outcomes. Of the seven areas audited, five had been closed and two remained open. These were: Clinical information has been clearly recorded by the consultant where a procedure has taken place in the outpatient department, which improved from 23% in November to 80% in May 2018. Has a signed copy of the consent form been given to the patient improved from 10% to 70%. The actions within the May 2018 audit were still limited and not assigned to a specific person for oversight.
- During the previous inspection in 2015, we found that consultants did not always store copies of patients records on site. During this inspection, we found that patient records were stored on site. This was an improvement from the 2015 inspection.

Medicines

- We found medicines management across all outpatient and imaging departments was good.
- We checked four medicines within the imaging department and found all to be within date and stored safely. The lead radiographer on shift held the keys to the medication cupboard, ensuring medicine safety. Within the main outpatient department, the lead nurse on duty kept the keys to the medication cupboards.
- We found all medication locked away and stored safely. The outpatient department had an established system in place for using FP10 prescriptions. FP10s are NHS prescriptions used by practitioners to prescribe medication. The system allowed senior nursing staff to track the use of prescriptions, including the nurse handing over the prescription and the consultant completing the prescription.
- Within the endoscopy unit, we found safe storage and use of medication. We checked three control drugs using the controlled drug register. We found all three medications matched the controlled drug register. The lead endoscopy nurse told us of an incident that had happened when the register did not match the stock. The incident was reported and the medication was accounted for. Lessons learnt were shared with staff to ensure the correct completion of the controlled drugs register in future.

Incidents

- Staff knew how to report incidents within outpatient areas. We reviewed incidents from physiotherapy, imaging, outpatient department and endoscopy. Staff reported 39 incidents across these areas between November 2017 and April 2018.
- The outpatient department reported a total of 21 incidents, physiotherapy three, endoscopy ten incidents, and imaging five incidents. However, three of the five incidents within imaging occurred on a mobile scanner operated by an a separately registered provider.
- Outpatient services reported no serious incidents and no never events between November 2017 and April 2018.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been

implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- During the inspection we found that staff reported infection control concerns with regards potential post-operative wound infection; however, staff did not report environmental incidents. Therefore, we did not have assurance that senior staff had complete oversight of actual and potential environment incidents.
- We were told about an incident during the inspection that happened in April 2018; however, this was in the information sent by the hospital. The incident involved a patient who deteriorated within the imaging department. Staff attended but no member of staff brought the resuscitation trolley. Lessons learnt had been informally shared with staff; however, these had not been communicated formally to staff at the time of the inspection. Following the inspection, the senior leadership team provided assurance that lessons had been shared with all staff.

Safety Thermometer (or equivalent)

- The outpatient service did not use a safety thermometer or equivalent within the service.
- The senior leadership team told us other services within the hospital use the National Safety Thermometer process; however, this contains no elements relevant to outpatients.

Are outpatients and diagnostic imaging services effective?

Good

We rated Effective as Good.

Evidence-based care and treatment

- We found evidence based care and treatment in place across outpatients.
- The World Health Organisation (WHO) Five Steps to Safer Surgery checklist was in use within endoscopy. The imaging department had introduced a modified WHO checklist for patients undergoing specific procedures, for example ultrasound guided injections.
- We found pathways and care plans in place for patients attending a nurse led dressing change clinic. These included which dressings had been used, treatment given and the next steps in relation to attending the clinic again.
- For detailed findings on evidence-based care and treatment, please see the Effective section in the surgery report.

Nutrition and hydration

- As part of the pre-assessment clinic, which assessed patients prior to admission for a surgical intervention, staff informed patients about how and when to fast. We found this to be in line with current best practice, and included no clear fluids after 6am for patients on the morning surgical list.

Pain relief

- We saw no patients during the inspection that required pain relief.
- Staff told us they would request the resident medical office to come to outpatients should a patient require pain relief during an outpatient appointment or procedure.

Patient outcomes

- Due to the nature of the work undertaken at West Midlands Hospital, senior staff measured outcomes centrally. For example, NHS PROMS data, which looks at outcomes following hip and knee surgery, was reported under the ward data.
- We found that the outpatient service did not measure outcomes for patients in relation to outpatient specific activity. For example, wound healing following attendance at wound clinic. However, these services were generally provided alongside surgical intervention, meaning outcomes were measured centrally in line with the surgical procedure.
- The physiotherapy service monitored patient outcomes through a number of methods, including a muscular skeletal health questionnaire that monitored the outcome of the physiotherapy treatment provided. The physiotherapy service also used the National Ramsay UK benchmarking system to measure outcomes.
- For detailed findings on patient outcomes, please see the Effective section in the surgery report.

Good

Outpatients and diagnostic imaging

Competent staff

- Staff within outpatient and imaging services underwent competencies relevant to their roles.
- We reviewed three records (two for registered nurses and one for a healthcare assistant) within outpatients. We found that all required competencies had been completed and required updates had been completed. For example, we found both registered nurses had undertaken intermediate life support and the HCA had undertaken basic life support.
- Outpatient department staff underwent updates on clinical competencies on a three yearly basis. All three staff had undertaken competency assessments within the last three years.
- Within the imaging department, we found that all radiographers underwent competencies on the use of the x-ray machinery, signed off by the lead radiographer within the department.
- All staff directly employed by the Ramsay Group underwent a yearly appraisal. However, we found that bank staff, including bank staff that work full time hours, were offered an appraisal but there was no requirement for them to undergo a yearly appraisal. We found one of the four bank staff within outpatients had received an appraisal within the last year.
- When asked, senior staff told us they would identify any concerns or development requirements on an ad hoc ongoing basis. The hospital told us this process was currently under review by the Ramsay Group.

Multidisciplinary working

- Staff worked across different departments within the outpatient setting to deliver care to patients.
- The imaging department working with radiologists to ensure the most effective review and reporting on images. We saw effective written communication from radiologists to consultants with regards the outcome from imaging tests.
- Nursing and medical staff worked closely together within the outpatient department. For example, consultants referring patients to the nurse led clinics for dressing changes and wound reviews.
- We found the endoscopy unit worked closely with anaesthetists and operating department practitioners to ensure the effective delivery of sedation for patients undergoing endoscopies.
- We saw evidence within medical records of consultants communicating the outcome of reviews and assessments with patients GPs.
- We did not find any multidisciplinary team (MDT) meetings within the outpatient department to review patients care and outcomes.

Seven-day services

- The outpatient department and imaging services were available for outpatient appointments Monday to Friday at the following times:
- Monday 8:30am to 9pm, Tuesday 8:30am to 6pm, Wednesday 8:30am to 8pm, Thursday 8:30am to 9pm and Friday 8:30am to 6pm.
- The department was closed at weekends and bank holidays.

Health promotion

- Refer to this section in the 'surgery' section of the report for details.

Consent and Mental Capacity Act 2005

- We found knowledge of all staff around consent was good. We observed staff gaining verbal consent from patients undergoing minor procedures, for example dressing changes.
- Within the imaging department, we found consent forms in use for certain patients and procedures. For example, those patients aged between 18 and 55 years undergoing an x-ray of their abdomen were asked for consent in relation to their pregnancy status.
- We found a good knowledge amongst staff around capacity and the Mental Capacity Act 2005. Staff asked were aware of their requirements to raise concerns around capacity and the ability to consent for treatment.
- We found that consultants did allow at least a two week 'cooling off period' for patients undergoing cosmetic surgery. This allowed patients to consent for the procedure, but allowed time for the patient to change their mind and required the patient to re-consent before undergoing to procedure.
- For detailed findings on the Mental Capacity Act 2005, please see the Effective section in the surgery report

Are outpatients and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging

Good

We rated caring as **good.**

Compassionate care

- Throughout the inspection, we spoke with two patients and observed three clinical assessments or interventions.
- We found staff to be kind, caring and compassionate in their approach to patients and families. We observed staff introducing themselves to the patient before undertaking any discussions or interventions.
- We found staff within the imaging department promoted patient dignity. We heard and saw a member of staff stop a patient from coming out of the changing room as the patient's gown was open at the back. Staff supported the patient to tie up the gown to ensure the patients dignity was maintained.
- The hospital gathered feedback from patients, both through the NHS Friends and Family Test and through Ramsay Group feedback forms. We reviewed feedback from outpatient services between January and April 2018. We found that the majority of feedback was positive. Between January and March 2018, 229 people responded to feedback. When asked how likely they would be to recommend West Midlands Hospital to friends and family, 222 of the 229 respondents stated, "extremely likely" and seven stated "likely". In April, nine patients responded, "extremely likely" to the same question.
- We found the hospital had a good chaperoning policy in place to help support patient choice around examinations. The outpatient department ensured that a chaperone was always in attendance for patients undergoing intimate examinations, or where they needed to remove clothing. Any patient could request a chaperone during a consultation or examination.

Emotional support

- We found nursing staff provided support to patients in relation to the reason for their visit to West Midlands Hospital.
- Staff showed compassion and understanding when dealing with patients.
- We did not see any patients that received bad news during our inspection; however, staff told us that patient would not be rushed and a nurse would stay with the patient if requested.

Understanding and involvement of patients and those close to them

- Staff encouraged patients and their relatives to be as involved in the care process as they wanted to be.
- We observed staff informing patients of the benefits and risks of a procedure and allowing them time to make an informed choice about the best pathway for them.
- Patients undergoing cosmetic surgery were given a 'cooling off period' of at least two weeks following initial consultation to reflect on the decision to go ahead with cosmetic surgery.
- We saw and heard staff ask patients for their opinion and input into the care pathway. Staff told us they would accommodate patient choice and preference as far as possible to enable them to be part of their own care.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- We found the hospital planned services with patients in mind.
- Outpatient appointments were available Monday to Saturday, and as far as possible the hospital gave choice to patients attending clinics.
- The structure of treatment at West Midlands Hospital meant patients received continuity in care. Consultants reviewed patients in an outpatient clinic before making a decision to progress treatment. Following treatment, patients were reviewed by the same consultant in outpatients. Patients nursing care from a small team, allowing for continuity in care.
- We found spacious, bright waiting rooms for outpatient clinics and imaging services. However, we found no specific waiting room for physiotherapy patients. Patients attending the physiotherapy clinics waited on

Good

Outpatients and diagnostic imaging

chairs in a narrow corridor. This did not promote the patients dignity, and made access down the corridor difficult due to patients having crutches or other walking aids.
- The physiotherapy room was small and contained a lot of equipment. Storage within the physiotherapy department was limited. Staff told us they felt this hindered their ability to undertake full physiotherapy sessions.
- We found car parking was available outside the outpatient department. We found clear signage to the main reception and the outpatient reception.

Meeting people's individual needs

- Staff could access information leaflets in multiple languages, and print these directly from their internal intranet. Staff told us that they could access translators for both spoken and signed languages. Translators could be access via telephone and in person.
- We found an accessible toilet within the outpatient department. However, the facilities within the imaging department for patient with accessibility needs were limited. Those in a wheelchair required to get changed before a procedure could use an accessible toilet. Those without accessibility requirements had designated changing cubicles within the main department and opposite the ultrasound room.
- Outpatient service had no specific infrastructure to see and treat bariatric patients. For example, no specific bariatric examination couches or bariatric x-ray facilities**.**
- We requested information on dementia, learning disability and mental health champions. The hospital told us they do not have champion roles but are considering implementing a dementia champion in the future. The hospital told us that staff undertake dementia training.

Access and flow

- The outpatient department saw 24,163 episodes of activity (attendances at outpatient clinics) between November 2017 and April 2018. The three busiest specialities between November 2017 and April 2018 were trauma and orthopaedic (with 4,995 episodes of activity), physiotherapist (with 4,116) and nurse led clinic (with 3,100). The three least busiest clinics were nephrology (with four episodes of activity), psychiatry (with four) and psychology (with four).
- The radiology department had 2,892 episodes of activity between November 2017 and April 2018.
- We reviewed the referral to treatment (RTT) times for patients between April 2017 and March 2018. NHS patients should been seen within 18 weeks of a referral being made. We found all except one speciality achieved the 18 weeks RTT target. For example, the average number of patients seen within 18 weeks between April 2017 and March 2018 were: general surgery 99.5%, urology 98.5%, trauma and orthopaedic 98.7% and ear, nose and throat 99.5%.
- The one speciality that did not achieve the RTT 18 week target was ophthalmology, with an average of 75.1% of patients seen within 18 weeks between April 2017 and March 2018.
- During the inspection, we found all clinics running to time. Between January and March 2018, 229 people gave feedback on outpatient service. Of the 229 respondents, two stated that delays had happened and they were not informed of the reason why.

Learning from complaints and concerns

- The hospital received 25 complaints between May 2017 and May 2018. The hospital did not separate these into different departments; therefore, we were unable to say exactly how many of these related specifically to outpatient services.
- Following the inspection the senior leadership team told us that two of the 25 complaints related to outpatient care.
- For our detailed findings on complaints and concerns, see the Responsive section in the surgery report.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership

- Each department had a head of department (HoD) overseeing the delivery of care and management of staff. We spoke to the HoD for outpatients, imaging, physiotherapy and endoscopy.

- Each HoD had an office located within the department they oversaw. This allowed them to be visible and accessible to staff daily. Staff told us across outpatient services that local leaders were approachable and they felt well support by them.
- We found each HoD was aware of the positive aspects of their department, but equally aware of the challenges faced. For example, within imaging, the HoD was aware the machinery was old within the department and had scoped to replace this. Within the outpatient department, the HoD was aware of the risk posed by carpeted flooring and of the split nature of the department.
- For detailed findings on the senior leadership team, see the Well-led section in the surgery report.

Vision and strategy

- Outpatient services had no specific vision or strategy in relation to development. Outpatient services used the hospital wide vision. We saw the hospital values and vision displayed across the outpatient department.
- The physiotherapy department did have a specific strategy for development. Ramsay Health Care UK have approved the significant capital investment required to build a new off site facility in line with the Hospitals strategy and vison.
- The values and vision were known as “the Ramsay way”, and consisted of: integrity, ownership, positive spirit, innovation and team work. We saw staff displaying the values during the inspection.
- We found the hospital had a vision over the coming year to build a new ambulatory and outpatient building that would house all outpatient and day case activity.
- For detailed findings on the hospital vision and values, see the well-led section in the surgery report.

Culture

- We found a culture of openness, inclusion and support throughout outpatient services.
- We found a culture that encouraged staff to make changes and speak up with service improvement ideas. For example, a healthcare assistant (HCA) within outpatients noted a lack of information for patients receiving corticosteroid injections. The HCA was encouraged to work with a consultant and has now produced an information leaflet that staff gave to patients.

Governance

- We reviewed team meeting minutes from the outpatient department from November 2017 and January and April 2018.
- Team meeting minutes were detailed and contained information such as incident, complaints and lessons learnt, overview of changes to policies and legislation, safeguarding concerns and actions to take away and complete.
- However, we did find some of the concerns raised throughout the minutes did not appear on the actions log at the end. For example, in the November meeting minutes we found a discussion on staff needing to check the fridge. Although clearly identified within the minutes, this had not been added to the actions log at the end of the minutes. The senior leadership team provided assurance following the inspection that this was down to human error and have addressed the concerns raised.
- We reviewed heads of department (HoD) meeting minutes from February, March and April 2018. We found the minutes detailed and covered areas including finance, risk register updates, agency use and performance.
- The HoDs meeting minutes showed that each head of department updated the rest of the HoDs on their department. We saw updates in each set of minutes from the radiology manager, outpatient department manager and physiotherapy manager. The theatre manager gave an update that included endoscopy.
- During the inspection we reviewed eight consultant records to ensure practising privileges were up to date and were regularly reviewed. We saw practising privileges were reviewed yearly. All files showed up to date medical indemnity insurance, disclosure and barring checks, and revalidation and appraisal paperwork. All consultants who’s files were checked were noted to be registered as fit to practise on the General Medical Council (GMC) register.

Managing risks, issues and performance

- We found clear escalation process in place for managing risk. Heads of department raised local concerns at the heads of department meeting, which happened once a month. We saw evidence of risks being discussed at these meetings.

Good

Outpatients and diagnostic imaging

- Staff escalated specific issues through the relevant committee. For example, the local health and safety committee oversaw the majority of the risks on the local risk registers. However, we found examples where the senior leadership team held responsibility for overseeing and updating the risks.
- We reviewed risk registers for the outpatient department, radiology, physiotherapy and endoscopy. All risk registers were detailed and included control measures to mitigate the risk, the person responsible for managing the risk and a date for next review.
- We found all the risk highlighted during the inspection were included on the risk register, for example carpeted clinical rooms, medication storage and infection prevention and control processes in relation to cleaning endoscopes.

Engagement

- Staff engagement was good across outpatient services. Senior staff included all staff in service delivery and improvement, taking their views into account. For example, one healthcare assistant raised a concern about the lack of information for a particular group of patients. The senior staff within outpatients encouraged the HCA to undertake some work, along with a consultant, to produce some information for patients. This was embedded at the inspection.
- We saw some patient engagement. The service sought feedback from patients through feedback cards, questionnaires and the NHS Friends and Family Test. The hospital provided additional evidence to show some development in the pre-assessment pathway for patients following patient feedback.

Learning, continuous improvement and innovation

- Local leaders told us that they strive for continuous improvement; however, had limited examples of changes made.
- Senior staff told us the future of outpatient services was being reviewed by Ramsay Group at West Midlands Hospital, which included the location in which outpatient services would be provided.
- The senior leadership team provided examples of improvement, change and innovation including: changes to the pre-assessment pathway through patient feedback and the hospital wide ‘speak up for safety’ campaign.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff maintain a complete, accurate and contemporaneous record for each patient, in line with current national best practice and guidance, local policies and procedures and regulatory requirements.

Action the provider SHOULD take to improve

- The provider should ensure that psychological assessments of patient requesting cosmetic surgery are undertaken and documented in full, in accordance with current national guidance and best practice.
- The provider should ensure all staff groups receive an annual appraisal.
- The provider should ensure that detailed risk assessments and actions in the event of body fluid spills in carpeted rooms are communicated to staff.
- The provider should ensure the ultrasound room is fit for purpose to safeguard staff and patients against cross infection.
- The provider should ensure that effective systems are in place to raise incidents and communicate learning in an efficient way.
- The provider should review waiting room facilities for patients attending physiotherapy appointments.

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 Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance Consultants within outpatients and on ward areas were not maintaining an accurate, complete and contemporaneous record of patient care. Medical staff did not document in full the consultation that occurred. We found examples where we were not assured a full psychological assessment had been undertaken for patients undergoing cosmetic surgery. Regulation 17(2)(c)