Care Quality Commission

Sandwell and West Birmingham Hospitals NHS Trust

City Hospital

Quality Report

City Hospital, Dudley Road
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Good
Neonatal services	
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Sandwell and West Birmingham Hospitals NHS Trust is a provider of both acute hospital and community services for the west of Birmingham and six towns in Sandwell. Serving a population of around half a million people. There are two main acute locations; City Hospital and Sandwell General Hospital, on the City site is also Birmingham Treatment Centre. The trust also provides community services in the form of inpatients at Leasowes Intermediate Care and Rowley Regis Community Hospitals. Alongside other community services such as district nursing and community palliative care. All community services are offered in the Sandwell area.

We carried out this comprehensive inspection because the trust is known as an aspirational trust wanting to become a foundation trust. The inspection took place between 14 and 17 October 2014 and unannounced inspections visit took place between on 25 and 30 October.

Overall, this trust requires improvement. We rated it good for caring for patients and effective care but it requires improvement in being responsive to patients' needs and being well-led. We rated the safe domain as inadequate.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Incident reporting shared learning needed to be improved across the organisation.
- Infection control practices were good but with pockets of poor practice which needed to be addressed.
- Medicines management was inconsistent. Pharmacy support was good and staff valued the input of the pharmacists. However, the safe storage of medicines was not as robust, which we saw across the trust. This was area in which the trust failed to meet its targets for 2012-2013.
- The trust has consistently not met the national target for treating 95% of patients attending A/E within four hours.
- Generally community services were good with the exception of safe which we rated as requiring improvement
- We were concerned about wards D26 and D11 at City Hospital which was not meeting basic care needs for patients.
- The trust had recognised that end of life care was an area for development for them the Bradbury Day Hospice
- The mortuary on both sites had longstanding environmental issues which needed to be addressed.

We saw several areas of outstanding practice including:

- The iCares service within the community and the diabetic service were outstanding and had received national recognition. Critical care services were good overall having both staff and patients feeling well supported.
- The compassionate and caring dedication for end of life care with regard to a minor was rated as outstanding, especially how the service utilised the wider healthcare team to meet the needs of the individual. We were confident in a similar situation this level of support would be repeated.

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

Importantly, the trust must:

- The trust must review the levels of nursing staff across all wards and departments to ensure they are safe and meet the requirements of the service
- The trust must ensure that all staff are consistently reporting incidents and that staff receive feedback on all incidents raised so that service development and learning can take place
- The trust must ensure that all patient identifiable information is handled and stored securely.
- The trust must follow through from findings of safety audit data and follow up absence of safety audit data.
- The trust must address systemic gaps in patient assessment records.
- The trust must take steps to improve staff understanding of isolation procedures.

There were also areas of practice where the trust should take action which are identified in the report.

Summary of findings

Professor Sir Mike Richards

Chief Inspector of Hospitals

January 2015

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The trust had systems in place, including internal and national audit, to monitor patient safety. However some practices were creating risk to patient safety. These included some doctors not reporting incidents and staff not properly following some procedures, such as for medicines storage and infection control. This was being inadequately managed by the trust and the trust must improve this situation to ensure patient safety.
Medical care	Requires improvement 	The medical care service required improvement, as staff training was variable and not meeting the trust's targets in most areas. There were not always reliable documentation in place to record care interventions. Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet their assessed needs. The service was addressing concerns regarding staffing levels, staff skill mix and monitoring the condition of deteriorating people. Staff recruitment was in progress to fill staff vacancies. All wards had introduced clearer systems for sharing information about the ward's performance with staff and visitors. The medical care service had higher rates for the development of pressure areas than the trust targets. People we spoke to were, in the majority of cases, very complimentary about the staff and the care they received. Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.
Surgery	Requires improvement 	The handover processes for both some nursing and medical staff were sub optimal. Infection control measures needed improvement mostly by medical staff. There was inconsistent security for storage of confidential patient records. Medical staff demonstrated a poor lack of understanding of the Mental Health Act and best interest decisions when patients lacked capacity to consent.

Summary of findings

Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the trust was undertaking which in turn affected their morale and made it harder to engage proactively with further change.

Critical care

Good

There were effective processes in place to learn from incidents. There were sufficient numbers of nursing and medical staff on duty. Medicines, including controlled drugs, were safely and securely stored.
We found there was good multidisciplinary team working across the unit.
There was strong medical and nursing leadership within the critical care unit. Staff felt well supported within an open, positive culture.

Maternity and gynaecology

Good

Overall we rated the maternity services as good. The service was effective, responsive, caring and well-led.
The service provided effective care and treatment that followed national clinical guidelines and staff used care pathways as required.
Staff were caring towards women and treated them with dignity and respect. Systems were in place for women to receive on going physical and emotional support throughout their pregnancy as they required. Staff had a good understanding of the need to ensure vulnerable people were safeguarded.
The trust had also introduced significant changes in response to audits which showed that a lot of babies were being readmitted to hospital.
Leadership of the maternity service was visible and promoted innovation and positive change.

Services for children and young people

Requires improvement

Services for children and young people at City Hospital were caring and effective and accommodated both children's and parents' needs. However; improvements are needed for the service to be safe and responsive; improvements are also needed in the leadership of the service.
A clear leadership structure is in place within the women's and children's directorate.
Children's services were well led at ward level. However, we recognise that staff perceived they had not been supported or involved in decision making processes in relation to the new ways of working.

Summary of findings

			We were not assured that incident management and learning at ward level was robust at City Hospital. We found checking systems ineffective for resuscitation equipment. Parents told us their children had received compassionate care with good emotional support. However, we also observed that on occasion parents who required the use of an interpreter had not always been offered this support. Good transitional arrangements are in place for adolescents.
End of life care	**Requires improvement**		The specialist palliative care team had developed tools, processes and training for generic staff in order to deliver, monitor and evaluate care in line with current best practice. Ward staff were familiar with the trust's end of life care plans. Records showed potential problems for patients were identified and planned for in advance. End of life patients were not always able to be in their preferred place of care as the discharge planning process was not fully effective. We were told recent reviews of the chaplaincy service would impact on the ability to be fully responsive to patient needs. Review of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in patient records and found one third had errors or information missing. Ward staff said they valued the support, expertise and responsiveness of the specialist palliative care team.
Outpatients and diagnostic imaging	**Inadequate**		There was a system for reporting incidents, but this was not always being used in a consistent manner. We saw practices that did not ensure the privacy and dignity of patients. The trust was struggling to meet the demand for outpatient appointments so overbooking of clinics was commonplace. We observed patients were cared for in a clean and hygienic environment. Within diagnostic imaging services, there were issues regarding staff training records and reporting times for completed imaging.

Summary of findings

There had been reconfiguration of the service which had put pressure on an already short staff department.
Forward planning was not evident, but the trust had recognised this and were using an outsource consultancy to produce a toolkit to improve service in the future.

Requires improvement

City Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people;End of life care; Outpatients & Diagnostic Imaging

Contents

Detailed findings

Background to City Hospital

City Hospital (formerly Dudley Road Hospital, and still commonly referred to as such) is a major hospital in the city of Birmingham, England. It is located in the Winson Green area of the west of the city.

City Hospital is in the Winson Green district of Birmingham city and is an acute hospital. Along with Sandwell General Hospital it is part of Sandwell and West Birmingham Hospitals NHS Trust, which serves a population size of 530,000 from across West Birmingham and cover six towns within Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

It was first built in 1889 as an extension to the Birmingham Union workhouse. It was originally known as the Birmingham Union Infirmary which later changed to the Dudley Road Infirmary before becoming Dudley Road Hospital.

The Birmingham Treatment Centre opened on the City Hospital site in November 2005. It includes an Ambulatory Surgical Unit with six theatres and extensive imaging facilities. The site also includes the Birmingham and Midland Eye Hospital which we did not inspect on this occasion.

The hospital has 304 beds Deprivation levels in Birmingham are rated at 56 compared to the England average of 20.3. 22.5% of adults are in long term unemployment. The life expectancy for Birmingham is worse than the England average. Men's life expectancy in this area is 77.3 where the England average is 78.9. For women it is 82 and the England average is 82.9. (Public Health England 2010)

The trust provides care from two main hospital sites, City Hospital in Birmingham and Sandwell General Hospital located in West Bromwich. Intermediate care is provided from Rowley Regis Community Hospital and Leasowes Intermediate Care Centre, which is where the trust's stand-alone birthing centre is located.

The trust is an integrated care organisation and by self-admission there is more work to be done. The executive team has seen newly appointed members over the past 18 months to include a Chief Executive Officer and Finance Director and the trust has made application for Foundation Trust Status, but is at the early stages and would use this report as part of their evidence.

The trust provides acute and community care to a diverse population of Sandwell and Birmingham with a high level of deprivation, ranked 12th and 9th out of 326 authorities.

Prior to the inspection the trust announced 1400 job cuts and strike action was planned during the inspection but later postponed.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing & Quality, Kent Community Health NHS Trust.

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included 15 CQC inspectors, 27 specialist advisors to include: Consultants, Doctors, Matrons, Nurses, Midwives, Therapist, Student Nurses and four 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting. The inspection team was supported by CQC analysts, planners and recorders.

Detailed findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits on 14 to 17 October 2014 and unannounced visits on 25, 27 and 30 October 2014. During the visit we held focus groups and interviews with a range of staff who worked within the service, such as, palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Facts and data about City Hospital

Sandwell and West Birmingham Hospitals NHS Trust serves a population of over 530,000. It provides acute services from City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. The trust provides community services across the Sandwell area, and has a community hospital at Rowley Regis and an intermediate care service at Leasowes in Oldbury. The trust's community services merged with the acute trust in April 2011.

The trust serves two main local populations Sandwell and Birmingham with a population of over 530.000. Sandwell and Birmingham local authorities have a significantly high level of deprivation compared to the England average, ranked 12th and 9th out of 326 authorities. There is a high level of health inequality between the most deprived and least deprived areas in Sandwell and Birmingham (a difference in male life expectancy of more than 10 years, and in female life expectancy of more than five years).

The trust has annual revenue of £439 million. Each year the trust spends £430 million of public money, £25 million is spent on new equipment and service expansion. By 2018/19 the trust plans to open The Midland Metropolitan Hospital (Midland Met) which will be built close to the boundary between Birmingham and Sandwell.

The trust employs around 7,500 members of staff, including around 760 medical & dental staff and 1990 qualified nurses.

The trust has 921 acute beds, including 70 maternity beds and 19 critical care beds. The trust has a further 44 beds in its community services.

In 2013-14, 5,586 women gave birth and 564,395 people attended outpatient clinics across the sites. There were 736,852 community contacts made within the same time frame and 176,496 attended both A&E departments and the trusts eye casualty centre called the Birmingham and Midland Eye Centre which was not inspected during the visit. The trust conducted 82,295 emergency and elective operations, of which 47,431 were on a day-case basis.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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Urgent and emergency services

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

Information about the service

Birmingham City Hospital's emergency department provides 24-hour emergency and urgent care to its local population. It provides care to children in a specialist emergency paediatric room for 12 hours a day. Over 100,000 new adult and child attendees visit the department each year, which equates to 270–300 patients each day.

The emergency department is in an inner city area with local issues relating to social deprivation, unemployment, varied and changing ethnicity, and homelessness. The percentage of patients attending the department who required admission increased during 2014/15 from the previous year when it was 16% of those that attended.

We visited the emergency department at Birmingham City Hospital over three days, including a Saturday. We spoke with 12 patients and their relatives, including parents accompanying children. We also spoke with approximately 40 staff, including: the matron; nurses at different levels; doctors at different levels; reception, administration, domestic, portering and security staff; student nurses; consultants; the clinical director; the general manager; the head of nursing; the head of infection control; and paramedics from West Midlands Ambulance Service (WMAS).

Summary of findings

Sandwell and West Birmingham NHS Trust had systems in place, including internal and national audits, to monitor patients' safety. However some practices were creating a risk to patients' safety; these included some doctors not reporting incidents and staff not properly following some procedures, such as for medicines storage and infection control. These aspects were being inadequately managed by the trust; the trust must improve this situation to ensure patients' safety.

Services were not as effective as they should be and required improvement. Care and treatment was provided in line with national and standardised procedures. The unplanned re-attendance rate for the emergency department fell during 2013 and the improved rate had been sustained. However, we found gaps in some patients' assessment records, which the department should address.

The trust had responded successfully to the challenge of recruiting sufficiently experienced nurses for the department, by appointing 25 nurses during 2012/13 and developing them with intensive support and training. However, professional relationships in the department were not as effective as they should be. The trust should improve this situation, because it could have an impact on effective communication and care.

Urgent and emergency services

We found that services were caring. Patients and their relatives said they found that all the staff in the department friendly and helpful and staff were visible and accessible.

Services were responsive, but improvements should be made to ensure patients' safety. The staff reflected the diverse community they served. Translation services were available, but staff relied heavily on patients' relatives. Arrangements were in place to support patients with complex needs, including those who required mental health assessment. The children's room was not open overnight; therefore children were treated in the same area as adults.

Waiting times for emergency ambulances had been improved by the trust, but the department was failing to reach the national target for seeing, treating, and admitting or discharging at least 95% of patients within four hours of their arrival. The trust had recognised the need to improve the situation, but some groups of staff felt blamed for failing to reach the target, and it affected professional relationships

We found that services were not well-led; the trust must improve this to ensure patients' safety. Risks to patients' safety that were identified were escalated to the board through risk registers. Staff perception was that no formal mechanism was in place for learning from incidents, however. Some departmental governance and operational meetings were frequently cancelled. The trust must improve its management of governance arrangements in the department in order for them to be an effective tool for patients' safety.

Staff at different levels and in different roles felt supported by local managers and by the trust in their learning and professional development. The chief executive officer was visible and accessible, but it was the perception of nursing staff that middle managers and those with lead roles were not. A problem with professional relationships between nursing and medical staff in the department had been recognised by the trust, but we found different views among managers about the extent to which professional relationships had improved. The trust must improve its management of these issues, because poor or ineffective professional relationships can have an impact on patients' safety.

Are urgent and emergency services safe?

Requires improvement

The trust had systems in place, including internal and national audits, to monitor patients' safety. However some practices were creating risk and the trust was not managing this effectively. The trust must improve its identification and management of emerging risk for services to be safe.

We found an open culture for reporting incidents, including medication errors. The perception of many staff was that no system was in place, however, for learning from incidents and errors, which meant they could reoccur. There was a risk of 'less serious' incidents being under-reported by doctors and trends being missed, and this was not being challenged by the trust; the trust must improve this situation.

Some safety audit data was missing, such as data from hand hygiene spot checks. The negative findings from some audits, such as on storage of medication, were not followed through to improve patients' safety.

Some important safety procedures, such as isolation procedures to prevent the spread of infectious disease, were not fully understood or fully put into practice by staff.

There was a lack of a consistent system for safe storage of medicines; the trust must improve this.

Systems were in place to assess and respond to patient risk, including using nationally accredited systems to identify early any deterioration in a patient's condition. However, we noted systematic gaps in some patients' records. The trust must improve this.

The trust had greatly reduced the handover time from the ambulance service and put in place measures to improve the flow of patients through the department. Escalation processes were in place for when the department reached full capacity, and breaches were monitored

Staff were aware of their responsibilities with regard to safeguarding patients. Potential safeguarding issues were addressed within a range of clinical training.

We did not observe any problems with cover by nursing or medical staff when we visited the department. The trust had, however, recognised difficulties in recruiting to the department suitably experienced nursing staff and a sufficient number of consultants, and was taking steps to improve this position. The department still depended heavily on agency and bank staff and to some extent on locum doctors.

Incidents

- The trust had reported two serious incidents for its emergency care department at Birmingham City Hospital and Sandwell Hospital since April 2014 – one regarding slips/trips and falls, and the other about suboptimal care of a deteriorating patient.
- NHS Safety Thermometer data was submitted on a monthly basis in line with national practice. (The NHS Safety Thermometer provides a monthly snapshot of safety and is a point-of-care survey instrument that allows teams to measure harm and the proportion of patients that are 'harm free' during the team's working day.) For urgent and emergency care across Birmingham City Hospital and Sandwell Hospital for July 2013 to July 2014, rates of pressure ulcers, falls and catheter-associated urinary tract infections were low; in a number of months there were no reports, as would be expected for this type of services.
- The trust board received a regular update for emergency care through a number of mechanisms such as an integrated performance dashboard, specific papers at the public trust board discussing the whole system of urgent care and system resilience and non-executive director (NEDs) visits to the ED.
- The trust used an electronic Datix system for staff to report incidents. This provided a system for incidents to be analysed, assessed and investigated as appropriate at a local and trust governance level, so that lessons could be learned to improve services.
- Most staff that we spoke with confirmed that they knew how to make reports in the Datix system, and had access to computer facilities to do so. However, our discussions with staff indicated that nurses were more likely to report incidents than doctors were. This could result in the trust missing trends.
- The matrons looked at incidents each day; the clinical director told us that he looked at reported incidents each Wednesday. The clinical director said that managers encouraged staff to fill out incident reporting forms, and this had resulted in a steady increase in reporting for the emergency department.
- Staff told us that they did not always get feedback about incidents that they reported. The clinical director told us that the reporting system was "long winded" and the emergency department was so busy that doctors would need to stay beyond their shift time to complete an incident report. A senior registrar told us, "We get no feedback, so we have given up; incidents happen every day." The registrar also reported not knowing how to report incidents using the Datix system.
- Senior doctors and doctors' managers told us that doctors used a notebook to record incidents they could decide to report later.They said that the duty consultant and divisional manager looked at this notebook each day and then decided whether incident report forms needed to be filled out and submitted.
- We noted that the notebook for reporting incidents had not been used since June 2014. We raised this with the general manager. The general manager told us that this notebook was not the full reporting system for the department, and not the formal system. The notebook system had been introduced for junior doctors to raise issues that could be taken to the department's consultant meeting each Friday. The general manager said that this system was "not robust". The general manager told us that the department was much better at using its incident requiring investigation (IRI) system, and commented, "There is more work to be done with the doctors over this."
- A nurse manager confirmed that, "Most [reported incidents logged currently] are done by security and nurses. Most doctors see it as a bit of a pain; they only do it for serious issues… there are some doctors who see the vision and regularly report; other doctors will report incidents in other departments, complaints basically, about how A&E has managed a patient. Doctors don't tend to report near misses." This meant there was a risk of 'less serious' incidents being under-reported and trends being missed. It also meant that opportunities to learn from near misses were being wasted.
- The trust had a policy on confiscating illegal drugs that patients brought into the department. Such an incident arose while we were visiting, and we found some

confusion among nurses and doctors as to the correct procedures. Although the substance was disposed of correctly, we found no incident report was made by either nursing staff or security staff.

Cleanliness, infection control and hygiene

- The department was a clean environment in which to treat patients.
- Cleaning-work-schedule duties for each job role were on display for staff to consult. The department had its own domestic and housekeeping staff during the day and access to the hospital's general team overnight.
- Staff confirmed that the trust provided sufficient stocks of personal protective clothing such as plastic aprons and gloves.
- Hand cleansing gel dispensers were accessible around the department to patients and staff. Information on the importance of hand hygiene was promoted on the trust's website, with information for patients visiting the hospital.
- The department had an infection control champion.
- In line with the trust's policy, nursing and medical staff were 'bare below the elbows' while working in the department.
- Consultants told us that doctors received hygiene and infection control training as part of their corporate induction, and that spot audits were carried out. Reception and portering staff confirmed that they had undertaken hand hygiene training.
- A nurse manager told us that the hand hygiene audit should be done monthly, but the department had not submitted an audit to the infection team for June, July and September 2014. This had been identified as a risk and at amber level in May 2014.
- These omissions were confirmed by data in the quality and safety patient experience dashboard, which was regularly submitted to the chief nurse and included in the exception report submitted by the department to the board in September 2014.
- We observed during our visit that some doctors attended patients in cubicles without using hand gel or hand wash first. Many staff routinely by-passed the hand cleansing gel dispensers at the doors to the department when they entered and left the patient treatment area.
- The matron carried out monthly audits of records to check that patients were routinely screened for MRSA. The department's dashboard showed that 92–96% of patients had been screened between April and October 2014. No cases of Clostridium difficile (C. difficile) were recorded for that period.
- Staff told us which cubicles were allocated at that time for isolation.
- We noted that isolation procedures were not being followed effectively. For example, we saw relatives visiting a patient without wearing protective clothing and walking in and out of the isolation cubicle with their own drinks. A family with small children was allocated an isolation cubicle because the children were unwell, but the parents were not given protective clothing. No notices were put on the doors of these cubicles to warn people of an infection risk.
- Nurses wore protective clothing with patients in isolation. Staff we spoke with were aware of the trust's infection control policy but did not refer to the need for a notice on the door of a cubicle when it was in use for isolation. We noted that this resulted in a doctor entering an isolation cubicle and exiting to put on protective clothing.
- We noted that isolation cubicles were deep-cleaned by domestic staff after patients left.
- The trust had a policy on the care and management of patients with viral fever, including Ebola. Nursing and medical staff told us they had training on these procedures; domestic and maintenance staff said they had received no training relevant to their role, although their managers and supervisors had.
- The policy on the care and management of patients with viral fever was augmented by a detailed handwritten procedure given to lead staff on the use of personal protective clothing in the emergency department; this was given out while we were on site on 16 October 2014. This document bore no date or signature and no indication that it was official trust policy. Staff expressed confusion about the current status of the policy in respect of the emergency department and risk escalation procedures.
- Reception staff confirmed they had been instructed to ask patients whether they had recently travelled from abroad. We observed that the staff shift handover report included whether any patients had known or suspected infection.
- Boxes of personal protective clothing were available to staff, labelled for low and for high risk situations.

- We noted that the floor covering in part of the department had been recently replaced. Other sections were worn in places of heavy traffic, and tears had been repaired with tape. This made it difficult to clean the floor effectively. We saw that the emergency care governance report for September 2014 put on hold this risk. Staff said that replacing the remaining flooring had been postponed for budgetary reasons. The trust have told us that the first replacement plan was not approved as it lacked an effective plan to sustain service provision and they have implemented a floor repair programme since our visit.

Environment and equipment

- A three-bed resuscitation room included a paediatric bed. The department had a room for relatives to wait in. The department was divided into pathways for minor cases and major cases, and included four high dependency beds.
- Emergency equipment was in the resuscitation room and included equipment for children.
- Two cubicles had doors, and could be allocated to patients that posed an infection control risk.
- A system was in place to check that equipment was in good order and functioning, and that necessary supplies were available each day.
- Some regimes for testing equipment around the department were not being consistently followed. For example: some call bells in cubicles were broken, and records for checking had gaps; their temperatures of some fridges were regularly checked, but there were significant gaps in records of checks on others.
- We noted that the department's risk register included the failure of emergency call bells as a risk that had been resolved, but it remained on the register for monitoring.
- The trust's governance recognised a lack of formal local health and safety inspection for key non-clinical risks in its September 2014 report for the department, and put in place an action plan to improve this.

Medicines

- Birmingham City Hospital had a well-established pharmacy team, who supported the safe use and management of medicines.
- We found that the pharmacy team were actively involved in all aspects of a person's individual medicine requirements. People's medicines were reviewed and checked for safety by a clinical pharmacist from when people were admitted through to discharge
- Nursing staff we spoke with told us that the pharmacy service was essential for medicine safety, and that for any medicine-related queries they had access to pharmacists' advice at all times, including through an out-of-hours pharmacy service.
- We found that the pharmacy team provided an efficient clinical service to ensure that people were safe from harm.
- Although the trust had an online Datix incident reporting system in place to record and report medicine incidents or errors, we found that learning from these errors did not always take place.
- There was an open culture of reporting medicine errors; however, nursing staff were not always informed of the overall outcomes in order to learn and change practice. The learning from these incidents would help to improve patients' safety.
- Medicines were not always stored securely to protect patients. The trust's own medicine storage audit had identified this issue; however, little or no action had been taken.
- The storage of medicine in the emergency department was chaotic. Loose strips of tablets removed from their original boxes were stored haphazardly in one cupboard. Pre-packed medicine boxes, which were labelled and ready to be used when people were discharged, had been opened and medicines removed; these boxes had then been returned to the cupboard, with the potential that they could be given to people on discharge without the correct quantity of tablets inside. We brought this to the attention of a nurse manager but it was not dealt with during the course of our inspection.
- There was no consistent system for safe medicine storage; the trust must improve this.

Records

- Electronic and paper record systems were in place to support care and treatment, but the trust should address some gaps and inaccuracies.
- We audited 15 sets of patients' notes, including for five children. Systems were in use to assess and record the condition of each patient. Monthly audits took place of pain assessment records September results showed

81% compliance against some systemic gaps in records, the trust target was 75%. During our inspection we found some systemic gaps in records, for example for pain assessment.

- The roster for the medical team that we were given for the week beginning 13 October 2014 was not accurate. It showed no consultant cover for Saturday and Sunday, expect on call overnight; however, we saw a consultant on duty in the department when we visited unannounced on the Saturday afternoon.

Safeguarding

- The trust had policies and procedures in place for safeguarding children and vulnerable adults.
- Nurses that we spoke with knew how to access the safeguarding policies and procedures on the trust's intranet.
- Staff told us that all emergency department doctors and nurses accessed level 3 safeguarding training, but were unsure about which staff should have access to level 3 child safeguarding training. The October 2014 report for the emergency department governance meeting showed staff uptake for child safeguarding level 3 training at 41% and noted as not meeting the trust's target.
- The mandatory training matrix for the department showed that all staff had up-to-date level 1 safeguarding training.
- Staff that we spoke with were aware of their responsibilities with regards to safeguarding patients.
- We noted that potential safeguarding issues were also addressed in other types of training; for example, female genital mutilation was addressed in a gynaecology/ urology staff nurse development study day which seven staff nurses and a student nurse attended in August 2014.

Mandatory training

- The department dashboard showed that staff uptake of mandatory training had been above 88% in each month since April 2014.

Assessing and responding to patient risk

- Analysis of data provided by the trust showed that the emergency department's time to treatment was better than standard and often better than the national average for this type of service.
- The number of handovers delayed by over 30 minutes was high in absolute terms, but the emergency department is a large one across Birmingham City Hospital and Sandwell Hospital. The trust had achieved a significant improvement in waiting times across both sites for ambulance handovers since August 2013.
- The department had an ambulance assessment bay with four beds. Ambulance crew brought patients directly to this bay, where a formal procedural handover was made between the paramedic and nurse.
- Hospital staff received information about patient's en-route by emergency ambulance, so they could alert specialists and teams as necessary. We noted this was a calm, quiet environment where information could be exchanged clearly and assessments made.
- Ambulance staff that we spoke with said there was generally a quick turnaround at the hospital.
- A triage nurse system was used for walk-in patients. Patients told us that they did not wait long to be seen.
- A GP service was integral to the department. Patients were referred to the GP service if their presenting condition did not require emergency care or treatment. This helped to take the pressure off the emergency service and improved the flow of patients.
- The department had its own x-ray facilities, which speeded up the process of assessment. People waiting see a doctor after x-ray told us that this wait was longer than for triage.
- A system was in place for a consultant to double-check, after patients' discharge from the emergency department, x-ray images of patients who had attended with possible fractures. We heard an account from a patient that confirmed that this system worked in practice; however, in this case there was a delay of three days, during which time the patient was admitted to a neighbouring hospital after a 999 call.
- Nursing staff confirmed that if patients experienced mental ill health and challenged the service, nurses, healthcare assistants and security staff worked together to try to settle and give support to them in order to treat them.
- The adult acute sites observation tool for the national early warning score (NEWS) was available and used to identify deterioration in a patient's condition. We noted gaps in the notes that we audited in NEWS recording notes for six out of 15 patients for which NEWS was appropriate. This could mean that deterioration in a patient's condition would not be accurately assessed.

- We noted large laminated posters on display in the clinician's station showing assessment flow charts for stroke and for transient ischaemic attack (TIA), which clinicians could refer to.
- Escalation processes were in place for when the department reached full capacity, and breaches were monitored.

Nursing staffing

- Other than the nursing managers, the nursing team in the department comprised band 7 charge nurses, sisters and a dedicated team of emergency nurse practitioners. The department operated a team structure with a band 7 nurse in charge of every team.
- New nursing staff were allocated a mentor and a team lead, and they had supernumerary status for four weeks.
- A shift co coordinator at band 6 or 7 attended the resuscitation room for all alerts, and was to be notified of any patient whose condition caused concern and informed of any problem that could affect patient care or nursing staff.
- Patients with complex needs were allocated particular cubicles and looked after by two nurses and healthcare assistants.
- We observed a staff shift handover meeting and noted it was clear, detailed and competent.
- Nursing managers told us they relied heavily on bank and agency staff. They said it was a daily "fight" to "beg" for approval for agency staff, including healthcare assistants for patients with complex needs, in time to cover the vacancies in a shift. This also had an impact on releasing nurses for training events.
- The department had developed its own staff by appointing 25 registered nurses during 2012/13and has supported them with training and development to bring them up to the appropriate level of competence. Nurse managers expressed confidence in this approach and were optimistic that these nurses would stay on in the trust.
- We visited City Hospital emergency department over three days, including a Saturday (unannounced), and we did not observe any problems with nursing cover at those times.

Medical staffing

- The trust told us that consultant cover across emergency services was an issue and that medical recruitment was ongoing. We noted that "inadequate number of medical staff" was rated as an amber risk on the emergency department's risk register.
- The consultant in emergency medicine told us that 20–30% of doctors were middle grades, 20% were consultant clinical staff, and most of the workforce were junior doctors.
- There were 6.6 full-time equivalent consultants at City Hospital emergency department, covering 8am to 10pm, Monday to Friday, with a shift in the middle of the day.
- Nursing managers told us that on-call consultants were reluctant to come into the hospital when nurses asked them to. They said there was a view among registrars that calling in consultants was a failure and used as a means of managing queues.
- We visited City Hospital emergency department over three days, including a Saturday (unannounced), and we did not observe any problems with medical or consultant cover.
- We noted that the medical roster for the week of our visit showed no consultancy cover for the weekend of 18 October 2014, except overnight on call. However, when we visited the department unannounced on that Saturday afternoon, we found a consultant was on duty.
- The medical roster for the week of our visit showed the use of a locum middle grade doctor for an evening and very early morning shift each day, including at the weekend.

Major incident awareness and training

- The trust had a named lead for major incidents.
- Nursing and reception staff told us that security staff provided effective support.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

Evidence-based care and treatment was provided in line with national and standardised procedures. The department contributed to national data collection and audit arrangements to improve patient outcomes.

The unplanned re-attendance rate for the emergency department was higher (worse) than the national average, but this fell dramatically in June 2013. The improving rate is been sustained by the trust.

Patients were given sufficient food and drink, as appropriate, while waiting for treatment, transfer or admission. Pain relief assessment was part of a standardised procedure, but we found that the assessment was not always recorded in patients' notes. There were also some gaps in the records of the National Early Warning Score (NEWS) used to detect deterioration in a patient's condition. This could have an impact on patients' safety.

The trust had responded successfully to the challenge of recruiting sufficiently experienced nurses for the department, by appointing 25 nurses during 2012/13 and developing them with intensive support and training.

Multidisciplinary working within the hospital and with external professionals was effective. However, the internal team had a medical power dominance and relationships in the department were not as effective as they should be. The trust should improve this situation, because it could have an impact on the effectiveness of patients' care.

Evidence-based care and treatment

- Staff we spoke with made references to appropriate national guidance and told us that the trust's policies and procedures were on the intranet, where they could easily access them.
- The department was part of the Trauma Network and submitted data to the National Trauma Audit and Research Network (TARN).
- We noted that a sepsis screening tool and care bundle was available, and a fast-track pathway for fractured neck of femur.
- We saw the notes of one recalled patient and noted that the trust's policy had been followed for the patient's assessment and treatment.
- We saw evidence of local clinical audit activity. These audits were reported in the monthly emergency care governance report.

Pain relief

- We audited 14 sets of patients' notes where taking a pain score was relevant. We found that a pain score had been recorded for only eight patients. This absence of a pain score could mean that some patients were not receiving the level of pain relief that they needed.

Nutrition and hydration

- We observed care and treatment in the department over three days. We found that people were offered food and drink by staff as appropriate to their condition and length of stay.

Patient outcomes

- The trust was participating in the 2014/15 round of College of Emergency Medicine audits, and had provided results for severe sepsis and septic shock. Having identified tackling sepsis as "the biggest single improvement" it could make in the care it provided, the trust designated September 2014 as "sepsis month".
- The unplanned re-attendance rate for the emergency department across Birmingham City Hospital and Sandwell Hospital was worse than the national average. The rate fell dramatically in June 2013, however, and the improving rate has been sustained.

Competent staff

- We noted the department participated in a staff nurse development programme throughout 2014, although records showed that fewer than 50% of the 25 participants were achieving 100% attendance.
- Staff told us they had an annual appraisal. Not all staff had one-to-one supervision meetings with their line manager, but nurses and junior doctors told us they had as much support as they needed, and that they felt able to ask for support. Paediatric nurses, however, told us that their team meetings were frequently cancelled.

Urgent and emergency services

Multidisciplinary working

- We observed a morning board round and noted that it was not, in effect, a multidisciplinary team function, but that doctors allocated tasks to nurses. This supported the nursing staff's perception that doctors dominated the working culture. This could have a negative impact on communication within the team and erode its effectiveness.
- We observed examples of satisfactory external multidisciplinary working, for example when making patients safe and stable for an effective transfer for treatment at another hospital.
- We noted a developing process in place to improve the integration of the emergency department with the rest of the hospital; for example, a member of the gynaecology ward team was scheduled to come to the emergency department and talk to the teams.
- Staff told us they were able to make good use of the Rapid Assessment, Interface and Discharge (RAID) team and had 24-hour access to psychiatric services.
- In the minor injuries part of the department, an emergency nurse practitioner treated and discharged patients.
- A GP service functioned within the emergency department at the 'front door' of the hospital. We observed the service working in partnership with other services by assessing patients' needs and directing them to other services where appropriate.

Seven-day services

- Senior medical managers told us that the trust was working towards achieving consultant cover in the emergency department across City Hospital and Sandwell Hospital for seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted that when patients were being examined, their clothing was not removed. This could mean that staff may miss other signs and symptoms not reported by the patient particularly if the patient was a vulnerable person.
- A dementia screening tool was in available to staff in the department. However, we noted that no audit of the dementia screening tool's use was recorded on the dashboard from April 2014.

Are urgent and emergency services caring?

Good

We found that services were caring.

Patients and their relatives said they found all the staff in the department friendly and helpful, and that staff were visible and accessible. Nurses, doctors, reception and support staff treated patients with dignity and respect. Families were supported when they attended with their children, and staff communicated well with patients who had learning disabilities.

The Care Quality Commission national survey found that the level of satisfaction with the trust's emergency department was about the same as for other trusts.

Compassionate care

- Although low response rates to the Friends and Family test are common in emergency departments, we noted that some patients had used the response display in the waiting area, and most of the tokens were in the 'very satisfied' slot.
- We spoke with 12 patients and relatives during our visits across three days. Each person said they found all the staff in the department friendly and helpful. The people we spoke with said that nurses and doctors had treated them with dignity and respect.
- Patients and relatives told us that staff were visible.
- We noted staff at all levels and in all roles treating patients with respect and kindness.
- The Care Quality Commission national survey found that the level of satisfaction with the trust's emergency department was about the same as for other trusts.

Understanding and involvement of patients and those close to them

- We noted that nursing staff offered support continually to parents attending with their children and being seen in the adult emergency room because the children's room was not open.
- Relatives that we spoke with who were supporting patients told us that staff included them.

Urgent and emergency services

- A person supporting a patient with learning disabilities told us that staff in the emergency department were very kind and competent in the way they communicated with the patient and explained the treatment pathway.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We found that services were not responsive and improvements were needed.

Hospital staffing reflected the diverse community served. Translation services were available, but staff relied heavily on patients' relatives, and this could result in an inaccurate assessment of the patient's condition.

The department had arrangements in place to support patients with complex needs, including those who required mental health assessment. The children's room was not open overnight, and this meant that children were treated in the same area as adults. The trust had already recognised the need to improve this situation.

The emergency department was failing to reach the national target for seeing, treating, admitting or discharging at least 95% of patients within four hours of attending, for most weeks since 7 July 2014. The trust had already recognised the need to improve this situation. However, doctors and nursing staff differed in their view about whether the trust saw this as an issue for the whole hospital system or just the department; this was affecting their professional relationships.

Waiting times for emergency ambulances had been improved by the trust. The trust closely monitored time flow from an ambulance arriving through to the patient being admitted to a ward or discharged in a way that provided up-to-date real-time data for the trust to respond to.

Most patients we spoke with over three days told us that they did not have to wait long to be seen by a triage nurse when they arrived, but said they had been given no indication of how long they might have to wait.

The trust had a complaints policy and procedure, but we saw no information about this on display to patients in the department. Opportunities to learn from patients' experiences might be being missed.

Service planning and delivery to meet the needs of local people

- We noted over three days that patients were from the range of ethnicities and nationalities in Birmingham's population. Department staff were also from a range of ethnicities.
- We observed that a number of patients did not use English as their first language. Most staff we spoke with were unclear about the trust's translation policy and interpreter arrangements.
- We noted that when staff were dealing with patients whose first language was not English, they communicated through patients' relatives. Staff told us that they used the language interpreter's telephone line only when getting a patient's history. This could mean that a patient's description of their symptoms would not be accurately described to staff.
- We noted that parents who brought in two young children were offered a phone link interpreter but said they did not need one.

Meeting people's individual needs

- Security staff we spoke with confirmed that the department made good use of the Rapid Assessment, Interface and Discharge (RAID) team, and this helped to avoid unnecessary admissions to hospital for people with mental ill health.
- We noted that some cubicles had specific décor. Staff told us that this was designed to support patients with mental ill health and dementia while they used the emergency department's services.
- Healthcare assistants confirmed that they worked one to one with patients with complex needs so that they were not left alone. Staff worked with the security team to support patients who challenged the service.
- People supporting a patient with a learning disability in the emergency department told us that hospital staff had taken time to communicate directly with the patient, and not only through the support worker.
- We noted a cubicle specifically designated for treating women who presented with gynaecological problems so they could have the privacy they needed.

- The department had a children's room with its own triage facility and a side room designated for adolescents. The children's room, however, was not available between 10pm and 10am. This fact had been recently added to the department's risk register.
- We observed that when the children's room was not available, children had to be treated in the 'majors' area of the department. This made it more difficult to isolate children with a suspected infection.
- Managers told us that most nursing staff were dual adult/paediatric trained. We noted that the staff induction book included a specific section on the children's room and how children should be cared for and families supported.

Access and flow

- The red phone in the 'majors' area of the department, answered by qualified nursing staff, enabled the ambulance service to inform the department when a patient requiring resuscitation was on the way. The nurse could then mobilise other specialist teams through contacting the hospital switchboard.
- The emergency department had failed to reach the national target for seeing, treating, admitting or discharging at least 95% of patients within four hours of attending, for most weeks since 7 July 2014. Overall month on month performance at City Hospital was highly variable. We noted that this was on the emergency care directorate's risk register as a red-level risk.
- The clinical director and the consultant for emergency medicine told us that the trust "owned" the problem of not meeting the four-hour target and acknowledged that its causes were systemic; for example, a high proportion of patients presented with complex needs and needed to be admitted and then wait for an appropriate bed.
- Nursing managers, however, did not express the same confidence as doctors did in the organisation's ownership of the problem of not meeting the four-hour target and believed that they were blamed. This affected professional relationships; the trust should improve this situation.
- The senior registrar told us that for one 24-hour period during our visit, 258 patients had attended and 53 of those were subsequently admitted to the hospital. There were 25 breaches of the national four-hour target during that time. The patient in the department for longest was there for four hours and 20 minutes. This was broadly in line with the national average.
- The department closely monitored time it took for patients who arrived by ambulance to be handed over to hospital staff, seen by a doctor and admitted to a ward or discharged on a scorecard, which provided up-to-date real-time data for the trust to respond to.
- Most patients we spoke with over three days who did not arrive via the ambulance service told us that they did not have to wait long to be seen by a triage nurse when they arrived.
- Patients told us that when they arrived they had been given no indication of how long they might have to wait. Reception staff confirmed that no system was in place to inform patients of current likely waiting times, and that patients were given such information only when the department was exceptionally busy.
- Data to May 2014 provided by the trust showed the average total time spent in the emergency department across both hospital sites (Birmingham City Hospital and Sandwell Hospital) was lower than the national average, at between 130 and 140 minutes for the first half of 2014.
- Trust data showed that the percentage of people waiting four to 12 hours from the time when it was decided to admit them to when they were admitted to the hospital was lower than the national average during 2014, and consistently less than 1% of those admitted.
- The department's urgent care scorecard showed that the 15-minute target for maximum waiting time for emergency ambulances had been breached for four weeks from 15 September to 6 October 2014. The 15- to 30-minute target was consistently met from July to October 2014.
- The number of adult patients leaving the emergency department before being seen was consistently higher than the English national average between May 2013 and May 2014, at 3–4%. This score declined steadily in the second half of 2013, but started to rise again from February 2014.
- We noted that the trust had taken some initiatives to improve flow through the emergency department. For example, the trust had provided an in-house plaster room and plaster training for healthcare assistants, so patients therefore did not have to spend time moving through the hospital to access this service.

Urgent and emergency services

Learning from complaints and concerns

- The trust had a complaints policy and procedure, but we saw no information about this on display to patients in the emergency department. There was a comments box with cards for patients to complete if they wanted to. We noted that a few cards were in the box.
- Nursing managers and the clinical director told us that they used the incident reporting system to review all complaints.
- Nursing and medical staff told us that there was no formal system for learning from incidents.
- Data from complaints and compliments did not appear on the department's dashboard after April 2014.
- The dashboard recorded scores in excess of 60% for "likely/extremely likely to recommend our hospital" from April to July 2014. However, no record was made for the months thereafter up to the time of our visiting October 2014.

Are urgent and emergency services well-led?

Requires improvement

We found that services required improvement. The trust had recently launched a "vision" project trying to change how it delivered safe care at ward level across the multi-professional clinical team.

Identified risks to patients' safety were escalated to the board through risk registers. Not all items on the emergency department's register were reviewed and updated as the register showed had been intended. Staff perception was of no formal mechanism in place for learning from incidents. Middle managers in the directorate had not effectively challenged the practice of doctors largely opting out of using the incident reporting system.

The trust had systems of audit in place to check regularly on the quality and safety of the service, but the systems were not always used effectively. A structure of regular governance and operational meetings had been put in place for the emergency care directorate, but senior nurses told us that some meetings were consistently cancelled and he trust did not follow up and address these issues. The trust must improve its management of governance arrangements in the department in order for them to be an effective tool for helping to ensure patients' safety.

Although the chief executive officer was visible and accessible, nursing staff told us that middle managers and those with lead roles in the department were not. There was a problem with professional relationships between nursing and medical staff in the emergency department. The trust had recognised this, but we found different views among department managers about the extent to which professional relationships had been improved. The trust must improve its management of these issues, because poor or ineffective professional relationships can have an impact on patients' safety.

Staff at different levels and in different roles felt supported by local managers and by the trust in their learning and professional development, and underwent appraisals of their performance and development needs. Team meetings were frequently cancelled, however, which meant that opportunities for innovation may be limited.

Vision and strategy for this service

- The trust had recently launched a project called Ten Out of Ten to try to change how it delivered safe care at ward level across the multi-professional clinical team.
- We noted that the Ten Out of Ten project featured in the chief executive's August 2014 "Hot Topics" bulletin for trust staff, and saw information about the project posted on the wall in the emergency department waiting room where patients could see details

Governance, risk management and quality measurement

- The trust had risk registers operating at different levels, including at trust level. We found that not all of the items on the emergency department register were updated as planned. For example, the amber-rated risk associated with having large numbers of newly qualified and new-to-the-department staff had not been reviewed in the current quarter.
- The trust had an incident reporting system and procedures. However, staff that that we spoke with across a range of roles consistently told us that no

formal mechanism was in place for learning from incidents. We noted, for example, that there was no evidence of action taken on the points raised from a controlled drugs audit in April 2014.
- Senior nurses and doctors told us that medical staff were less likely than nursing staff to use the incident reporting system. Middle managers in the directorate did not effectively challenge the opting out of incident reporting by medical staff.
- The trust had systems of audit in place to check regularly on the quality and safety of the service. The clinical director told us that he had improved the governance arrangements since recently coming into the post.
- We found that the quality and safety check system was not always effective, and that this was not always followed up by the trust. For example, where there had been gaps in the submission of hand hygiene audits and this was noted in the exception report that the department submitted to the board, the trust did not follow this up or address it.
- Senior nursing staff told us that the dashboard system was new and replaced the ward review process. The staff said that the dashboard system was not an exact fit for the emergency department and needed some revision in order to be an effective tool.

Leadership of service

- Staff at all levels and in all roles in the emergency department told us that the chief executive officer was visible at the hospital. Senior nursing staff said that middle managers, leads and directors were not so visible, and that concerns raised about this had not been acted on by the trust.
- The chief executive produced a monthly bulletin for trust staff called “Hot Topics”; we saw copies of this in the department. The bulletin included reporting back on the previous month’s topics.
- ‘Hot topic’ sessions were run, and the chief executive held a series of open staff meetings during September 2014
- We found that while senior nursing and senior medical staff agreed that the breach of the target for seeing, treating, and admitting or discharging at least 95% of patients within four hours ‘four-was a significant risk, they differed in their perception of ownership of the problem.
- A structure of regular governance and operational meetings had been put in place for the emergency care directorate, which including reviewing and updating items on the risk register. A monthly report was produced. However, senior nursing staff told us that they felt frustrated because these meetings were consistently cancelled when doctors were unable to attend. Beyond these meetings, there was no formal system for adjusting and updating the risk registers.
- We observed that staff treating a patient with suspected Ebola were working with a handwritten, undated and unsigned-off version of a set of procedures for the use of personal protective clothing. Staff were unsure whether the trust was specifically addressing the risks of Ebola infection, and it was not on the department’s risk register.
- Matrons across the two hospital sites in the emergency department told us they had a good relationship, and that although they spoke on the phone they would also benefit from shared meetings.
- Reception staff told us their induction was good, the manager was always available to them, and staff meetings were held each month. They were satisfied with the support they received from security staff when they needed it.

Culture within the service

- Before our visit, the trust had recognised a problem with professional relationships between nursing and medical staff in the emergency department.
- The clinical director told us that a lot of work had been put into creating a team environment in emergency medicine, and that the clinical leads worked across the two hospital sites (Birmingham City Hospital and Sandwell Hospital). A clinical lead consultant told us that relationships were improving and that doctors and nurses had interacted more over patients in the last 12 months.
- We found, however, when we observed a multidisciplinary board round, that doctors directed it and it was not equally inclusive of nurses.
- Senior nurses told us that nurses were constantly criticised by middle managers and directors and blamed for breaches of targets. What nurses saw as poor quality medical leadership contributing to breaches was unchallenged by the trust.

- Healthcare assistant staff we spoke with told us that local managers responded positively when they raised concerns about bullying in the department.
- Students that we spoke with were positive about their experience in the department.

Public and staff engagement

- The trust had a token box and a text message system in place for obtaining Friends and Family test data. However, senior nurses told us that encouraging patients to engage with the Friends and Family test had not been a priority for staff in recent months.

Innovation, improvement and sustainability

- Staff at different levels and in different roles told us that they felt supported in their learning and professional development, and that they underwent appraisals of their performance and development needs. Team meetings were frequently cancelled, however, which meant that opportunities for innovation may be limited.
- The trust had developed competencies such as for nurses to prescribe and for healthcare senior assistants to apply plaster casts, perform electrocardiogram (ECG) tests and take blood samples, to help improve the flow of patients through the department.

Medical care (including older people's care)

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

Information about the service

City Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust. It is an acute hospital with 198 medical care beds across 11 wards. City Hospital provides a wide range of general and specialist hospital services. These include medical and nursing services such as general medicine, respiratory, gastroenterology, rheumatology, cardiology and care of the elderly. City Hospital (formerly Dudley Road Hospital) is a major hospital in the city of Birmingham, England. It is located in the Winson Green area of the west of the city. There are two cardiology wards, one male and one female, having a combined total of 27 beds. There are two gastroenterology/respiratory/ haematology wards (one male and one female) providing 49 beds. There are two acute medical assessment wards (AMU 1 and 2) with a combined total of 51 beds and two wards provided general medicine and care of the elderly beds with a combined total of 42 beds. There is also a discharge ward (D43) providing 24 beds.

During our inspection, we visited 10 out of 11 wards, and spoke with 21 patients, 64 staff, and 7 people visiting relatives. We also looked at the care plans and associated records of 25 people. We carried out an unannounced visit on the 25th October.

Summary of findings

The medical care service required improvement as staff training was variable, and not meeting the trust's targets in some areas. Some essential care documentation was poorly completed. Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet patients assessed needs. The service was addressing concerns regarding staffing levels, staff skill mix, and monitoring the condition of deteriorating people. Some staff recruitment was in progress to fill staff vacancies, whilst the Trust has a long term workforce plan to reduce 1400 staff over a five year period. At the time of the visit a workforce review was in progress. Wards had introduced clearer systems for sharing information about performance with staff and visitors. People we spoke to were, in the majority of cases, very complimentary about the staff and the care they received. Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We found a range of concerns and risks particularly in one ward, ward D26 that contributed to the overall judgement of inadequate for safety for this service. These included poor recognition of risks to patients, poor records, poor infection control procedures and poor administration and storage of medicines. We found poor record keeping with regard to people's observations and lack of recognition of risks to patients presented by the environment. The systems for storing medicines were not appropriate on some wards. We found the medical care wards to be clean and well maintained. Whilst the hospital had an acuity tool for measuring patient dependency and wards could request additional staffing when required, we found the numbers of permanent nursing staff were variable, and staff generally said that they felt pressurised, due to high patient dependencies. Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of harm to people. The introduction of the performance boards across the wards was seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them. Regular audits were being carried out on the main risk areas. Staff training was variable across the wards.

Incidents

- Staff were aware of the trust's policy for reporting and recording incidents and accidents. Senior staff said there was a high level of incident reporting. Junior staff were aware of how to use the hospital's computerised system to report concerns. Performance, patient safety data and learning from incidents was discussed at monthly ward meetings.
- Staff told us how incidents were recorded and reported via the trust's computerised incident recording system. Some staff told us that they had had feedback about the incidents, but some staff told us that they did not know what happened to the reported information. Learning from incidents in other ward areas was not always shared across all sites provided by the trust.
- Senior staff told us that general feedback on patient safety information was discussed at ward staff meetings, and that patient safety information was displayed on ward performance boards.
- Senior staff were aware of the monthly integrated governance reports, which included quality, safety and performance indicators, but not all junior staff were able to tell us about these reports.
- Senior staff told us that morning handovers (safety briefings) including risks and incidents and that learning from these was shared at these meetings.
- Across medical wards for the trust, there were 52 serious safety incidents between April 2013 and March 2014 in medical care wards, 20 were due to slips, trips and falls, and 15 were due to the development of grade 3 pressure ulcers.
- Some staff were able to tell us of how people's falls were investigated, and what plans were in place to reduce the risk of further falls. However, not all staff across the medical care service had an understanding of falls' prevention. The trust said falls' prevention was part of all staff's mandatory training but some staff were not able to demonstrate an awareness of how to manage this risk other than to refer to the trust's falls' advisory service. We saw some evidence that movement sensors or alarm mats had been used as a potential measure to reduce the risk of falls.
- We saw on ward D11 that all falls were investigated and preventative actions to minimise the risk of further falls were put quickly in place.
- Senior staff were reviewing the nursing dashboard on ward D17 as not all incidents had been recorded on the dashboard. The ward manager and lead consultant were developing an action plan to address these concerns.
- Staff on ward D26 said they did not always get feedback from reported incidents.
- Although the Trust had an online 'Incident Reporting' system in place to record and report medicine incidents or errors we found that learning from these errors did not always take place. There was an open culture of reporting medicine errors however nursing staff were not always informed of the overall outcomes in order to learn and change practice. We were informed that a medication safety group had been set up to discuss medicine errors however this group was not always well attended by nurses. We found that although one directorate had developed a change in practice

following a medicine error this learning had not been openly shared in order to prevent the error happening in other directorates. The learning from these incidents would help to improve patient safety.
- Senior staff told us that general feedback on patient safety information was discussed at ward staff meetings, and that patient safety information was displayed on ward performance boards.
- Senior staff were aware of the monthly integrated governance reports, which included quality, safety and performance indicators, but not all junior staff were able to tell us about these reports.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm-free' care. Monthly data was collected on pressure ulcers, falls and urinary tract infections (for people with catheters), and blood clots (venous thromboembolism, VTE).
- Staff told us that summary information from the monthly Safety Thermometer audit was shared with them regularly via team meetings.
- In the trust's integrated governance report for August 2014, medical wards for both sites reported 98.83% compliance with blood clots (VTE) risk assessments being completed on admission, which was above the trust target of 95%.
- In the trust's integrated governance report for August 2014, medical wards for both sites reported that there were 11 falls with serious harm in the year to date, out of the trust total of 220.
- The incidence and timing of falls was being monitored on all wards, and some wards had extended visiting times, so that visitors would be able to spend more time with their relatives in the afternoons, which was a peak time for falls on these wards.
- There were three grade 3 or grade 4 pressure tissue damage reported in the month of July 2014 with a total of 11 grade 3 pressure damage in the year to date, which was above the trust target of zero across both sites. Not all staff with whom we spoke were able to explain clearly what actions were being taken to prevent pressure ulcer development.
- Wards carried out local audits on a monthly basis, including the safety thermometer audit, which looked at prevalence of pressure ulcer, falls, urine infections associated with catheters and whether Venous Thrombo Embolism (VTE) assessments had been completed.
- Ward managers were able to tell us their ward's results for the Safety thermometer: for example, ward D5 had had 100% "harm free care" from February to September 2014. There had been no falls for over a year on this ward. This ward did display this safety information on the ward, but the format made it hard to read for visitors.

Cleanliness, infection control and hygiene

- Wards and communal areas were visibly clean and odour free. Personal protective equipment (PPE) was available in all areas for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage, regarding hand washing for staff and visitors, was on display.
- All wards that we visited had facilities for isolating patients with an infectious disease, and we saw appropriate signage on people's doors to indicate that barrier nursing was in place.
- Generally, cleaning schedules had been completed as required. One storeroom in ward D26 had last been cleaned three months prior to our inspection, as per the cleaning schedules for this area.
- Housekeeping staff told us that there were sufficient supplies of cleaning materials available to use.
- Personal protective equipment was available for staff to use.
- Staff followed universal infection control procedures when we carried out observations.
- Cleaning store rooms were generally clean and tidy and we noted that Control of Substances Hazardous to Health (COSHH) information sheets for cleaning materials were available for staff.
- Green "I am clean" stickers were used to show that equipment had been cleaned and was ready for use.
- Staff told us that wards had Band 6 nurses acting as a "champion" for certain key risk areas e.g. for falls, infection control and records.
- Hand washing audits were carried out monthly on all wards. D5 ward had had a recent audit which showed 100% compliance with hand washing protocols for both doctors and nursing staff.

- We observed a phlebotomist enter ward D26 and start to take blood from a patient without washing their hands. The observation of poor infection control practices was raised to the Group Director of Nursing at the time of the incident. Immediate action was taken and the member of staff educated as to the Trust policies relating to correct hand hygiene procedures.

Environment and equipment

- The environment was generally clean and tidy, but the décor, particularly in some communal areas and corridors, was in need of redecoration. Clinical areas were generally well maintained.
- There were systems to maintain and service equipment as required. Firefighting equipment had been checked regularly. Hoists had been serviced regularly. Portable electrical equipment had been tested regularly, to ensure it was safe for use.
- Whilst on AMU 2 ward, we found one patient in a toilet area, who due to layout of the ward was not visible to staff, was in a state of distress; staff immediately assisted this patient when we informed them.
- We noted on some wards that sluice rooms were not always lockable, but staff were aware of the potential risks if people with cognitive impairments went into these areas. However, on D5 ward, the sluice room was unlocked and we found a cupboard inside that contained bleach tablets had been left unlocked. These chemicals could have presented a risk to patients or visitors if they had accessed this area.
- We found on D5 ward that the clinical treatment room was not lockable and contained a variety of medical equipment, and needles that could have been accessible to patients and visitors.
- We found on ward D26 that the door to the staff kitchen area was left open and a range of chemicals that could have posed a risk to patients with a cognitive impairment were not locked away.
- The store room in ward D26, which should have been locked, was open and contained a range of medical equipment that was accessible to patients and visitors.
- Oxygen cylinders were stored in accordance with trust procedures.
- Nurses on most wards told us that protective bumpers were not routinely used to cover bed rails on beds, unless a risk assessment highlighted the need for them to be used.
- Daily check records of resuscitation equipment were carried out on wards and generally checks were carried out and recorded in accordance with trust procedures. However, on ward D5, we found that the trolley for Central Venous Lines placing had not been signed as checked 11 times in September and 15 times in August.
- On ward D26, we found that the defibrillator check sheet had not been signed on three occasions in October, three times in September and five times in July. Trust procedure was that daily checks should be carried out and recorded.
- The trust had appropriate systems in place to manage the risk from water-borne viruses, and regular tests had been carried out.
- A lack of appropriate storage areas in some wards, for example D26 ward, meant that equipment was stored in the corridor areas.

Medicines

- All wards had appropriate storage facilities for medicines, and generally had safe systems for the handling and disposal of medicines.
- Generally, staff administered medication according to trust procedures, but on Ward D5, we saw a nurse carry out a cannula flush without wearing protective gloves. We also saw a nurse handling medicines to give to patients without wearing protective gloves or using an administration pot. We informed the ward manager, who confirmed that this was not in accordance with trust procedures.
- Wards were recording medicine fridge temperatures in accordance with trust policy.
- Nurses wore red tabards when administering medication, in accordance with trust procedures.
- Staff said they had had relevant training, and that their competencies for medicine administration were assessed regularly.
- City hospital had a well-established pharmacy team who supported the safe use and management of medicines. We found that the pharmacy team were actively involved in all aspects of a person's individual medicine requirements. People's medicines were reviewed and checked for safety by a clinical pharmacist at the point of admission through to discharge. In particular people admitted to the hospital had their medicines checked by a pharmacist to ensure the information provided was up to date and accurate. Any concerns or advice about medicines were written

directly onto the person's medicine records or discussed with the prescribing doctor. Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times including an out of hour's pharmacy service. We found that the pharmacy team provided an efficient clinical service to ensure people were safe from harm.

- Medicines were not always stored securely for the protection of patients. This issue had been identified by the Trust's own medicine storage audit however little or no action had been taken.
- Medicine trolleys were locked and chained to the wall when not in use. The trolleys were visibly clean and the contents stored tidily. However, two wards (D11 and D26) were using a system of placing carrying cases with handles on top of a metal dressing's trolley to transport medicines to people during the medication rounds. This system had not been risk assessed for safety or security.
- Whilst on ward D26, we saw on three occasions that the medicines carry case was left unattended and open for a period of five minutes. This was not in accordance with trust procedures.
- On ward D26, there was no record of checks on the medicines in the plastic carry cases and there was no record of when the carry case had been cleaned. We saw the pill crushers in the clinical room were not cleaned after having been used. This was not in accordance with trust procedures.
- Ward D26 had a "Hypo box" to provide immediate support in terms of diabetes management, but we found the box did not contain the required stock of medicines and there was no record of when this box had been checked last. Staff confirmed there were patients with diabetes on the ward and took action to restock the box.
- Ward D26 was not monitoring the ambient room temperature in the medication store.
- One patient on ward D11 did not have some medicines administered as there was a two day wait in the medicines being prescribed; this had been recorded as an incident by the ward.
- In a trust report from April 2013 to March 2014, there were 502 reported errors in the medical care service for this hospital, with the largest number of 154 being as a result of medicines being "omitted". Summary reports were produced by the trust to show performance across each service area and so that learning from the themes of these errors could be cascaded to staff teams.

Records

- Senior staff said that the hospital did not use an electronic patient record and paper patient records were maintained. However, the hospital used an Electronic Bed Management System (eBMS). This system had a multi professional function for notes and was used on the Board rounds and by the capacity, social care and community teams for communication daily.
- We looked at the documentation kept to record peoples' vital signs observations, fluid balance charts, food intake and repositioning charts. We found inconsistent recording on some of the wards that we visited.
- The hospital had provided personalised signature stamps for doctors and nurses, which provided clarity for staff signatures in patients' notes.
- On D15 ward, not all fluid intake and output records had running totals recorded.
- On ward D11, fluid intake charts were not completed at the time drinks were given and therefore the record did not reflect a current, accurate record for the patients.
- One patient on D11 had a gap in fluid intake records for 13 hours so it was not clear whether drinks had been offered or not.
- Most wards had lockable patient note trolleys but not all trolleys were locked when not in use. Some ward patient boards did respect patient confidentiality by using symbols to denote medical conditions.
- We noted that not all updates and amendments to nursing risk assessments and care plans had been dated or signed, so it may have been difficult to check who had made the entry if required.
- Not all moving and handling assessments on ward D11 had been dated and signed, which was not in accordance with trust policy.
- On ward D26, we found gaps in three patients' repositional charts: one patient, who was at risk of developing pressure areas, did not have any recorded positional changes for over 12 hours the day before our visit.
- On ward D26, we found that the printed handover sheet for nurses had incorrectly recorded two patients as not

being for resuscitation, when there was no Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) assessment in place. Senior staff confirmed this was an error in the handover sheet and took immediate action to review all patients' information on the handover sheet.

Safeguarding

- Adherence to safety and safeguarding systems and procedures was monitored and audited on a risk basis, and necessary actions were generally taken as a result of findings.
- The trust reported that it generally took a proactive approach to safeguarding, and focused on early identification, so that people were protected from harm, and children and adults at risk of abuse do not experience abuse.
- There were effective safeguarding policies and procedures, which were generally understood and implemented by staff, including agency and locum staff.
- The trust had a safeguarding lead for the hospital. We found that there was effective multidisciplinary communication with safeguarding leads in other organisations, and all referrals and concerns were triaged by the local safeguarding authority. Staff told us that this worked quickly and efficiently to safeguard people from harm.
- We found that the majority of safeguarding investigations were carried out within the target timescale of 28 days, and we saw evidence of effective protection planning to keep people safe, apart from discharge planning. Monthly reports were produced on safeguarding activity for senior managers.
- Not all staff were fully aware of the trust's whistleblowing procedures. Some staff did not know which external agencies could be contacted with a whistleblowing concern
- Not all wards were fully compliant with the trust target for safeguarding training: for example, on AMU 2 ward, 67% of staff had had safeguarding adults training, against the trust target of 95%. The trust had an ongoing programme of safeguarding training available for staff and was anticipating that all staff will have had this training by the year end.
- Whilst on ward D43, we found a safeguarding concern, which we reported to the ward manager who immediately took action to report the concern in accordance with the trust's safeguarding adult's procedure.

Mandatory training

- Staff told us that they had had mandatory training events annually, which included infection control, moving and handling, and health and safety. Some staff told us that at times, covering the wards took priority over training. Domestic staff also had mandatory training provided they said.
- As of August 2014, 78% of staff in medical wards had completed mandatory training, which was significantly lower than the trust target of 95%. Senior staff said priority was given to staffing the ward rotas so staff were not always able to attend training.
- Each ward manager had access to training information for their ward staff. For example, AMU 2 Ward showed 83% compliance with mandatory training staff.

Assessing and responding to patient risk

- Some wards had implemented the trust's "Ten out of Ten" initiative in which the trust was focussing on 10 key things that must be done for each admitted patient to reduce the risk of harm, including ensuring patient identification identifiers were correct, the risk of pressure area damage was assessed and care plans put in place, and risk of falls was assessed and a care plan put in place. Other wards had not yet introduced this initiative. Some staff were not sure when this initiative was to be introduced. The trust was planning to fully implement this initiative across all ward areas by the end of March 2015.
- We observed a morning handover between staff on D5 ward, and we saw that handover sheets were used, which listed people's conditions and treatment.
- The hospital used the trust's National Early Warning Score (NEWS) tool to record patient's observations at regular intervals and calculate an overall score designed to alert nursing staff when a patient was showing signs of deterioration. Based on the scoring matrix, a review by a doctor would then be requested.
- The hospital had now implemented an electronic system for recording patient observations based on the NEWS tool; this electronic recording system was used on all wards. Staff said they had had training on how to use the system and how to input patient observations onto

handheld devices. All patients' electronic observations were accessible to senor nurses via a desktop computer at the nurses' station and this also sowed when each patient was due to have the next set of observations taken and recorded. This electronic recording system data was available to doctors throughout the hospital; however this electronic system did not automatically make a referral to a doctor to review the patient if their NEWS score indicated a review was needed. Nurses would make the referral and record this on the patient's written notes.

- We looked at five sets of patients' observations and NEWS scores on ward D17 and saw that in all cases, some observations were overdue by two to three hours.
- On ward D26, we saw that in four NEWS records, there was no overall risk score in three records. This was not in accordance with trust policy.
- On ward D26, we saw that not all required documents, such as peripheral cannula checks, had been completed at the required frequencies.
- On ward D26, we found that for one diabetic patient, there was no recorded daily check on their blood sugars levels for three day period: this should have been done daily according to the staff and the patient's care plan.
- Staff on ward D11 told us of one recent incident where a patient with a cognitive impairment nearly absconded from the ward, as a member of ancillary staff had opened the locked door ward for them to leave, as they were not aware of the risks that doing so may have presented to this patient.
- We saw that the NEWS risk assessment system was used effectively on Ward AMU 2 to monitor and identify those patients that may have shown signs of deterioration.
- The hospital used the trust's Electronic Bed Management system (EBMS) to record clinical concerns and to flag up those patients that needed a review by a doctor and this was linked to the hospital at night team handovers.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if any shifts were not covered. Senior staff said they would carry out a risk assessment if their ward was short staffed and escalate to senior managers. Staff said at times nurses and Health Care Assistants (HCAs) would be asked to work on other wards to cover. Some wards reported an increase in short term sickness recently. Senior nurses were able to tell us their ward's staffing vacancy position and at what stage the recruitment process was at. Staff said recruiting new nurses was a lengthy process at times and was not always successful.
- Wards used the trust's tool to assess patient dependency and acuity.
- Wards used the trust's E-Rostering system to plan rotas but this was not yet linked to the trust's Nurse Bank. Shifts not covered by the Nurse Bank within 48 hours were then put out to the trust's preferred agency provider of staff. Senior nurses said requests for agency staff were never refused however the process was time consuming and ran the risk of not receiving the support required in time.
- The NICE guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' was used by the trust to report on its monthly safer staffing levels information.
- D43 ward had a nursing establishment rota based on 24 beds; the additional three beds in the ward, which were used for escalation purposes, were not staffed by permanent staff when open, so the ward was reliant on bank and agency staff to oversee patients in these three beds. Some staff said that the continuity of care was variable given the ward was reliant on agency staff at these times. Staff said that these escalation beds had been used consistently over the previous two weeks.
- The trust was publishing safer staffing data on its website, and made it available on performance boards in ward areas.
- The average staff to patient ratio was 1:7 during the days and 1:9 at nights for Ward D43. At the time of our visit, three patients also needed one to one staffing care. Additional staff were on duty to provide this care. All shifts were supplemented by health care assistants and on occasions had additional staff to support patients who require additional focused care.
- D43 had a number of patients living with a dementia; there was not a qualified mental health nurse on the staffing establishment and staff said this was not required as staff said they received good support from the safeguarding team as required to manage difficult behaviours.
- Ward D5 (cardiology) had 5 qualified nurses on duty in the day, and four at nights, to look after up to 17 patients. This gave a nurse to patient ratio of 1: 4 during

the day and just above 1:4 at nights. This reflected the fact that this ward provided up to 6 coronary care beds. This ward also had a supernumerary senior nurse acting as a co-ordinator during the day.

- Ward D7 (cardiology) had three qualified nurses on duty through the day and night to look after 10 patients, giving a nurse to patient ratio of 1: 3.3. Staff said recruiting experienced cardiology nurses was a nationwide issue and the trust had been training its own staff successfully. Cardiology wards had 10 band 6 nurses vacancies out of 23 posts. Band 5 nurses were undergoing training to provide them with the competencies to become cardiology nurses.
- Ward D17 had nine band 5 nursing vacancies and staff told us that recruitment had been "put on hold" pending a staffing review but recently the trust had approved external recruitment adverts. The trust said no posts had been frozen and that the vacancy position on this ward had been identified and a series of actions undertaken to address the concern. This ward was reliant on bank and agency staff to cover these permanent vacancies. Nurses told us that at times they were asked to work on other wards as their contract was with the trust. This was to cover escalation beds on some wards, which were not permanently staffed.
- Some wards reported higher than average staff vacancies and sickness, and were reliant on bank staff and agency staff to maintain staffing levels. Staff told us that they tried to use the same staff, so there was consistency in the level of care for people.
- The newly employed staff we spoke with told us that they had had a good induction, and that there was effective support in this process.

Medical staffing

- Junior doctors worked from 8am to 4pm or 5pm. After 5pm, doctors would be on call on a twilight shift rota. The hospital had a hospital at night team which started at 9pm, including doctors and Clinical Nurse Practitioners. Consultants generally worked week days and would work an on call medical rota at the weekends.
- The hospital at night team included registrars, junior grade doctors, and senior nurses and was designed to be a multi-speciality team, with both medics and surgeons attending the nightly handover meeting at 9pm each day.
- Doctors said that there was a dedicated 'hospital at night' team for doctors, and that there were formal face-to-face handovers between day and night doctors.
- The trust provided an on call rota for consultants to respond to emergency gastro intestinal bleeds.
- Consultants for medical wards generally worked 8am to 4 or 5pm for weekdays and worked an on call rota at weekends.
- The cardiology wards had on site consultant cover at the weekends and operated an on call consultant cover rota during out of hours. Staff said there was effective support from all grades of doctors on these wards.
- Out-of-hours cover was provided by the hospital's on-call rota of doctors, who were from all types of different medical specialisms.
- The AMU wards had a consultant on site from 9am to 1pm and 5pm to 9pm at the weekends and the trust was working towards having consultants on site for 12 hours at the weekends, as per the Royal College of Physicians guidance.
- Ward D17 had two consultant wards rounds per week for gastroenterology and respiratory patients and daily haematology consultant led ward rounds.
- Staff told us that not all wards had doctors working on them out of hours, and would therefore be reliant on the doctors' on-call system.
- Some staff on the care of the elderly wards told us that there were usually more doctors on the other wards.
- Staff told us that consultant cover was good during the working days in the week, but that consultant cover, out of hours and at weekends, was variable.
- Some wards reported that the doctor's cover rota was reliant on the use of locums.
- The medical handover that we observed on ward D5 was efficient, and there was effective communication displayed regarding people's conditions. Handover sheets were used to record treatment options and agreed actions. Priorities for review and discharge plans were discussed.
- The majority of people we spoke with said that when they needed to, they saw a doctor quickly.
- Doctors told us of a lack of consultant cover at nights for some specialities.
- Ward D43, the discharge ward, was nurse led and had GP led ward rounds three times a week and staff said the trust was planning to increase this to five times a week.

Medical care (including older people's care)

Major incident awareness and training

- The provider had plans in place to manage and mitigate anticipated safety risks, including changes in demand, disruptions to staffing or facilities, or periodic incidents, such as bad weather or illness.
- Senior staff told us that the trust had business continuity plans in place, and had systems and processes in place, to be able to respond to major incidents.
- The trust had made available its business continuity plans on its internal computer system, for staff to access, but not all staff we spoke with were aware of this.
- Staff were aware of emergency protocols and fire safety risks. Staff told us that fire drills were carried out routinely.

Are medical care services effective?

Good

Care was generally provided in line with national best practice guidelines and the trust did participate in all of the national clinical audits they were eligible to take part in. Performance and outcomes did meet trust targets in most areas. There was evidence of progress to providing seven day a week services, but this had not been consistently achieved across the medical care service. Most staff said they were supported effectively, but there were limited opportunities for regular supervisions with managers. The medical care service was below the trust target for staff appraisals. Care planning generally met patient's needs, but care plans were not generally person-centred.

Evidence-based care and treatment

- Staff carried out accurate, comprehensive assessments, which covered most health needs (clinical needs, mental health, physical health, and nutrition and hydration needs), and social care needs. They developed care plans to meet some identified needs. Care plans were mostly regularly reviewed and updated. People's care and treatment was mostly planned, and delivered in line with evidence-based guidelines. However, for all the care plans we looked at, they were not person-specific, and did not always reflect the holistic needs of the patients.
- One patient on ward D11 did not have care plans in place for risk of malnutrition and dehydration, although there was reference to these risks in the daily notes.
- Six patients (out of six records we looked at) on ward D11 did not have personalised care plans in place to meet their individual needs. Care planning for people living with a dementia was not personalised and care plans did not provide staff with clear guidance as to how to manage difficult behaviours. AMU 1 and D43 ward, we looked at the care plans for patients living with dementia, who were displaying aggressive type behaviours. There were no effective care plans in place for staff detailing how to manage these behaviours. The only intervention was 1:1 care being provided. There was not clear guidance for staff in place on how to recognise triggers to behaviours and the use of de-escalation techniques.
- In most wards, we saw that the majority of beds did not have protective bumpers in place for the use of bed rails. Bed rails risk assessments had been completed, but there was no reference to consideration of use of protective bumpers.
- AMU 2 ward were using effective guidance in the form of the West Midlands Poisons Unit assessment forms for alcohol withdrawal assessment form, based on the national guidance: the Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar).
- Senior staff said the hospital did not generally have a culture of using clinical pathways in all instances and that clinical pathways were focused on certain conditions, for example, variceal bleeds. Senior staff were not clear if all clinical pathways were reviewed and updated regularly.
- Wards also carried out a weekly memory screening audit (a dementia screen) to assess whether these assessments had been done and to inform how the hospital performed against the Commissioning for Quality and Innovation (CQUIN) goal.
- The cardiology wards had effective systems in place for assessment of patients' needs, and followed clear protocols for medical procedures.

Patient outcomes

- The trust had an effective system for monitoring patient 'free from harm care' that was delivered in each ward

area, and monthly feedback reports were cascaded to staff. The main performance issues and safety risks information were displayed on the wards' performance boards.

- Both of the trust's hospitals offered an on-site diabetic support service, but as there were fewer diabetologists at Sandwell hospital, the results of the national diabetes audit were poorer at Sandwell than at City hospital. For the National Diabetes Inpatient Audit (NaDIA) in September 2013, City hospital performed worse that the national average in 4 out of the 20 audit measures and better in 16 audit measures. The trust had subsequently increased the provision of diabetic nurse and consultant time to inpatient care.
- The Hospital at Night team of doctors and senior nurses were not using the Royal College of Physicians Toolkit for handovers as recommended in 2011. This toolkit gives clear guidance and structure to ensure effective handovers are completed that address patient's needs and conditions.
- The Trust's Hospital Standardised Mortality Ratio (HSMR) for the most recent 12-month cumulative period is 85.2, which remained better than peer trusts. The City hospital site HSMR was below the national average with 70.4, as reported in the trust's Integrated Quality and Performance report for the second quarter of 2014.
- The Integrated Quality and Performance report for the second quarter of 2014 showed 100% compliance with the 90% target set by the Commissioning for Quality and Innovation (**CQUINs**) payment framework for July 2014 form dementia screening.
- The heart failure audit for 2013/13 showed that the City hospital performed better than the national average in all eleven audits measures.
- In the **Myocardial Ischaemia National Audit Project** (**MINAP**) audit for the years 2012/13 saw City hospital perform better than the national average in all three areas reported.
- Data from the year 2012 to 2013 demonstrated that the trust performed better than the national average for people with nSTEMI (a common type of heart attack) being seen by a cardiologist (with 100% on the audit results compared to the national average of 94%), and for those people who were referred for or had angiography.
- Also, for the same period, the hospital performed better than expected against the national average for those people with nSTEMI who were admitted to a cardiac ward (with audit results of 57% compared to the national average of 53%). The quicker a person is admitted to a cardiac ward, the better their prognosis would be.
- Wards were required to report on key performance Indicators (KPIs) on a monthly basis, including tissue viability audits, safety thermometer results, staff training and sickness levels. Ward managers said this information was shared with staff.

Nutrition and hydration

- Staff told us the hospital used red trays and red beakers to designate those patients that were at risk of malnutrition and dehydration and needed staff support to eat and drink.
- We saw that red trays were being used to denote those patients at risk of malnutrition. Red beakers were being used for those patients at risk of dehydration.
- On ward D26, we saw that three out of four patients needing a red tray, according to their care plans, were not using red trays at breakfast time.
- All wards had protected mealtime arrangements and notices for visitors about these protected mealtimes were on display on all ward entrances. Mealtimes were protected within the ward areas we inspected. This meant that patients could eat their meals without interruption, and staff could focus on providing assistance to patients who were unable to eat independently.
- We observed that the detailing of nutritional intake and fluids was not always accurately recorded within patient's records. Three patients (out of six records we looked at) on ward D11 did not have their food intake charts completed for two days prior to the date of our visit.

Competent staff

- Most staff told us that there were no formal systems in place for regular supervision sessions with their line managers, apart from annual appraisals, but that any issues were addressed via informal support from managers. Bank nurses solely working on the bank register told us that there was not an effective system for their supervision or their appraisals.
- Senior staff told us that they had regular supervision sessions which did include reviews of their training and development needs.

- Only a small proportion of qualified staff we spoke to said that they had opportunities for clinical supervision. However, there were supervision arrangements in place for newly qualified nurses.
- Most staff told us that they had had an annual appraisal, and their training needs were discussed, and individual development plans completed.
- Newly appointed staff said that their inductions had been planned and delivered well. Permanent staff were provided with induction packs, but not all ward areas had separate induction packs for agency staff.
- On D43 ward, the bank staff member we spoke with, who was providing one to one support for a patient living with a dementia who was displaying difficult behaviours, did not show an awareness of behavioural triggers and de-escalation methods for managing these difficult behaviours. This staff member was not aware of any care plan in the patient's file that gave guidance on how to manage these behaviours.
- For August 2014, medical wards did not meet the trust target of 95% compliance for having an annual appraisal, as only 84.1% of staff had had an appraisal. However, many staff told us that their appraisal had been booked. The trust was anticipating all staff would have had their appraisal by the end of the reporting year.
- AMU 2 ward had carried out appraisals for 81% of the ward staff. For D5 ward, 91% of staff had had their annual appraisal.
- Doctors told us that there was an effective system for assessment and revalidation. From August 2014, 86.8 % of revalidations had been completed which was below the trust target of 95%. The trust was anticipating all doctors would have had their revalidation by the end of the reporting year.

Multidisciplinary working

- There was a multidisciplinary collaborative approach to care and treatment that involved a range of professionals, both internal and external to the organisation. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.
- Staff told us that multidisciplinary working on the stoke ward was excellent with clear handovers given that discussed the needs of patients and action points for staff.
- We saw that multi professional medical ward rounds were being held daily on wards to ensure patients' needs were reviewed daily.
- Staff told us that there was robust multidisciplinary working at ward level, but sometimes links with other departments were not always effective. Staff told us there was effective liaison between nurses and doctors. Doctors told us that nurses knew people's condition, and would report any changes so as to deliver best outcomes for people.
- The Ambulatory Care unit had effective liaison with the emergency department and the AMUs.
- Ward D43, the discharge ward, worked closely with the Complex Discharge team particularly with those patients who had significant social care needs. Therapists we spoke with said there was effective communication within the team and positive support from the doctors.
- Staff on D17 ward said there was effective multidisciplinary working and all staff were actively involved in meetings.
- Each ward had a daily board round in the morning. These were a multi professional review of all inpatients.

Seven-day services

- Staff told us Medical ward rounds were held on each ward during weekdays, but most did not have ward rounds at the weekends. The trust told us that two consultants worked a combined 10.5 hours at weekends and reviewed patients across wards as required. Specialty consultant rota were also in place including cardiology and stroke. Senior staff told us that not all patients were therefore routinely reviewed at the weekends. Staff would refer any concerns to the on call team of doctors at the weekends. Staff reported there were no difficulties in getting doctors to review patients promptly at the weekends. During the night, staff would refer patients to the hospital at night team for review.
- There were two consultants at on duty at weekends; one on-call consultant was based in the AMU and was on site from 7.30am -10.30am and then 18.15pm – 9.15pm. A second consultant was present from 8.00am -12.30pm and reviewed patients on the wards. The total cover was 10.5 hours of consultant time each weekend

day. In addition there were specialty consultant rotas including cardiology and stroke. All wards had out of hours medical cover provided by the on-call Medical Consultant and their team. Specialty cover included an on call Cardiology Consultant and team. D11 ward had an effective consultant presence on the ward with daily ward rounds during the working week. At weekends, unwell patients would be reviewed by the duty medical registrar supported by the consultant on call.

- Staff said junior doctors were readily available at the weekends and out of hours and patients did not have to wait for medical reviews when needed.
- Staff told us that the level of cover by doctors in the evenings and weekends varied from ward to ward. However all wards had equal access to the on call Consultant and their medical teams.
- Staff told us that the process for having X-rays taken, and getting the results for people, could be slow at times, particularly in the evenings and at weekends, due to the out-of-hours cover rota.
- Access to therapists was variable in the evenings and at weekends.
- Pharmacists did not work at the weekends, but senior staff told us that patients' discharge medication could be arranged by using the on-call pharmacist.
- Staff told us arrangements for patients' medications for discharge was more co-ordinated now using the online computer system that linked to the trust's pharmacy department.
- Some wards had a nurse acting as a discharge co-ordinator and patients appropriate for weekend discharges were identified before the weekend, in order to try and facilitate appropriate discharges.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Some assessments correctly recorded specific decisions and the reasons for the judgement made, whilst others did not. The involvement of family members or people's representatives was only recorded in a minority of cases.
- In one case on ward D43, we saw that an urgent Deprivation of Liberty Safeguards (DoLS) assessment had been authorised and was in place. However, there was no record of the Mental Capacity Act assessment being carried out on the patient's notes to inform this application for a DoLS authorisation. Staff were maintaining a safe environment for the patient and had ongoing contact with the trust's safeguarding lead to ensure the patient's needs were met safely. Senior staff confirmed it was trust policy to document mental capacity assessments clearly.
- We saw one patient on D43 ward that was having staff one to one due to displaying aggressive behaviours, but we found this patient did not have a care plan in place for the management of their behavioural issues. This put the patient at risk of having their liberty deprived.
- On ward D26, we found there had been a four day delay in a consultant countersigning a DNACPR form: trust policy said this should have been done within 24 hours.
- Nearly 83% of medical ward staff had completed the training event for Mental Capacity Act awareness and DoLS awareness, as of July 2014, which was below the trust target of 85%. Staff told us that they had had training sessions regarding DoLS, and that this had met their training needs in this area.

Are medical care services caring?

Good

Patients told us that the staff were caring, kind and respected their wishes. We saw that staff interactions with people were generally person-centred and unhurried. Staff treated patients with respect and dignity.

Most people we spoke to during the inspection were complimentary, and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams.

Compassionate care

- Patients and those close to them were treated with respect, including when receiving personal care. Staff in all roles put significant effort into treating people with dignity. Patients generally felt supported and well-cared for. Staff responded compassionately to pain, discomfort, and emotional distress, in a timely and appropriate way.
- We saw that interactions between staff and people were positive, respectful and caring.

Medical care (including older people's care)

- Most people we observed were well presented, and appeared comfortable in their surroundings.
- People's dignity was respected whilst they were being supported with personal care tasks.
- On ward D26, we did see some instances where patients' dignity was not respected as curtains were not always closed around the beds when care was being provided. We also saw instances of poor levels of interaction between staff and patients as staff focussed on the task at hand, as opposed to the patient. We saw incidents where staff did not respond to patients' needs in a timely fashion as they were focussed on other tasks. One patient waited 10 minutes for a drink. Another patient, who had asked four times to go to the toilet, had to use a commode by the bedside instead.
- Patients told us "this is much better than other hospital's I have been in ", and "they give very great care and the staff are nice".
- The relatives we spoke with were complimentary about the care and attention their relatives had received from staff. Some wards had extended visiting times, to allow people to see their relatives for longer and more easily.
- Most people told us that staff answered their call bells in a timely fashion.
- We carried out a Short Observation Framework for Inspection (SOFI) observation on ward D26. We observed three patients for 20 minutes and noted that out of the two staff interactions with these patients in this time, one interaction was positive: the other was negative as the staff member did not acknowledge the patient's needs and did not respond to their request for a drink.

Understanding and involvement of patients and those close to them

- All staff we observed communicated respectfully and effectively with patients.
- Most care plans that we looked at were not personalised to the individual people, and most did not reflect their involvement in agreeing to the plan of care.
- The majority of patients we spoke with across all wards visited said they were aware of their care and treatment plans.
- Most patients on AMU 1 we spoke with said that they had been informed of their conditions and treatment plans. Staff kept people informed of any changes. Four out of five patients we spoke with on ward D5 ward were able to tell us about their longer term individual treatment plans. One patient said "they keep running tests but do let me know what is happening."
- In AMU 1, patients had a named doctor and this was displayed on the bedside noticeboard. Relatives said they were generally kept well informed of how their relative was progressing.
- Most care plans that we looked at were not personalised to the individual people, and most did not reflect their involvement in agreeing to the plan of care having not been signed by the person or their representative.

Emotional support

- Some staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workload meant this did not always happen.
- Most staff said that an extra staff member could be requested if a person needed specific one-to-one support from staff, but that this did not always happen due to lack of available staff.
- People spoke highly of the hospital's chaplaincy service, and found it easy to access support.
- Staff told us that timely assessment and support was generally available for people from mental health practitioners. Sometimes ward D43 had difficulty in accessing support from mental health professionals staff told us.
- Some patients said that they had lost some independence whilst in hospital, but that staff kept them informed and did offer choices where appropriate.
- Visiting times met the needs of the relatives that we spoke to. Open visiting times were available to relatives if patients needed additional support from their relatives.

Are medical care services responsive?

Requires improvement

Some problems with the effective discharge of people were highlighted across the medical care service, from both staff and some of the patients we spoke to. There was an elevated demand on bed availability at times, and the trust had escalation plans in place.

Medical care (including older people's care)

Whilst the trust had implemented a dementia care strategy, there was more work to do in terms of effective care planning and staff training, to provide effective person-centred dementia care.

The trust had systems in place to investigate complaints and record compliments.

The trusts' ambulatory care service was delivering an effective service to prevent admission or readmission to hospital.

Service planning and delivery to meet the needs of local people

- AMU 1 ward provided "hot clinics" and these daytime clinics took referrals from all medical specialities. An acute physician on the ward would also review all patients who returned to the ward after discharge, as the ward provided a "walk in "service for newly discharged patients. The ward also had introduced "virtual clinics" whereby ward doctors would ring patients and their GPs to discuss the patient's progress.
- AMU 2 ward had two beds specifically designated for the management of patients with poisoning and substance misuse detoxification treatment.
- Ward D43 was a discharge ward, currently under the medical care service, and had 27 beds for those patients that were medically fit for discharge. The ward had a bed co-ordinator during the working week and the ward worked with the trust's Complex Discharge team to facilitate appropriate discharges. Staff said delays in discharges were mainly due to complex social care needs, including homeless people, and the trust was working with commissioners and the local authority to address these areas of need. This ward had admission criteria to ensure new patient referrals could have their needs met appropriately.
- Senior staff said the trust was planning a winter pressures plan to cope with increased demand for beds in the coming months. This plan included reducing the number of patients with a delayed discharged of care. The trust was engaging with partner organisations, such as the local authority and Clinical Commissioning Group, to address this area of concern establishing a joint health and social care assessment for discharge team in the assessment units in the winter. The Trust had a comprehensive winter plan that included establishing 20 additional flexible intermediate care beds, increasing capacity for community in-reach service, transport, critical care and staffing. During the period March 2013 to June 2014, the hospital was meeting the 18 week standards for referral to treatment times in all seven specialty groups (including cardiology, dermatology and gastroenterology).
- The trust had introduced a life history profiling document, 'Patient Passport', but we found that it had not been completed for all people living with a dementia.
- Staff were able to tell us how the needs of people from culturally diverse backgrounds were met.
- Staff told us that the translation service worked well when needed, and we saw posters on display in some ward areas. Wards also had access to independent interpreters when required.
- The trust had a range of information leaflets available for patients and their relatives, to signpost them to other providers of support, including social services, and charities.

Access and flow

- The Acute Medical Assessment Unit 1 (AMU 1) had 28 beds and mainly took referrals from the emergency department. On the day of our visit, six out of the 28 patients were awaiting transfers to other wards. Staff said some patients were transferred after 10pm at night to specialised wards. This ward had a pharmacist on the ward during weekdays to facilitate effective medication reviews for new patients.
- Ward leaders told us it was trust policy not to move patients after 10pm at night, unless their medical condition required it, for example transferring someone to intensive care. If patients were moved at night to alleviate bed capacity issues rather than for medical issues, senior nurses carried out risk assessments and would log the night move on the trust's incident reporting system. Staff told us 80% of moves at night were for medical reasons and 20% were for bed capacity issues.
- Staff on AMU 1 ward said five patients were moved after 10pm the night before our inspection and this was to alleviate bed capacity issues.
- Cardiology ward staff told us night moves did not happen as they always sought to identity patients for transfer by 5pm and facilitate moves and discharges before 7.30pm.

Medical care (including older people's care)

- One patient on Ward D15 told us that they had been moved during the night at 2.30am but was not told why they were being moved.
- AMU 1 also provided a small Ambulatory Care Unit with seating for 15 patients and four trolleys available. This was a nurse led service, with support from consultants in the AMU wards.
- The use of the Ambulatory care unit and the hot clinics provided were designed to avoid unnecessary hospital admissions for patients.
- AMU 1 ward had also introduced two designated beds in the event of patients requiring care and treatment for the Ebola virus infection, in accordance with national guidance.
- Staff told us there was no designated length of stay for AMU 2 ward but the average length of stay was 72 hours primarily catering for those patients needing a short term admission. Patients were generally admitted to AMU 2 within 12 hours from admission to hospital, usually via the AMU 1 ward. The trust said this ward had an intended length of stay of up to 48 hours. AMU wards had a Band 5 nurse acting as a discharge co-ordinator during the week, who liaised with the hospital's Complex Discharge team of nurses to facilitate safe and appropriate patient discharges.
- Ward leaders told us they used the trust's Electronic Bed Management System (EBMS) and the bed co-ordinators for wards used this tool to communicate capacity and flow information between wards.
- The hospital had a matron on duty daily in the Capacity Team focusing on bed capacity and bed management across the hospital.
- The hospital had bed management meetings every two hours during the week days from 8am to 8pm during the week to review and plan bed capacity and respond to acute bed availability pressures, for example in the AMU wards.
- Senior nurses said there was good strategic management of bed capacity across both hospital sites and effective liaison with the emergency departments to monitor patient flow and bed capacity.
- Senior staff said during each ward round during weekdays, there was a clear focus on effective discharge planning for patients. However, discharges at the weekends were half of what was achieved during the week and some wards did not always clearly identify patients for potential discharge routinely.
- Each ward did have daily Board Rounds at 8.45 am during the week with relevant multi-disciplinary professionals to plan potential discharges. These Board Round meetings had recently been brought forward from lunch times and the hospital was promoting a "home for lunch" discharge initiative.
- On the day of our visit, the trust had 48 patients medically fit for discharge and were classified as delayed discharges, mainly due to social care support reasons. City hospital had 33 patients on a delayed discharge.
- Ward leaders told us that 90% of patients were admitted to the correct medical ward for their condition and that medical outlier patients normally went to surgical wards. All medical outlier patients were logged on the EBMS system so it was clear where these outlying patients were. A search under a consultant's name would show all patients under the care of that consultant that were on outlying wards.
- Staff told us that there were medical patients outlying on other wards on "a daily basis" but that support from doctors was excellent in ensuring appropriate reviews were carried out. Senior staff said there could be up to 10 cardiology patients in outlying beds at any one time: ward reviews for these patients were carried out daily but sometimes it would be with a middle grade or junior doctor as consultants were busy with their own ward rounds.
- Patients did not always receive their medicines promptly on discharge. We were told that sometimes people were discharged or transferred without their prescribed medicines which were then sent on later using hospital transport. Both nursing staff and patients told us that discharge was often delayed due to waiting for medicines to return from pharmacy. There were many reasons discussed for the delay. These included the time taken for the doctor to write up the discharge prescription or if there were any changes made to a person's medicines which resulted in further delays in dispensing new medicines. The trust said it had implemented an earlier start to Board Rounds. Patients for discharge were to be seen first so medications and plans for discharge could be completed, to avoid the delays and achieve a timely and quality discharge experience.

Medical care (including older people's care)

- In the trust's Integrated Quality and Performance report for the second quarter of 2014, it reported Delayed Transfers of Care increased during the month to 4.3% (from 3.7% in June).
- The average length of stay for the general medical wards was five days, which was below the trust average of six days. The average length of stay varied in each medical speciality, ranging from one day in cardiology to 21 days in neurology. Staff on ward D43 said the average length of stay was 15 days but could go to 3 months in some cases.

Meeting people's individual needs

- Most people we spoke with knew who their consultant was; but some did not, and said that they did not know what their treatment plans were, and when they may be able to go home.
- Not all wards were using the trust's symbols on patient information boards to indicate that a patient was living with a dementia.
- The AMU 1 ward had twice daily medical ward rounds carried out by consultant physicians during the week to review all patients on the ward. The ward had rolling consultant-led evening ward rounds.
- There was a lack of dementia friendly signage and of signs in alternative languages in ward areas, although we did see posters in different languages in some corridor areas.
- The care of the elderly wards were not specifically designed to provide an appropriate environment for people living with dementia, such as with dementia-friendly appropriate décor, flooring, and appropriate lounges for activities. Side wards used for patients who were at risk from falling were not always visible to the majority of staff.
- Care for people with dementia, particularly those who became agitated, and displayed challenging behaviours, was an area that the trust was looking to improve. Behaviour charts were available for staff to use to help monitor and understand patient's difficult behaviours; but we found that these charts were not always being used, when they have been shown to assist with effective care planning.
- Ward staff said that whilst activity equipment and games were provided, there was little time for them to sit with patients to engage with them in meaningful activity. Ward D43 had visits three times a week by the trust's dementia co-ordinators to provide meaningful activities for those patients living with a dementia.
- Some wards did not have activity co-ordinators employed, and staff said that whilst activity equipment and games were provided, there was little time for them to sit with patients to engage with them in meaningful activity.
- Ward D43 had been provided with a cinema room, which was used occasionally. However, the majority of patients did not use this service as they needed close staff supervision we were told.
- The trust was not meeting its target for providing single sex accommodation in the medical wards as there had been 93 breaches from April 2014 to August 2014. However, there had been no breaches in the past two months.
- Staff told us that they gave people's relatives the 'Patient Passport' document to complete, but they did not get many completed documents back. This meant that care and treatment was not always delivered to meet people's needs, as staff did not have appropriate guidance to follow.
- Some people had the trust's care for people with dementia document, 'Patient Passport', completed and available for staff to read; however, some did not. People's life stories and likes/dislikes included in the document had not been effectively transferred into the main care plan, especially regarding people's behaviours and known 'triggers' for aggressive behaviours.

Learning from complaints and concerns

- People generally knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them, or their representatives, to provide feedback about their care however, complaints procedure leaflets were readily available in ward areas. Not all areas we visited had posters on display regarding the trust's complaints procedures or the Patient Advisory Liaison Service (PALS).
- Some patients knew about the hospital's Patient Advice and Liaison Service (PALs), and leaflets were available in all areas we visited.
- Ward leaders told us how they were now working to achieve 'on the spot' resolutions to concerns where

possible, and would hold meetings with people and their families to seek to resolve the concern. Some ward leaders said there were delays in being informed of complaints by the hospital's PALS service.
- D5 ward rarely received complaints staff told us but any issues of concern were resolved quickly and feedback discussed at team meetings.
- Some staff told us that some formal complaints had been dealt with slowly and that there was not an effective process for sharing learning from complaints across the hospital.
- The medical service at City hospital had had 124 complaints in the year ending July 2014 with the main areas of complaints being gastroenterology, general medical care, and cardiology. The trust produced summary reports of the general themes of complaints so that learning could be shared with all departments.
- From April 2014 to August 2014, there had been 126 formal complaints about medical ward wards with 130 complaints shown as still being dealt with via the complaints' process.
- Staff told us that there had been a number of complaints regarding the discharge process, and that these were usually relating to ward discharges processes.
- We saw that all wards displayed the compliments they received.

Are medical care services well-led?

Requires improvement

The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, and the implementation of information boards for staff to highlight each ward's performance. However, the range of concerns about the performance of one ward in particular had not been effectively addressed by senior managers contributing to the judgement in the rating for this domain. The visibility and relationship with the management board was less clear for junior staff, not all of whom had been made aware of recent initiatives. Not all junior staff were fully aware of the vision and strategy of the trust, and said work pressures, due to higher patient dependencies, was an area of concern. Not all staff felt able to contribute to the ongoing development of their service.

Vision and strategy for this service

- Most ward leaders spoke positively about the vision and strategy that the board had for the ongoing development of the medical care service.
- Some staff were able to tell us about the "Ten out of Ten" initiative, and how this would lead to improved outcomes for patients in the planning and delivery of care. Some staff told us this initiative had only just been introduced into their wards, after a pilot in a few wards six weeks prior to the inspection. Half the wards we visited had not yet fully implemented this initiative.
- Ward leaders were able to tell us how their ward's performance was monitored, and how performance boards for staff were used to display current information about the staffing levels and risk factors for the ward.
- Some ward leaders felt that the pace of change in recent months was significant and the staff team needed clarification regarding the workforce reduction plans that were being implemented. One ward was awaiting the outcome of a staffing reconfiguration with the probability of a loss in staff posts, as the ward had been allowed long term use of additional staff to meet patients' needs, but this had not been budgeted for.
- Some staff were able to tell us about the trust's plans to review the nursing establishment at the hospitals with plans to provide a 1; 8 nurse to patient ratio on wards.
- Some senior staff said there was not effective shared learning from both hospital sites with best practice not always being shared.
- Some senior staff said the staffing reconfiguration was led by the trust's financial position and not to meet needs of patients and the local community.

Governance, risk management and quality measurement

- We were told by senior staff that CQC standards were incorporated into the quality assurance programme for the trust.
- Ward leaders were able to tell us about the ward's performance against the trust's targets and objectives, and were aware of the current risks on the risk register. However, junior staff were not always able to tell us how the ward was performing, or what actions were being taken to mitigate risks to people.
- The trust had in place regular governance meetings, and incidents, audits and complaints were discussed.

Formal reports about quality, safety and governance were produced, and made available to the public via the trusts' website. Not all staff we spoke to had read these reports, but senior staff were able to tell us about them.

- Each ward had feedback findings from audits, complaints and areas of risk from audits, and information was cascaded down to all staff via team meetings. However, not all wards had displayed the findings of audits in public ward areas, with information available in staff areas only.
- Staff told us there was no public display of the hospital's audit information as decided by the Chief Nurse. Information was available in staff rooms for staff to read.
- Ward leaders were able to tell us about the main risks and areas of concern on their ward dashboards. These dashboards showed complaints, staffing issues, finance issues and the ward's performance on audits. Not all junior staff were fully aware of these dashboards. Wards had implemented action plans to address main areas of concern: for example, AMU 1 ward had action plans in place for medicine omissions and patients being transferred to other wards without their medicines.
- Not all staff were able to tell us about the trust's "Ten by Ten" campaign, to promote patient safety and dignity. Posters and information about this initiative were not on display in all ward areas.
- The risks arising from ineffective care planning, incomplete documentation, equipment checks not being carried out at the required frequencies and medication errors not being addressed at ward level were not effectively represented on the service's risk registers.

Leadership of service

- Most staff told us that leadership at ward level had improved, with clearer communication. For example, performance boards that highlighted key issues and messages, and also recognised staff achievements, were available for staff to read. A few staff felt that there was a lack of consistency in ward leadership. Most staff felt well supported by local managers. Not all senior nursing staff said that the chief nurse was visible and some had not met him. Staff did consider the chief nurse was aware of the issues affecting staff on the wards, including the staffing reconfiguration but were not certain what the outcome would be for their wards.
- Some ward leaders told us that leadership and management courses were much more accessible for them.
- Senior nursing staff and doctors said that the leadership from the board and the senior executive team had improved, and that two-way communication was more effective. However, some staff said the trust board members did not visit the wards.
- Ward leaders and staff told us about most wards having weekly informal staff meetings that were held for staff, to share their issues, and also to get feedback from senior managers. Staff told us that generally, they were well supported by their managers.
- Some ward leaders said they had not been consulted about the recent change in their wards' patient noticeboards. Some staff said there had been no discussion with them about the trust's "Ten out of Ten" initiative and that it was seen by staff "as the executive team's idea". Some staff said the introduction of this initiative was "rushed".
- Some staff told us that the board members and executive team were more visible and accessible to staff, whilst others said there had been little improvement. Some staff said the chief executive had visited their wards, whilst others had not seen the chief executive visit their ward.
- Some HCAs told us that they did not know what the ward performance boards were for, and some of the HCAs were not aware of the trusts' overall vision.
- Some senior staff expressed concern about the "complicated red tape" system to book agency staff and said this did not provide timely responses to urgent staff shortages.
- Senior staff told us that there was not effective communication between key personnel in the oncology service (which was primarily provided by a service level agreement with another NHS trust) and the executive team and that as a consequence, the service had declined. Senior staff told us that management structural changes and procedural changes happened without consultation and there was not effective staff engagement in succession planning.
- Whilst we were informed by senior staff that there were areas of concern about the performance of Ward 26, there were not clear plans in place to address these concerns.

Medical care (including older people's care)

Culture within the service

- Senior staff reported an improvement in staff morale over the last few months, however, some staff reported feeling pressurised, and said keeping morale up was "a struggle", especially when staff were asked to work on different wards that they were unaccustomed to working on.
- Some senior staff expressed concerns about proposals to close beds on medical wards and to use these beds as escalation areas. This would effectively reduce medical wards bed numbers and the escalation beds may not have permanent staffing rotas so would be reliant on bank and agency staff when in use. The trust told us that their Clinical Group had escalation plans to open additional beds as part of winter planning. These were funded through winter pressures monies. Staffing was to be provided in part from the permanent staff pool and supplemented with bank staff. A matron would oversee the escalation ward.
- Most staff reported an improvement in effective communication to and from the trust's board.
- Some support staff felt that work pressure had increased, as the workload was rising due to the increasing dependency of patients.
- Some staff were concerned about the implications of the trust's workforce reduction plans being implemented and felt reducing staffing levels could compromise patient safety.
- Staff generally were very positive about the team working on their wards.
- Doctors on the AMU wards spoke positively about the learning culture of the organisation and said the biggest challenge for them would be the expansion of weekend cover arrangements.
- Some wards reported a higher than average sickness absence rate; this was usually down to the impact of having staff off on long-term sick leave. Ward leaders told us of the trust's more robust approach to supporting staff with attendance issues. Medical wards had a sickness absence rate of 4.2% for August 2014, which was worse than the trust target of 3.15%.
- The majority of ward leaders were very positive, and spoke well of support from senior managers.

Public and staff engagement

- Some people told us that having the board meeting minutes available to the public online helped them to understand more about the hospital and how it was performing.
- Some HCAs told us that they were not well informed of the trust's plans to reorganise staff teams.
- Feedback from patients was regularly sought, and results displayed in ward areas.
- For the period April 2013 to July 2014, medicine's Family and Friends Test score response rate was an average of 38%, above the trust average of 33% and the national average of 30%.
- Wards had recent FFT results for the trust on display on their notice boards but the data was not always ward specific.
- Friends and Family Test (FFT) results for the medical care service in July 2014 (for those wards with responses above 100) showed that from the nine eligible medical wards, five performed better than the national average of 70%.

Innovation, improvement and sustainability

- Innovation was encouraged, but staff told us that they were not always able to recommend changes, due to time pressures. Some staff felt well supported in being able to voice their opinions on how services should be run, whilst others did not.
- Senior staff said the service was under supported in terms of Information Technology and hospital informatics data and this was hindering innovation and redesign of services.
- Ward leaders felt confident about managing the pace of change if it were carried out in a planned fashion.
- Staff had objectives focused on improvement and learning as part of their appraisals.

Surgery

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

Information about the service

The surgical service was provided within surgery A and surgery B, which incorporated theatres and wards at City Hospital. Day surgery was provided at the treatment centre. From data the trust sent us we saw that at City Hospital the surgical service treated 28,126 people a year. We spoke with 14 members of staff including consultants, registrars, new doctors, nurses, matrons and healthcare support workers. We also spoke with 11 patients and their relatives at this site. We visited preoperative assessment, the day surgery unit, all theatre suites, and the surgery wards. Please note we did not visit the Birmingham and Midland Eye Centre as this is a specialist service which will be scheduled for inspection separately.

Summary of findings

The surgical service had identified for itself some areas that required improvement and had further identified that some plans to improve were not progressing as required. Staff told us that improving safety was their main objective. However, the handover processes for some nursing and medical staff were suboptimal. Basic infection control measures such as cleaning hands on entering and leaving ward areas were largely ignored by medical staff. There was inconsistent security for storage of confidential patient records.

Patients told us they received good pain relief. The trust engaged with national surgical audits, but local audits to further review these findings or explore reasons for results were not in place.

Patients and their visitors were happy with the care they received and told us that staff were kind and helpful. Visiting times were clear and relatives told us, “Staff were polite but firm about this.”

Medical staff demonstrated a poor lack of understanding of the Mental Health Act and best interest decisions when patients lacked capacity to consent.

Consultants and nurses found being involved in the devolved complaints process helpful in understanding complaints.

Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the

Surgery

trust was undertaking, which in turn affected their morale and made it harder to engage proactively with further change. Some staff were confident about this review whereas others felt insecure. The view expressed by most staff was that they had not been adequately consulted about what the changes meant for them. The trust had sent us an overview of the changes and confirmed they had started consultations with staff early in October 2014. This did not match the views expressed by staff to us in conversation or focus groups.

Local leadership in most wards and departments was clear and senior staff were committed to act as positive and proactive role models.

Are surgery services safe?

Inadequate

We judged the surgical safety domain as inadequate. Although we saw some areas of good practice we saw many areas where patient safety was compromised.

The surgical service had identified for itself some areas that for improvement and had further identified that some plans to improve were not progressing as required. We found that when a plan to reduce risk was implemented it was not followed consistently by staff so patient safety was compromised.

Infection control practices were poor in surgery; staff were re-using some disposable items. Cleaning procedures needed to be improved and consistent. Medication storage was an issue; we found unlocked cupboards where medication was stored.

Mandatory training compliance was very low for medical staff compared to nursing staff.

Incidents

- Surgery had reported two 'never events' for the trust (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the operating theatres (across all theatre suites) during 2013–14. We saw that recommendations had been made to resolve some of these issues and that difficulty with information technology (IT) systems had been identified as a contributory cause and raised with the trust.
- Staff we spoke with on both sites told us that there were still difficulties with IT systems and bookings for patients who required theatre procedures. Orthopaedic surgeons, in both focus groups and one to one conversations, told us it was still of great concern to them. Following the inspection the trust informed us they were aware of the issue and mitigating actions were in place.
- Within the theatre department senior staff told us they were still waiting to get a monthly review of reported incidents, which would identify grade and trend. At the

time of inspection the report had still not been received, even though the trust had been made aware that monthly incident reports were important for theatres and would enable timely safety improvements.

- Nursing staff gave us mixed responses about incident reporting, across wards and theatres. Some staff told us it was important to keep reporting even though feedback was limited. Other staff told us that there was little point in reporting due to poor feedback. One ward manager told us that they actively discouraged staff from reporting incidents so that they did not have to deal with trivial day to day concerns. However, the trust told us that they knew reporting across the trust was good and that they continued to take positive steps to improve reporting rates.
- Senior medical staff told us that they shared learning from incidents within directorate and groups but were less sure that they received information about learning from elsewhere in the hospital. Middle grade doctors told us that feedback was variable and that grading was dependent on the subjective view of the person that read it. Nursing staff told us that there was limited opportunity to learn from incidents as feedback was poor and not timely.
- The trust system for reviewing hospital mortality and morbidity involved the group director and the clinical director for the care area. A template for the review process had been reviewed earlier this year to ensure consistency and enable shared learning. These meetings were sometimes postponed and therefore did not always occur monthly as planned. Mortality meetings were chaired by the Associate Medical Director for Governance and Safety.

Safety thermometer

- We looked for information about the safety thermometer (a national tool used to improve patient safety) on the wards we visited. Staff told us that they used internal and external measures boards. The internal measures boards contained information about staff levels and sickness rates. One of the nurses told us it was for staff only. Staff told us the board got updated when they remembered, although it was intended to be updated monthly. The external measures board told us what the vision for the ward was. It explained visiting times and that meal times were protected. There was a section with graphs on it titled 'Monthly audits for harm-free care', which showed a positive outcome. However, on closer inspection the graph actually had "no data available" written across the graph. This meant that data about safety, although recorded by the trust, was not displayed. What was displayed could mislead people. Although we had been told that another measure, the 'safety cross', was no longer in use, we saw this at the entrance to one of the wards at City Hospital.
- The trust had reported 11 pressure ulcers of grade three during the last year. We found inconsistencies throughout the surgical wards in how the risk of pressure ulcers was managed. For example on some wards a high risk score ensured that the patient received a high profile mattress and that this had been recorded in the notes.
- The theatre safety dashboard which captured the current rate of staff sickness and theatre vacancies, which were within acceptable parameters. The board did identify safer surgery information about audit and completing checklists. It did not identify how many days there had been since the last event or incident, which could be helpful to staff committed to improving safety. There was information about a 'new' product that was not dated. Senior staff agreed the date the product was launched should be included on the board. The theatre safety dashboard did not capture some safety information. Senior staff told us that they were working with the new clinical director to improve the safety dashboards at both hospitals.

Cleanliness, infection control and hygiene

- We observed that the majority of medical staff entering ward areas failed to follow the hand hygiene protocol. Nurses in training did not always apply gel to their hands immediately before or after patient contact. We reviewed the trust-wide infection control audit and found that it was aware of poor hand hygiene. The audit had been completed in April 2014, and the trust took steps to further review hand hygiene in July. Although we noted that the trust results showed some positive improvement, the trust had used a self-audit tool, and this, had failed to ensure that all staff followed appropriate hand hygiene protocols.
- Within the theatre departments we found that all grades of staff from all disciplines failed to put on and remove face masks appropriately. We observed that most staff pulled masks off their faces and wore them around their necks during coffee breaks and then pulled them back

up. When asked, the staff told us that this was what they did in theatres. Failure to remove the mask and dispose of it appropriately when taking a break generates the risk of infection.

- Senior theatre staff shared the infection control action plan for theatres with us. This was based solely on the environment for two of the three operating theatre departments.
- We had found some areas of work surface within the day case theatres that were no longer sealed and which could create a risk of infection.
- We observed that theatre staff entered theatres through an ante room, thus ensuring that the clean air flow was not directly interrupted. Medical staff told us about the importance of keeping theatre doors closed. Medical staff also knew how long the air cycle took to complete so that the emergency theatre could manage any type of case safely.
- On one of the wards we saw that the plastic apron dispenser was empty. Staff did not know how long it had been empty and we did not see any member of staff take steps to get it restocked. This meant staff who needed an apron would have to go further for one, and this could increase the likelihood of not following infection protection and control best practice.
- Each ward had dedicated domestic staff responsible for ensuring the environment was clean and tidy. Some staff told us the trust was making changes to the way domestic staff worked, but could not tell us what these changes would be.
- Ward and department staff wore clean uniforms with arms bare below the elbow.
- We saw separate hand-washing basins, hand wash and sanitiser in the ward bays. We found hand gel available for visitors and staff at the entrance to wards.
- There had been no episodes of methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile) reported on the surgical wards during the last six months. The trust had reported three cases of C. difficile during the last year. This indicates that the pre-operative screening measures for MRSA have been effective.
- From data the trust supplied to us we saw that it had a higher than expected rate of post-operative chest infections. We asked middle-grade and junior doctors if they routinely listened to chests postoperatively and they told us this was not a routine postoperative check, although this is not part of guidance from the Royal College of Surgeons or National Institute for Clinical Excellence. Nursing staff told us that sitting patients up was an important step in reducing the risk of a postoperative chest infection. Nursing staff also told us that they asked the physiotherapists for advice when needed. This meant that nursing staff were aware of the risk of postoperative infection and took suitable steps to reduce this risk. However, without the whole multidisciplinary team engaged in preventative measures the incidence of chest infections had risen.
- We found that equipment in one theatre recovery area had not been adequately cleaned. Among a pile of syringe drivers ready for use, one syringe driver was covered in a yellow sticky substance. Senior nursing staff told us that they did not use the green sticker (cleaned and ready for use) system in any of the theatres. We were told that theatre staff cleaned all equipment at the end of each day. This cleaning system used for the equipment did not adequately protect people from the risk of infection.
- We saw that the surgical wards used the green sticker system and that these were up to date. This demonstrated that equipment was properly cleaned in between patients and appropriately labelled, signed and dated as ready for use. This system helps to prevent healthcare-acquired infection.
- With the exception of one theatre suite, we found that emergency equipment was cleaned and signed for. In the one exception, we were told the documents were being updated. We checked again on our way out of the theatre department and found that a suitable cleaning schedule was in place. However, not all staff were following the checking procedure consistently. An out of date book for signing remained on the theatre emergency trolley, last signed October 2013. We drew the attention of the senior nurse to the inconsistencies we found.

Environment and equipment

- Senior theatre staff had taken steps to improve the tray system which held instruments used in surgery and ensure that an auditable process was in place for any instrument that required replacement or repair. We saw that this was clearly identified in the storage area.
- Ward areas had suitable records of daily checks for emergency equipment, which were up to date.
- The preoperative assessment department had reported broken chairs with ripped seating over a year ago. The

trust had failed to make repairs to this environment even though it had been told about the problems. The emergency trolley was a long way away from the assessment rooms, and housed in an unlocked room. Staff told us that they had reported difficulties they had with the environment, including small rooms and inadequate facilities, and non-sounding call bells (only a light came on outside the door, there was no audible sound). We asked them if they had escalated this within the trust and they confirmed that they had.

Medicines

- We found that there was out-of-date saline on the emergency trolley in the pre-operative assessment area.
- This meant that medicines management required more formal arrangements and audit to ensure that medicines were stored safely.

Records

- Emergency booking forms for patients requiring emergency surgery were hand written in script. This meant that it was not always possible to be sure what the intended procedure was. Theatre staff told us that they were trying to get emergency booking forms completed electronically to reduce this risk. As an interim measure, staff booking emergencies had been asked to print on the forms, but this was not being done consistently. Incomplete or illegible forms were returned to the booker for clarification.
- Some staff told us that they did not know how to use the electronic system for booking routine theatre patients. This put patients at risk of receiving incorrect theatre procedures.
- Preoperative assessments were supported with written protocols. There was anaesthetic support for the nurse-led clinic and information about how to prepare for surgery. Postoperative instructions were provided.
- Preoperative assessments were recorded. These contained decision-making information that included conversations with patients.
- We reviewed patient records on a variety of surgical wards and found that some risk assessments were incomplete or no action had been taken when significant risk of developing pressure ulcers was highlighted.
- Medical notes were not always kept in secure note trolleys.

Safeguarding

- Safeguarding training for adults levels one and two had been taken by most staff working in surgical wards and departments. For new staff this was part of their induction.
- Nursing staff we spoke with told us about the trust intranet and flow charts for safeguarding matters. Staff were confident about who they would contact and what they would seek support with if they had safeguarding concerns.

Mandatory training

- The trust provided us with a spreadsheet of mandatory training and the percentage of staff who had completed this. With the exception of medical staff (who had only achieved an average of 33% year to date), 80% of all other surgical staff had completed this. Theatre staff had done even better with over 94% of staff having completed their mandatory training. Steps needed to be taken to address the medical staff take up mandatory training throughout the year.

Assessing and responding to patient risk

- We witnessed a patient in a recovery area who required emergency support. We saw that this support was provided rapidly and appropriately by anaesthetic and nursing staff. A member of nursing staff sought further support from staff within the theatre the patient had received treatment in. However, we observed that the surgeon complained to the senior theatre staff that his list could overrun, as he had a patient waiting in the anaesthetic room. This meant that that there was an incomplete patient-centred safety culture in the department.
- The trust used the 'National early warning system' for all patients and used electronic hand-held devices. This enabled them to promptly identify patients that became medically unwell. We saw that when the outreach team was required out of hours, the bleep escalation process was to call the onsite hospital mangers. The onsite managers were clinical nurse practitioners, who supported the night staff to reassess patients before an anaesthetist was called.
- The trust used a bed ratio and dependency acuity tool daily. This tool was used to ensure that they had sufficient staff to safely meet the needs of the patients on the wards.

Surgery

Use of 'Five steps to safer surgery'

- We found that not all World Health Organisation safety checklists were completed properly. We found five out of six checklists had either not been signed by the whole team or had only been partially filled in.
- Some theatre staff had taken ownership of the safer steps and ensured that all staff within the theatres checked the appropriate equipment, procedures and operation at required times.
- We observed that some staff used the checklist as a tick box only, without involving the patient appropriately at check in.
- Senior staff we spoke with told us that they and the clinical director were involving theatre staff in a review of the checklist. This would ensure that band six staff had greater confidence and support to challenge medical staff when appropriate. The team brief should ensure that all staff are encouraged to ask questions about the surgical procedures to be carried out. This makes the operating theatre a safer place for patients.

Nursing staffing

- Wards and departments had expected and actual staff numbers on display. Nursing staff on most wards and departments worked eight or twelve hour shifts. The Health and Safety Executive identified that long shift patterns could increase fatigue levels and could contribute in safety-related incidents. Most wards and departments had clear leadership with substantive leaders in post.
- Ward and department managers told us that they tried hard to ensure the skill mix was suitable to safely support the patients in their care.
- The trust had told us that when bank/agency staff were needed, they were committed to ensuring these were regular staff on a dedicated agency contract. Bank staff were the trust's own staff, paid a premium rate to support shifts at short notice. Staff told us that the bank booking system closed at 6pm, which could be a barrier when additional staff were needed at short notice overnight.
- The trust had assured us that agency staff were booked through a named agency as part of the trust's commitment to safety. However, the standards expected by the trust were not experienced by the staff requesting agency staff. We were told by staff on several wards and departments that the booking system was cumbersome, took an overly long time and was sometimes not responded to in a timely way, which resulted in the shift shortfall not being covered.
- Staff had to fill in a request, then send it to the matron, who sent it to the divisional nurse, who sent it to the executive nurse. Staff told us that sometimes they got a fast response for approval which was three to four hours. Some senior staff told us they felt that the system was designed to be obstructive. More senior staff told us that the executive nurse did not understand the issue and should spend time with them to understand their problems.

Surgical staffing

- The trust had a higher number of registrars (middle grade doctors) to consultants compared with the England average. This made the on-call arrangements for general consultants more challenging across both sites. The trust has told us that it has plans to reduce this burden on general consultants. However, some of these plans were in the early stages of development and consultants expressed concern about the on-call patterns they worked, which expected consultants to do more on-call work than trusts of similar size.
- There were always junior and middle grade doctors on duty for the surgical service. Out of hours there were always two consultants on call. Some breast surgeons formed part of the general surgical on-call group, as there were not enough general surgeons to support the on-call arrangements. The trust told us that it knew about this issue and would work to resolve it.
- The surgical handover was well organised with a printed list of patients, working diagnosis and tests undertaken so far. At the handover the team just going off duty went through each patient with the team coming on duty. Concerns were explored and further tests requested as part of the next teams' job plan where required. Patients for theatre or discharge were identified. A clear job plan was drawn up and surgical doctors knew where they were going on rounds and what surgical/medical interventions patients required.
- Consultants conducted ward rounds for all patients (that is both planned and emergency admissions) on both Saturday and Sunday.

Major incident awareness and training

- Staff we spoke with were aware of the trust procedures for major incidents. Staff could tell us about the table

top reviews they completed annually and that the trust intranet provided detail and information about these events. Staff told us that the last big rehearsal had been three years ago.

Are surgery services effective?

Requires improvement

We judged this domain to require improvement. The surgery core service did use all management data to ensure they delivered effective care.

Patients told us they received good pain relief. The trust engaged with national surgical audits, but local audits to further review these findings or explore reasons for results were not in place.

Medical staff demonstrated a poor lack of understanding of the Mental Health Act and best interest decisions when patients lacked capacity to consent.

The emergency theatre was not staffed out of hours as required, staff were on call, but staff on the Sandwell site were not aware of this and thought the emergency theatre at City was manned at all times out of hours.

Evidence-based care and treatment

- The trust participated in a number of national audits. For example, Hip Fracture Audit was worse than average on 6/10 metrics.
- We saw that guidance was produced for preoperative assessments in line with best practice, including the NICE (National Institute for Health and Care Excellence) and The Association of Anaesthetists of Great Britain and Ireland guidelines. This meant patients could be assured that appropriate assessments would be carried out to ensure they were medically fit for their operation.
- Best practice guidelines were followed for the enhanced recovery programme for some elective surgery such as colorectal surgery. Enhanced recovery programmes are designed to enable patients to recover to full health as quickly as possible after surgery.
- We asked consultant surgeons if they had audited the rate of postoperative chest infections; they had not. There was not an up-to-date local audit programme for surgery, and consultants had not been made aware that postoperative chest infection was an issue at the trust.

Pain relief

- The trust supported postoperative patients with patient-controlled analgesia, or epidural pain relief. We asked the trust about its entire audit processes completed during the last year and those that might still be in planning. We saw that the trust did not audit the benefit of epidural pain relief against less invasive and less labour intensive pain relief methods. Best practice guidelines for epidurals indicate that the decision to continue using epidural techniques should be guided by regular audits and risk–benefit assessment.
- The preoperative assessment for postoperative pain relief prepared patients to use patient-controlled analgesia. Patients told us that they felt well prepared especially when using patient controlled analgesia. Patients also told us that they did not have to wait for pain relief.
- There was a dedicated trust-wide pain team available Monday to Friday in core hours and that an anaesthetist provided this cover out of hours.

Nutrition and hydration

- We found that patients had food and drink within their reach at meal times.
- Meal times were protected, which meant that wards had as few visitors and interruptions as possible for patients to eat.
- If people needed help to eat or drink, staff were free to help with this.
- Relatives and other visitors we spoke with told us that they were happy with the way this worked. Patients we spoke with told us that snacks were always available if they wanted them.

Patient outcomes

- The trust took part in the national bowel cancer audit. It had mixed results, which meant it should further explore some of these areas. For example, how many of the patients with bowel cancer were seen by a specialist nurse.
- The trust undertook patient reported outcomes measures (PROMs) for both hips and knees surgery. These were largely in line with England averages.
- The trust did worse in the national fractured neck of femur audit than the England average on six out of ten measures assessed. For example, patients who

developed pressure ulcers after surgery. This corresponds with our findings that people at risk of developing pressure ulcers did not have an appropriate management plan.

- For the standardised relative risk of readmission we found that City Hospital was worse than expected in all specialties. We asked about further audits in this area. Staff we spoke with were not aware that they had a higher readmission rate for surgical patients across the trust.
- The hospital had an emergency department on each acute site. This meant that either site could provide emergency surgery. However, at City Hospital had on-call arrangements if an emergency theatre was required. National Confidential Enquiry into Patient Outcome and Death (NCEPOD guidance 2003 for non-elective surgery in the NHS) standards for unscheduled care require a staffed emergency theatre on a site where non-elective surgery could be needed. Medical staff told us that the NCEPOD theatre was on the Sandwell site and that the on-call theatre at the City site would be used if patients could not be transferred between the sites. Some staff thought that the hospital had two emergency theatres, one on each site. Lack of clarity about the status of the emergency theatre at City Hospital could pose a potential risk to patients who needed emergency interventions.

Competent staff

- Surgeons told us that they had not had their job plans updated or reviewed for over three years. The surgeons were positive and passionate about the improvements they made to the quality of the service, but found not having a job plan an arduous burden.
- The NHS Employers organisation and the British Medical Association (BMA) together produced a guide to consultant job planning. Consultant job planning would be an important part of organising resources effectively and efficiently.
- Nursing staff, healthcare support workers and ward clerks on surgical wards and departments all received annual appraisals. The document the trust provided us with recorded 100% of surgical staff as having completed an annual appraisal for the last financial year.

Multidisciplinary working

- There was some good multidisciplinary team working making the hospital team at night effective, for example radiography were supportive if surgeons needed an opinion or further scan. However, there were concerns when surgical doctors required support from medical doctors. The surgeons told us that they were used to multiple teams supporting a patient when their condition needed input from more than one medical speciality. However, doctors from medicine did not engage as readily as other speciality groups, which put extra pressure on the surgeons.
- We saw that the colorectal team had a positive multidisciplinary approach to patient care. Records demonstrated that the team communicated effectively and followed up patients in a timely manner. This team included medical staff, nurses and therapists.
- There were suitable arrangements in place for the transfer of patients between sites when this was required.

Seven-day services

- Consultants conducted daily ward rounds after each morning handover. After the evening handover the middle grade doctors conducted ward rounds.
- Consultants were on call for all out-of-hours periods and conducted ward rounds on Saturdays and Sundays for all surgical patients.
- Arrangements were in place for out-of-hours imaging support. Middle grade doctors told us that they did not encounter issues when urgent imaging was needed as part of the diagnostic process.
- Staff told us that there was no out-of-hours pharmacy support.

Access to information

- The day surgery unit provided leaflets about a large number of procedures and what to expect, which was an important part of preparation for surgery.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Medical notes did not include suitable information about how decisions were reached if a patient did not have capacity to consent.
- Junior doctors we spoke with were not able to tell us about the requirements for consent when a patient lacked the capacity to make the decision for themselves.

Are surgery services caring?

Surgery

Good

Patients and their visitors were happy with the care they received and told us that staff were kind and helpful. Visiting times were clear and relatives told us, "Staff were polite but firm about this."

Compassionate care

- Patients and their relatives told us that they were happy with the care they received.
- One relative told us that the care was good and that this had surprised the family in a good way.

Understanding and involvement of patients and those close to them

- Patients and their relatives told us that they had received suitable explanations and understood what was happening with their care.
- Patients told us that they had information about what was expected to happen next.
- Nursing handovers did not always ensure confidential details were handed over appropriately and we observed that these details could be overheard by other patients in the ward.

Emotional support

- We observed two female members of staff support a female patient to the theatre. As they passed through various areas of the department they did not speak with the patient or offer any explanations about where they were. The senior theatre nurse explored this with the staff involved. They explained that the patient had received preoperative medication and that they had not spoken to the patient because of that. The staff understood that they could have improved the emotional support they offered this patient.
- Senior staff told us they were committed to improving patients' experience in theatres, and that appropriate emotional support was an essential part of this.
- Clinical nurse specialists were available for specialties including breast surgery, colorectal surgery and pain.

Are surgery services responsive?

Requires improvement

We found this domain to require improvement. Consultants and nurses found being involved in the devolved complaints process helpful in understanding complaints.

Referral to treatment (RTT) time was below average and was not improving especially in trauma and orthopaedics.

The trust had a variety of translation services, these included pick and point cards, multi-lingual staff and a commercial service. We did see that at times this was not arranged in time for some patients requiring surgery.

GPs were able to refer patients directly into the surgical assessment unit, which ensured patients did not have to wait in the accident and emergency (A&E) department before being seen or treated.

Service planning and delivery to meet the needs of local people

- Patients could be referred directly by their GP to the surgical assessment unit or be admitted from the emergency department. This ensured patients did not have to wait in A&E before being seen.

Access and flow

- The referral to treatment (RTT) time percentage within 18 weeks was below standard and decreasing for this Trust, with Trauma & Orthopaedics performing the worst.
- We found that theatre sessions mainly started and ended on time.
- Patients could be late being discharged because of a lack of available medicines. Staff told us that there was no out-of-hours cover from the pharmacy and that some patients were asked to collect their medications the following day.
- Patients needing treatment for fractured neck of femur received surgery by a consultant within 48 hours of admission, as required by best practice pathways and guidance.

Meeting people's individual needs

- The trust had a variety of translation services. These included pick and point cards, multi-lingual staff and a

commercial translation service. The commercial translation service was accessed via a twin handset telephone. We saw that there were twin handset telephones available on surgical wards and departments. Patients whose first language was not English were supported to make informed decisions.

- However, the preoperative assessment unit told us that they sometimes cancelled patients' appointments when interpreters did not arrive as booked. They could not tell us when this had last occurred or if they had escalated this within the trust. We could not see a twin handset phone within this department. If patients' appointments are cancelled due to inadequate translations services being available, this could result in a delay in their treatment.
- The trust had a specialist nurse for learning disabilities who was able to provide advice and support to ward, department staff and patients when needed.
- Some surgical wards had taken steps to make the environment dementia friendly.
- Patients told us they found the environment uncomfortable and did not help them maintain their dignity. For example people told us that curtains were not always adequately drawn around them.

Learning from complaints and concerns

- The trust told us that it had recently changed the way it managed complaints. The new process was a devolved complaints system. This meant that clinicians involved in treating patients would investigate complaints about peers or neighbouring areas. Staff would not be able to investigate complaints that were about the care they had given.
- All complaints were overseen by a complaints manger to ensure complaints had been answered appropriately and in a timely manner. The chief executive reviewed every complaint response before it was sent out to the person that had complained.
- Consultants told us that they found being involved in complaints useful as a learning tool.
- Nursing staff told us that they were sometimes involved in looking at complaints, and that they tried where possible to resolve issues as they arose for patients.

Are surgery services well-led?

Requires improvement

Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the trust was undertaking, which in turn affected their morale and made it harder to engage proactively with further change. Some staff were confident about this review, whereas others felt insecure. The view expressed by most staff was that they had not been adequately consulted about what the changes meant for them. The trust had sent us an overview of the changes and confirmed they had started consultations with staff early in October 2014. This did not match the views expressed by staff to us in conversation or focus groups.

Vision and strategy for this service

- Senior staff in theatres knew what the vision and strategy for the department was and that the "six c's" were part of it. Fewer senior staff understood that improving safety was the focus, and also told us about the six c's. The six c's were: care, compassion, competence, communication, courage and commitment. Ward and other department staff told us about the six c's. This meant that the surgical divisions had a shared and understood vision and strategy for the service.

Governance, risk management and quality measurement

- We reviewed one of the 'never events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) reported by the operating theatres. We were concerned that the root cause analysis included the patient as part of the problem stating that the patient might not have known the difference between two named surgical procedures.
- The information given to the patient should have been clear about this and related it to the expected surgery. Best practice consent processes would ensure that the patient received sufficient information about their surgery.
- The consent process was not considered to be part of the problem or a contributory factor in the root cause analysis. However, changes to the consent process were included as part of the recommendations. This indicates that the route cause analyses process was not

sufficiently robust to correctly identify all contributory factors and system errors. Patients put their trust in hospital procedures and it is unreasonable to expect patients to understand the difference in surgical procedures without adequate explanation and documentation. Checking with the patient their understanding of the anticipated procedure is part of best practice in 'five steps to safer surgery'.

- Risk registers were in use to identify risks within surgery and the mitigation actions in place. We saw that RTT time was on the register, the mitigation actions identified had reduced the risk, but audits had not shown an improvement at the time of the inspection.

Leadership of service

- The clinical director responsible for theatres had identified some areas for safety improvement but there was no substantive or consistent directorate management in place to support these essential changes. For example the safer surgery World Health Organization checklist was audited electronically and not directly. This enabled the audit to generate a positive result that did not account for omissions and members of staff who did not take the time to sign the document. The guidance does not require the document to be signed, but if the decision had been made locally to seek a signature on the checklist, then this should be done. We found that the checklist in use at the trust required signatures.
- The new clinical director demonstrated commitment to improving patient safety within the theatre environment and had drawn up a plan to address immediate issues.
- The clinical director was responsible for reviewing a current hospital death. There was a dedicated template and the trust sought to share learning through the mortality and quality meetings. The trust sent us minutes from mortality and quality meetings held during the year. The meeting recorded hospital-related deaths and reviewed those where actions could have been taken to prevent them. We could see from the minutes that the trust considered where it could have made improvements in care.
- Senior theatre staff told us that they felt supported by the new clinical director and were confident that changes would be made to further improve safety in theatres.
- Management of the surgical divisions had been destabilised by a lack of consistent senior management. The trust had either interim managers or vacancies within the surgical divisions' senior management structure. This meant that there was no consistent support for the general surgeons and their day to day management issues.
- Additionally the lack of stable management support had caused stress for the general surgeons. In focus groups and individual discussions, general surgeons told us how frustrated they had felt due to the absence of consistent management within surgery. We could not find evidence that the trust had taken suitable steps to ensure that the surgeons felt supported while their managerial support was not substantive. The surgeons told us that they were committed to and keen to work with the trust, but the lack of stable divisional management had led to them feeling unsupported. The surgeons were positive about the contribution stable management support would make to surgery.
- Surgeons had not been supported by the medical director with the job planning process. Surgeons had discussed this issue with the medical director and requested a review of their jobs plans.

The consultant job plan is a key mechanism through which the shared responsibility of providing the best possible patient care with the resources available to them can be agreed, monitored and delivered. Management should not abdicate their share of the responsibility in this mechanism.

- Nursing staff in both focus groups and individual consultations told us that they were concerned about the process senior leadership had developed for requesting agency staff. Senior nursing staff expressed concern that this process was obstructive and time consuming. The length of time this process took could result in shifts being understaffed.
- The management of the bank staff system could be a factor in the volume of requests for agency staff out of hours. Senior staff from both wards and departments told us that the executive nurse did not come and see them to understand their issues. They expressed the view that the executive nurse managed remotely and had not accepted offers to spend time on some wards and departments or with some senior staff to see the issues at first hand. Some staff who had never met the chief nurse told us that they thought the chief executive was the chief nurse.

- Staff from surgical wards and departments told us that they had not seen the executive team on their 'First Friday' (of the month) walk about. The trust told us that it used the 'First Friday' initiative to see wards and departments at first hand.

Culture within the service

- We found that there were differences in the way that theatres undertook morning briefings and sending for their first patient. The discussion at the briefing should include each patient and any potential problems or challenges. Although this was a trust policy, this did not always correlate with the distance between wards and theatres. For example in the day surgery unit at the Birmingham Treatment Centre where patients are close to the theatres, the briefing took place after the patient had been sent for. Although there is no prescriptive guidance for when a briefing takes place, briefings are about informing the whole team about what is going to happen during the list. The guidance advises that local policy should take account of the local geography and the distance from theatres of wards or admissions units. Staff told us that this led to a non-collaborative culture, which generated inconsistencies in practice. Surgery staff were at risk of not completing the safety briefing if the first patient had arrived.
- General surgeons told us about the culture within senior management at the trust of emailing consultants about important changes. Although the consultants told us that they usually agreed in broad terms with the subject of the emails, they found the tone and method disempowered and excluded them from being involved in seeking active solutions to surgical problems.

The trust used a variety of printed and electronic methods to communicate, such as the trust news sheet, email, chief executive question and answer sessions and a once a month executive team 'First Friday' walkabout. However, the general surgeons told us that they did not feel fully informed about changes to surgical trust plans to separate breast surgery from general surgery for on-call purposes. The general surgeons were concerned about the on-call commitments and did not feel this had been addressed. The disconnection between the executive and surgical management could have contributed to the surgeons feeling less informed than the trust believed they were. The trust confirmed to us that it was aware about this disconnection within the surgical division and executive management.

Public and staff engagement

- The trust had set up a 'ten out of ten' challenge. This is a patient safety checklist of ten standards within 24 hours of admission. They explained to patients and visitors what ten out of ten meant to them and encouraged patients and their visitors to challenge staff about their treatment and experience at the trust.
- Some ward areas used an electronic hand-held device for the friends and family test. This enabled patients to record their views in real time once their care was completed.
- The trust had an internal award scheme for staff. We saw that a number of staff from surgical wards and departments had received nominations for leader of the year. Staff told us that this scheme made them feel appreciated by the trust.

Innovation, improvement and sustainability

- The experience of general surgeons working without agreed job plans was not sustainable and could impede the development of the surgical department.
- The general surgeons were active in clinical research and were contributors to the international online portal 'Research Gate'. For example, there was active research that identified digestive disease as a precursor to cancer.
- The general surgical consultants would be keen to see consultant-led research clinics as part of their role. This could be both innovative and part of an improvement programme.

Critical care

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

Information about the service

The intensive care units (ITU) at Sandwell and West Birmingham Hospitals NHS Trust has capacity to care for up to 14 level 3 patients across the two sites at City and Sandwell Hospitals. The unit provides both level 3 care, which is for patients requiring one-to-one support, such as those ventilated, and level 2 intensive care beds for high dependency care. The outreach team provides support with the care of critically ill patients who are on the wards. The critical care service has consultant cover 24 hours a day, seven days a week. The two units function as a single service to address capacity and demand.

As part of our inspection, we spoke with 28 staff, five patients and six relatives. We spoke with a range of staff including nursing staff, junior and senior doctors, a physiotherapist and managers. We observed care and the treatment patients were receiving and viewed 10 care records. We sought feedback from staff and patients at our focus groups and combined listening events.

Summary of findings

There were effective processes in place to learn from incidents. There were sufficient numbers of nursing and medical staff on duty. Medicines, including controlled drugs, were safely and securely stored.

Patients received treatment and care according to national guidelines. The intensive care unit (ITU) was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. ICNARC is a research centre that collects national audit data on clinical outcomes in critical care.

We found there was good multidisciplinary team working across the unit.

Staff cared for patients in a compassionate manner with dignity and respect. Both patients and their relatives were happy with the care provided.

There was strong medical and nursing leadership within the critical care unit. Staff felt well supported within an open, positive culture.

Critical care

Are critical care services safe?

Good

There were effective processes in place to learn from incidents. There were sufficient numbers of nursing and medical staff on duty. The environment was clean and staff followed infection control procedures. There were good systems for monitoring the NHS Safety Thermometer data and improving practice. The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm. Medicines, including controlled drugs, were safely and securely stored.

Incidents

- There was a good system for learning from incidents. All incidents were reported and reviewed, and action plans were developed. Staff were updated on the outcomes of incident reports via monthly emails.
- Mortality and morbidity meetings were held 6-weekly. All incidents of death and poor outcomes for patients were reviewed, and appropriate action was planned and implemented to improve outcomes for patients.

Safety thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm. This includes the development of new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls.
- This information was being monitored alongside nursing documentation to ensure that specific clinical checks related to the intensive care unit (ITU) were taking place. For example, we saw monitoring of sedation scores and regular endotracheal cuff pressure checks, and other safety checks were undertaken.
- Action plans were developed whereby, if 100% compliance was not gained in these audits, the learning was shared with staff to improve results.
- Risk assessments for patients for pressure ulcers and VTE were completed on admission, regular monitoring of pressure sites was maintained throughout their stay and prophylactic therapy initiated for VTE prevention.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to. There were hand-washing facilities and protective personal equipment (PPE), such as gloves and aprons, available. We observed staff using gloves and aprons and changing these between patients. If necessary, staff reminded people entering the unit to wash their hands.
- Since April 2014, there had been no incidences of MRSA. There had been one incident of Clostridium difficile (C. difficile) in the same timescale.
- There were effective arrangements for the safe disposal of sharps and contaminated items; these included dating when the sharps box had begun to be used. All sharps boxes we inspected had their lids closed.
- The latest hand hygiene audit, completed in October 2014, showed that staff had achieved 95% compliance. However, we noted that for observations of intravenous sites the unit scored 84%, which was red rated as a high risk. These audits were repeated ahead of the monthly schedule if 100% compliance was not achieved.
- The Intensive Care National Audit and Research Centre (ICNARC) data reported low levels of infection rates in the ITU. ICNARC is a research centre that collects national audit data on clinical outcomes in critical care.

Environment and equipment

- We found equipment was clean and fit for purpose.
- The resuscitation equipment was checked daily and records of these checks were maintained. We noted a couple of days where signatures to confirm that checks had been made were not present.
- There were regular safety checks of other medical equipment used in the ITU and these checks were signed by the individual undertaking them.
- Equipment was serviced on a routine basis by the medical electronics department. Specialist equipment such as ventilators, haemofilters and cardiac monitors were on service contracts with the respective companies.
- The unit environment was bright and spacious and in good decorative order. There was adequate space between each bed area. The Trust acknowledged that the space did not meet best practice guidance and that this would be addressed in the new hospital build.
- There was a relatives' room available. Overnight accommodation was provided elsewhere in the hospital.

Critical care

Medicines

- Medicines, including controlled drugs, were safely and securely stored. The medication records we looked at during our inspection were found to accurately reflect the prescribed and administered medicines for the patients concerned.
- Fridge temperatures were monitored daily; this ensured that medicines were maintained at the recommended temperature. We saw that the staff undertaking the checks signed on their completion.
- There were arrangements for the effective access to medicines out of hours. The ITU had its own dedicated pharmacist who visited the unit daily, Monday to Friday, and reviewed all medical prescriptions to ensure that sufficient stocks were available.

Records

- There was standardised nursing documentation kept at the end of each patient's bed. Observations were recorded clearly.
- All medical records were in paper form and followed the same format; this meant that information could be found easily.

Consent and Mental Capacity Act

- Staff we spoke with were aware of the Mental Capacity Act 2005 and how this related to the patients they cared for.
- The nursing documentation contained a specific section on mental capacity assessment; this ensured that the capacity of each patient in the ITU was assessed on each shift.
- There appeared to be a lack of understanding of how Deprivation of Liberty Safeguards (DoLS) had an impact on critical care patients. Some staff we spoke with said they would appreciate more training on this.

Safeguarding

- Staff completed training on safeguarding vulnerable adults and children as part of their mandatory training and updates.
- Staff demonstrated an understanding of safeguarding procedures and its reporting process.

Mandatory training

- Staff had a training plan for all nursing and medical staff to ensure that they met their mandatory training targets the governance team told the nurse manager each month which staff needed specific training.
- Records showed that 94% of staff had completed their mandatory training and 98% had received appraisals. Staff we spoke with confirmed this.

Assessing and responding to patient risk

- The national early warning score (NEWS) of acutely unwell adult patients was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff. The hospital had just introduced 'Vital Pac', a computerised system whereby all observations were electronically recorded on an iPad. This enabled staff to access information from elsewhere in the hospital.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of a patient's illness. Alarms were set on monitoring equipment to alert staff to any changes in the patient's condition. This meant that deteriorating patients would be identified and action or escalation to the appropriate team initiated without delay.

Nursing staffing

- The staffing roster was planned and staff worked on a rotational basis of days and nights. All level 3 patients were nursed one-to-one and level 2 patients had one nurse to two patients.
- The nurse manager told us that they tried to cover staff shortfalls with their own staff and the use of agency staff was being reduced. When agency staff were used, they were given an induction to the unit before starting work.
- Nursing staff were moved across both acute sites of City and Sandwell General critical care units to respond to capacity and demand. The staff we spoke with acknowledged that this was a requirement of their role.

Medical staffing

- Care in the ITU was consultant led and delivered. ITU consultants provided cover seven days a week 8am to 6pm and were available on call at other times. They lived within 30 minutes of the hospital and were readily available and easily contactable. Staff said there were no problems contacting consultants or getting them to come into the unit out of hours.
- All admissions to the unit were discussed and admitted under a consultant.

Critical care

- Comprehensive handovers were undertaken twice a day and each patient was discussed. These handover notes were in written format and kept by each patient's bed. Potential admissions from the medical assessment unit were also discussed at the morning handover.

Major incident awareness and training

- Major incident plans were in place and staff were aware of how to access information. The trust had produced a business interruption policy to support staff.
- Staff were aware of their roles and the procedures in the event of a fire.

Are critical care services effective?

Good

Patients received treatment and care according to national guidelines. The intensive care unit (ITU) was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit. However, the full multidisciplinary team did not attend the ward rounds.

Evidence-based care and treatment

- The Intensive Care Society guidelines were implemented to determine the treatment provided.
- There were care pathways and protocols in use. For example, a ventilator-associated pneumonia care pathway was in place that all staff followed to deliver optimal care.
- Nursing care plans had not been reviewed since 2003. There appeared to be a disconnect between the descriptors used on the ITU charts and in the core care plans. The management was aware of this and the nursing documentation was currently under review.

Pain relief

- Patients' pain scores were assessed and documented. There were clear links between the pain scores and the level of analgesia administered.

Nutrition and hydration

- Staff on the unit used the Malnutrition Universal Screening Tool to assess the nutritional needs of patients.
- In the ITU, staff followed a protocol for the hydration and nutrition of ventilated patients, and initiated enteral tube nutrition when necessary. Dietician support was available Monday to Friday.

Patient outcomes

- There were low mortality rates in the unit compared to the England average.
- The ICNARC data outcomes compared well with national comparators.

Competent staff

- All staff received one-to-one supervision and appraisals. These processes covered training and development needs and practices. In the ITU, 98% of staff had completed their appraisal. Staff we spoke with said that their appraisal had been well conducted and linked to training plans.
- All nursing staff new to the unit had a comprehensive 6-week induction, during which they were supernumerary and supported by a mentor.
- Over 80% of the nursing staff had the post-registration award in critical care nursing. All staff were working towards the national ITU competencies and were being assessed by a mentor.
- Medical staff had weekly 2-hour education sessions. All junior medical staff were given to a mentor.
- All the consultants covering the out-of-hours on-call service had regular daytime sessions in the ITU and provided weekly education sessions.

Multidisciplinary working

- There was a multidisciplinary team that supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist who provided advice and support to clinical staff. The lead nurse attended the doctors' ward rounds. The pharmacist attended them when possible. Patients told us that the unit's team worked well together.
- There was adequate support and input from dietetics and physiotherapy, whose staff obtained patient updates from the nurses caring for the patients The support and input would reflect the patients' condition and the plans made for them on the ward round'. Microbiology staff did daily ward rounds and were available for advice at weekends.
- There was an outreach team that was fully integrated and provided valuable support in the care of the

critically ill patients. Members of the team obtained daily updates from the nursing staff on patient movements. They supported patients who were identified as deteriorating.
- There was a 'follow-up service' that monitored patients' physical and psychological needs after discharge from the unit. Staff from the service held weekly focus groups for past patients to return to the unit to discuss their experiences.

Seven-day services

- There was consultant cover for patients in the unit during the day, 8am to 6pm, and an on-call service out of hours.
- There was 24-hour consultant cover. The consultants carried out twice-daily ward rounds and were available for advice and support at other times.
- Pharmacy, dietetics and microbiology staff were available Monday to Friday and physiotherapy staff 7 days a week. Microbiology and pharmacy staff were available on call at weekends.
- There was an outreach team that provided support 7 days a week from 7.30am to 8.30pm for the management of critically ill patients in the hospital. Outside of these hours they could contact an anaesthetist.

Are critical care services caring?

Good

Staff cared for patients in a compassionate manner with dignity and respect. Both patients and their relatives were happy with the care provided.

Compassionate care

- We observed staff caring for patients in a kind and professional manner. Care was delivered in a compassionate manner to patients. We saw patients were always treated with respect and dignity. Nurses were attentive and had a good rapport with patients.
- One patient told us, "Staff are exceptionally caring, very attentive even though busy."
- Staff on the unit had achieved 94% in the NHS 'Friends and Family' audit for September 2014.
- Staff went out of their way to provide supportive, individualised care. For example, they bought a television for a long-term patient to enable them to communicate with their children via Skype.

Patient understanding and involvement

- Patients and relatives spoke highly of the staff. Relatives told us that they felt they were kept informed and were treated sensitively with understanding.
- One relative told us, "Care has been excellent. Staff have been very attentive."

Are critical care services responsive?

Good

The unit was responsive to patients' needs. Staff worked across site to ensure patient to nurse ratio was met. They also had a bed occupancy rate of 85% which enabled them plan admissions and accept emergencies also.

Translation services were available to people who first language was not English, we also saw that patients with learning disabilities were well supported by for example the use of a learning disability passport. These are information booklets produced by the person and those close to them, with information to help healthcare professionals improve their communications with the patient.

Staff within the unit learnt from complaints.

Service planning and delivery to meet the needs of local people

- The number of patients admitted was based on the number of available nurses, worked out on a points system over the two critical care unit sites based at Sandwell and City Hospitals. This allowed them to be flexible in managing capacity over the two sites. ITU appeared to largely meet the demand of the local patient population, except during periods of unpredictable activity.
- The unit had five single-sex breaches during the past year. It tried to ensure timely discharge whenever possible. Attempts would be made to cohort patients by sex and also use single rooms if possible.
- Staff on the unit were currently assessing their potential unmet need – for example, in the case of high-risk surgical patients and deteriorating patients.

Critical care

- The bed occupancy for adult critical care beds was 85% across the trust. The Department of Health has found that bed occupancy rates exceeding 85% in acute hospitals are associated with problems dealing with both emergency and elective admissions. However, the scope for flexibility to meet demand had been identified by the trust as a current issue and was red rated on a risk register (02/09/2014 Surgery A Risk Register – Group Level – August 2014). Although the trust had identified control measures, it had not reduced the risk.

Access and flow

- The length of stay on the City unit was similar when compared with the national average. The ICNARC data range for Q4 2013 to Q1 2014 the length of stay was around four days. The previous two quarters had been lower at 3-4 days.
- Early readmissions that were admitted to the unit within 48 hours of discharge were slightly above the national average of approximately two. We saw that over the measurement time it was high and had reduced to be mostly in line with the national figure, but had risen again toward the end of the measurement period. There were six readmissions, which were all reported as incidents. These were discussed at the multidisciplinary governance meetings.
- Just below 5% of patients were discharged out-of-hours (that is, patients' discharge between 10pm and 7am). These were below those for similar units compared with the national average.
- Delayed discharges were below those for similar units compared with the national average.
- Non-clinical transfers out (that is, patients discharged to a level 3 bed in an adult ITU in another acute hospital) were below those for similar units compared with the national average.

Meeting people's individual needs

- There was an outreach team as an integrated service for the management of critically ill patients across both hospital sites. The purpose of the service was to assess acutely ill or deteriorating patients on wards, and to provide advice to the managing teams on monitoring, investigations and management plans. The aim was either to stabilise patients at ward level and so avoid the need for escalation to critical care, or to facilitate timely referral and admission to critical care when a higher level of care was required. The team also followed up patients after discharge from critical care in order to optimise their recovery. Out of hours, there was a hospital at-night team. The outreach service had put in a business plan to provide a 24-hour service and this had been approved recruitment had commenced.
- Patients and staff had access to translation services. Staff could contact the NHS interpretation service by telephone.
- Staff were aware of how to support people with learning disabilities. For example, they told us how they would use people's learning disability passports within their plan of care. These are information booklets produced by the person and those close to them, with information to help healthcare professionals improve their communications with the patient. There was a lead nurse for learning disabilities who provided support to staff on the unit.
- There was a lack of staff training regarding caring for people with dementia. This could put patients at risk because they might require more staff input, but the trust was at risk of not having staff with the skills and experience to meet their needs.

Learning from complaints and concerns

- Information on how to make a complaint was available to patients and carers. However, we noted that the complaints leaflet and other information leaflets were only available in English, whereas the hospital cared for a multicultural population.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings.

Are critical care services well-led?

Good

There was strong medical and nursing leadership within the critical care unit. Staff felt well supported within an open, positive culture.

Vision and strategy for this service

- The matrons and the clinical lead were involved in the development plans for the critical care services in the new hospital the Midland Metropolitan.
- Both the matrons and the clinical lead felt that the constant change and reduction in middle management had led to a lack of communication between the clinical teams and the executive team.

Critical care

Governance, risk management and quality measurement

- There were 6-weekly multidisciplinary governance meetings, and morbidity and mortality meetings.
- There was a risk register with clear action plans that were regularly reviewed. Risks for inclusion were identified by senior clinical staff who used analysis of incident reporting as one way to identify risks.

Leadership of service

- There was strong leadership from the matrons and the clinical lead.
- The matrons were very visible within the clinical environment. Staff we spoke with articulated their respect for the matrons.
- The staff felt valued members of the team and this was reflected in the low turnover of staff in the unit.
- All the staff we spoke with said they were well supported by their managers.
- Staff said the executive team were not visible within the unit.

Culture within the service

- Staff spoke of being proud of the open, supportive culture in which they worked.
- One member of staff told us, “It is a privilege to be an ITU nurse; there is a supportive, family atmosphere.”

Public and staff engagement

- During our inspection, we saw a number of cards and letters from patients and their relatives expressing their thanks for the care they had received in the ITU.
- Staff monitored the results of the NHS ‘Friends and Family audit’. They also conducted their own patient and relative feedback survey. Results of these surveys were shared with staff to improve practice.

Innovation, improvement and sustainability

- Staff were proud of their bereavement and follow-up services, which provided valuable psychological support to relatives and patients.
- The outreach team was keen to develop its service further to provide 24-hour cover to its patients.
- Band 6 nurses were encouraged to attend leadership development programmes once they had completed their ITU course.
- Staff were supported to attend conferences to improve their practice.

Maternity and gynaecology

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

Information about the service

Sandwell and Birmingham NHS Trust provides maternity services at the Maternity Unit at City Hospital includes:

- Serenity Midwifery Birth Centre,
- Day Assessment Unit
- Antenatal ward
- 21 bed inpatient maternity ward providing antenatal and transitional care
- 12 roomed delivery suite
- 21 bed postnatal ward
- Two high dependency beds
- Two theatres
- Transfer Lounge
- 29 cot neonatal unit
- Facilities for close relatives to use in special circumstances
- Clinics and screening services
- Parent craft courses.

Maternity services also include Halcyon which is a midwifery led birth centre. This is based at the Leasowes Hospital.

Antenatal clinics and birth preparation classes are also held at Sandwell Hospital and other venues throughout the geographical area covered by the trust.

Community midwives provide care before birth (antenatal), during birth (intrapartum) and after birth (postnatal) to all pregnant women in Sandwell and West Birmingham.

During our inspection we visited all areas of the maternity services including Halcyon the stand alone birthing unit.

We spoke with 43 members of staff and nine women and relatives and observed care and treatment. We also looked at care and treatment records for ten women and eleven babies.

We gathered further information from data that was provided by the trust. We also reviewed information about how the trust checked the quality of the service and compared their performance against national expectations.

The service comes under the Women & Child Health (WCH) clinical group and is within the Maternity and Perinatal Directorate inclusive of neonatal services. The directorate management team was comprised of the Director of Midwifery, the Clinical Director, two Midwifery Matrons, one neonatal matron and one Risk Lead for the directorate.

The service averaged 5630 births a year which is about the average number of births for a maternity unit nationally.

Maternity and gynaecology

Summary of findings

Overall we rated the maternity services as good. The service was effective, responsive, caring and well-led.

The maternity service provided effective care and treatment that followed national clinical guidelines and staff used care pathways as required. The service ensured that staff were competent and well informed about how to provide the best possible care throughout pregnancy and so whenever possible good outcomes were promoted and achieved for women who used the service.

Staff were caring towards women and treated them with dignity and respect. Systems were in place for women to receive on going physical and emotional support throughout their pregnancy as they required. Staff had a good understanding of the need to ensure vulnerable people were safeguarded.

There were many good examples of the maternity service being safe including robust incident reporting systems; comprehensive audits concerning safe practice and compliance with best practice guidance in relation to care and treatment plans. The trust had also introduced significant changes in response to audits which showed that a lot of babies were being readmitted to hospital.

We noted areas for improvement. The trust needs to improve with regards to safety because of the risks associated with poor communication caused by the changeover to a computer based record keeping system. We also found consistently poor hand hygiene on the postnatal ward which put babies and women at risk of cross infection.

Leadership of the maternity service was visible and promoted innovation and positive changes.

Are maternity and gynaecology services safe?

Good

The trust had effective systems in place for reporting, analysing and learning from incidents and took active steps to improve safety when required.

There were systems in place for reporting actual and near miss incidents across the maternity services.

Incidents logged on the system were reviewed and investigated by the appropriate midwifery manager. Serious incidents were investigated by staff with the appropriate level of seniority.

Security measures kept babies safe. Staff had a good knowledge and understanding of the need to ensure vulnerable people were safeguarded.

The midwifery staff used standardised assessment tools to monitor the health and well-being of women who were identified as being at risk during their pregnancy.

Robust systems were in place for dealing with emergencies and staff were well rehearsed in using these.

We found midwifery staffing levels were calculated using a recognised dependency tool, however the ratio of staff to birth was 1:29 and slightly worse than the England average standard of 1:28.

Staff voiced concern that the newly introduced record keeping system had significant gaps in maintaining a track of vulnerable women and babies and felt the risk needed to be more closely monitored while the new system was becoming embedded.

The trust informed us that this was not the purpose of the new system and separate processes managed by the safeguarding midwife.

The Women and Child Health Clinical risk Group risk register did not include all of the safety risks identified by senior staff such as the potential for an imbalance of experienced to junior midwives in the community or the concerns about a new record keeping system. Although in

general staff we spoke with and observed, understood and followed best practice infection control guidance; however we saw some instances of staff not following these rules which meant there were infection control risks.

Incidents

- Midwives and doctors told us they were able to report incidents directly onto the corporate electronic incident reporting system.
- Medical and midwifery staff described an 'open culture' towards incident reporting.
- Staff also told us that they received feedback about the outcomes of incidents through personal 1:1 feedback; team meetings and trust publications such as newsletters and the safety bulletin called 'Risky Business for maternity and perinatal services'.
- We reviewed Risky Business July 2014 issue number 7 and this provided a summary about incidents and alerted staff to common themes when they were identified.
- We reviewed the initial records for five incidents reported through the incident reporting system and found that investigations had been thorough.
- The trust held regular monthly meetings to discuss injuries (morbidity) or deaths (mortality) that had occurred during a woman's labour.
- In May 2014 the trust was identified, when compared to units at other hospitals, as having too many (outliers) readmission of neonates within 28 days of discharge between April 2013 and October 2013. The numbers readmitted were 203 babies and the expected rate was approximately 140.
- The trust had also triggered as an outlier with respect to the number of perinatal deaths in one year which stood at 2% when the expected rate was 0.5%.
- The trust was quick to provide a response to these concerns which included information about their investigations and proposed actions. The trusts investigations in May 2014 showed that the closure of a jaundice clinic meant that mothers brought their babies to the paediatric ward. This matter has been investigated and closed.
- During the visit the nurses on the paediatric ward completed the required investigations and provided advice about feeding. Mother and child would leave the unit between four to six hours after arrival. However, nurses were coding these episodes as 'admissions' when previously these visits would have been logged as a 'clinic attendance'. Trust investigations found that about 60% of the readmissions came under this category.
- Paediatric staff were trained in correctly recording the type of attendance to the paediatric wards. Senior midwives reviewed the codes for accuracy.
- The trust provided updated action plans in September 2014 for both areas of concern.
- These reports identified that the trust had completed more detailed investigations and so had looked for ways to reduce the numbers of hospital visits and the length of time it took for mothers and babies to leave the unit when they attended due to jaundice.
- Action taken included providing community and hospital midwives and paediatric nurses with a hand held diagnostic instrument called a Bilirubinometer. This identified the type of jaundice and so the correct advice could be provided quickly or further medical investigations ordered if required.
- The trust also employed additional infant feeding specialists and introduced during the antenatal period additional infant feeding classes to educate mothers about the benefits of correct breast and bottle-feeding.
- We discussed these plans with community and hospital midwives and nurses on the paediatric wards. They confirmed that bilirubinometers and training had been provided and this had made a positive difference in how jaundiced babies were managed. Demonstrating at interim audit a reduction of 50% for readmissions rates within 28 days of discharge.
- The trust concluded that their figures in relation to perinatal mortality were in keeping with other maternity services in the locality which also triggered above national average. However their investigation highlighted that low 'for gestation' birth weight was a common factor and so strengthened the level of intervention provided to promote good maternal health during pregnancy.
- These plans included ensuring that women were assigned the appropriate care pathways following risk assessments. Additional support for smoking cessation and regular checks on the effects of smoking. Improved surveillance and monitoring to ensure that foetal growth progressed as expected and increased education through literature and closer collaboration with GP's to ensure good advice about supplements, diet and lifestyle was provided.

- Records from the maternity and perinatal governance group dated July 2014 confirmed that 85% percent of midwives had completed additional training in using electronic foetal monitoring machines.
- The updated action plan confirmed good progress in completion, review and revision of previous plans. These processes showed that appropriate responses had been made to improve and promote safety in the areas required.
- Monitoring will be conducted through an electronic recording system. The trusts action plan will be subject to routine checks by the CQC.

Safety thermometer

- The women and child health group has collated data collected by the trust for the safety thermometer which looked at the number of falls; hospital acquired pressure ulcers; completion of venous-thromboembolism (VTE) (blood clots) assessments and number of MRSA infections and CDiff infections.
- An investigation into a hospital acquired pressure ulcer which a woman had developed on the postnatal ward had commenced at the time of the inspection and so the trust needs to take additional action to ensure that the maternity service always provides harm free care in this area.
- The trust should ensure that audits are robust and consistent so that reliable information is available when assessing the safety of the service so that the correct action to promote safety is taken.
- Data in the 'Integrated quality and performance report for July 2014' the on the page headed 'women and child health group' showed that the average percentage for VTE assessments between October 2013 and July 2014 was 84%. This was scored as 'red' under maternity indicating that expected outcomes had not been met.
- A quality and performance report also showed that between April and July 2014 the trust tended towards being 'fully met' in compliance with the World Health Organisation (WHO) maternity theatres safety checklist, which was an improvement from previous months.
- The trust did not display the results of their safety checks prominently on the maternity unit this meant the public were not well informed about things the units did well and what needed to be improved when they visited the maternity wards.

Cleanliness, infection control and hygiene

- The July 2014 'Integrated Quality and Performance' report showed that between October 2013 and June 2014 no MRSA and CDiff infections had occurred within the women and child health group.
- The trust completed cleaning and infection control audits and provided reports and actions plans for areas where improvement was needed.
- We observed personal protection equipment such as gloves and aprons in all areas.
- Some hand wash taps and hand gel dispensers were non-touch and operated through a sensor.
- The trust provided records of hand cleansing audits completed on the maternity unit. We reviewed the results for the postnatal ward.
- The most recent audit for hand cleansing on the postnatal ward (22 September 2014) showed 100% compliance and previous reports showed similar compliance. However our observations during the inspection did not support this level of compliance.
- Throughout the inspection period it was noted that staff, particularly on the postnatal ward, did not routinely wash their hands or use hand gel. This meant there was a risk of cross infection because good hand cleansing is one of the most important elements in preventing the spread of infection.
- We reviewed the trusts infection control policy and this provided good information about preventing the spread of infection.
- Each of the areas visited had side rooms that could be used to isolate patients if there was a risk of cross infection.

Environment and equipment

- We reviewed the completeness and management of resuscitation equipment in all the areas we visited. Records showed that resuscitation equipment in all but the pool area of the labour ward and the postnatal ward had been complete and had been checked on a daily basis.
- Within the pool area on the labour ward and the postnatal ward the resuscitation equipment had not been checked for 8 out of the 14 days prior to the inspection. This meant that the trust could not always be sure that resuscitation equipment in these areas was complete, ready and safe to use.

- All the maternity wards we visited were secure and could only be entered with a swipe card or door release operated by maternity staff.
- A baby tagging and tracking sensor system had been installed throughout the hospital. This would alarm if a baby left the ward whilst still tagged. There was also a process for locking down sections or departments preventing people leaving the hospital if this was required.
- Midwives had ready access to equipment when required.
- We saw that equipment such as the foetal monitoring machines, vital sign observation monitors and fire safety equipment had been maintained and stickers applied to confirm that checks were up to date.

Medicines

- The medication optimising policy provided overarching guidance about the safe handling of medication and also included specific policies for different scenarios including 'Management of women undergoing epidural anaesthesia in labour' and 'Management of antimicrobial therapy.'
- The medication management policy was clear, up-to-date and due for review in 2015.
- Guidance included the safety checks that needed to be taken before administering certain drugs to babies such as gentamycin and other antibiotics.
- Medication errors such as delays in administering medication were reported through the electronic incident reporting system.
- The July 2014 'Integrated Quality and Performance' results showed that between October 2013 and June 2014 the trend in medication errors fully met expectations and 'zero' errors which caused harm were recorded. We saw, however, that a significant number of 'no harm' incidents had been reported.
- Discussion with staff including the risk manager and director of midwifery identified that the majority of the incidents concerned delays in administration caused because the policy required a specialist paediatric nurse to be the second checker for intravenous medication administered to babies on the maternity unit and these nurses were not always immediately available.
- Medication storage rooms were secured with a coded key pad lock and so medication administration was not delayed through midwives having to locate keys.
- The majority of medication was securely stored; the exception was intravenous fluids on the postnatal ward. This was because we observed that the treatment room with fluid was left open and unattended for significant periods, this meant that items could be removed or tampered with.
- We were told that in response to the pattern identified in recent medication errors from November 2013 a medication exam was going to be introduced to check staff competency.

Records

- In April 2014 a new electronic record keeping system was introduced for the maternity services.
- We reviewed documents which demonstrated that the trust had utilised many different communication platforms to inform staff and stakeholders about the new system.
- During focus groups for staff and we received mixed responses regarding the new IT system and its functionality to support their work. This included concerns about a lack of historical information about previous births and also a lack of information received by health visitors about postnatal care. The community midwives expectations of BadgerNet was to have access to historical data but the system was not designed for this.
- Some staff thought once embedded the system would help to promote safety and continuity of care. In the main staff we talked with were positive about the changes although many staff were concerned about teething problems with the system.
- Problems included:
  - a risk that vulnerable women and babies could be missed because it was difficult to cross reference with previous concerns;
  - Information such as past history was not been uploaded onto the new system and so staff were dependant on what women told them.
- We found that senior staff were aware of many but not all of the problems raised. They were not aware of the lack of safeguarding interface and provision of historical information meaning a risk of midwives not being fully informed about potential child protection concerns.

- The trust had allocated 'super users' for the system and a lead community midwife had been allocated to champion and support the staff in the roll-out. There was IT support available when more technical support was required.
- There was also a 'staff questions' log which provided a long list of questions but there was no indication about when or how these questions were going to be addressed which indicated that the systems in place to review, monitor and resolve the problems needed to be revised. The trust informed us that the BadgerNet project Board with the software company introducing information management system continue to meet monthly to resolve on-going issues, however the feedback to staff required improvement.
- We looked at 10 sets of records these were in paper and electronic format.
- The records provided complete information about the care pathway for mother and baby.
- The electronic record appeared easy to use and the record we looked at showed that as well as completing the required tick box staff also entered information in the free-text field to describe the individual experience of mothers. The record for babies was input on to a different system called BadgerNet.
- We found that the systems did not communicate and cross reference mother and baby so it was necessary to close one system in order to enter the other which was time consuming and the break or gap in updating information and changes between systems gave an opportunity for errors to occur.
- Senior staff acknowledged that the roll out of the new system was in the early stages and the service was still able to influence the development of the system.
- We found that the new system was not on the 'women and child health clinical group' risk register but was on the 'maternity directorate' risk register and so was being monitored by senior staff in that division.
- The paper records reviewed held detailed information about antenatal; intrapartum and postnatal care.
- We saw that mothers were provided Personal Child Health Record (red book) used to record birth weight, immunisation and other health information about the new-born. This was then used as a means of communicating and recording immunisations and the child's development between health visitors; GPs and allied health professionals as required.
- We reviewed the trusts 'midwife and health visitor communication and handover policy'. The policy was due for review and outdated in that information referred to primary care trusts (PCT) which no longer exist.

Safeguarding

- We interviewed the head of adult safeguarding and dementia care and the safeguarding children's lead nurse.
- We found that the trust ensured that safeguarding issues were discussed with partner agencies. Senior nurses attended multiagency Local Children Safeguarding Boards and other related external planning meetings. We found that the children's safeguarding team was well resourced which also included a specialist domestic violence nurse.
- Midwives were clear about the processes for reporting safeguarding concerns and all members of staff could describe scenarios that they would report.
- The child safeguarding procedure was readily available on the trust intranet site and gave clear directions about how to raise and record safeguarding concerns.
- 85% of maternity staff had received level three child safeguarding training, this was below the trusts expected percentage of 95% however 85% meant there was always at least one person on duty who had received the training required to recognise and responded to abuse.
- The level three course was an in-depth modular course completed over a number of sessions.
- Women's & Child Health safeguarding adult's level 1 training was 99% which was compliant with the trusts target. Level 2 training was approximately 71% which was below the target.
- We found that the maternity service took appropriate action to ensure that the wellbeing of women and babies was promoted while on the unit. We attended a handover meeting for the midwifery unit and information about safeguarding was, recorded, shared verbally and discussed at length between the shift co-ordinators.

Mandatory training

- Records showed that mandatory training provided midwives and other midwifery staff with regular updates in a variety of topics relevant to their role and responsibilities.

- Mandatory topics included: infant feeding; breech delivery; management of pre and postpartum haemorrhage and other aspects of providing safe care to patients.
- The trust reported that the trend for the number of staff to complete mandatory training was an elevated risk scoring 'red' and therefore 'not met' in relation to expected outcomes. This was because between October 2013 and June 2014 84% of midwifery staff instead of 95% of staff had completed mandatory training.
- Senior staff were reviewing action that could be taken to improve this figure which included monitoring the reason why staff who were booked onto full courses failed to attend.
- Midwives, doctors, health care assistants and other staff said that role specific mandatory training was provided and they felt well prepared to carry out their roles in supporting patients.

Assessing and responding to patient risk

- The maternity service offers home birth; a stand-alone midwifery led unit called Halcyon; the midwifery led unit Serenity attached to the Maternity Unit at City Hospital for low risk women and the Delivery suite at City Hospital.
- We saw that detailed risk assessments were completed to ensure that women had full information to make informed choices in relation to management of their pregnancies and where to give birth.
- We saw that more detailed and specialist assessments were completed if women who did not meet the 'low risk' criteria still wanted to give birth on one of the midwifery led units.
- We noted plans for these women were discussed at 'Maternity and Perinatal Alert' meetings and involved obstetricians, the consultant midwife and allocated community midwife to ensure that all staff were aware of each case and the suggested plan of care including a contingency plan.
- The clinical observation records reviewed showed that midwives used early warning scores effectively so safety and wellbeing was promoted when additional support and intervention was provided as required.
- Midwives and doctors were available at all times and able to respond immediately in the event of a complication with labour. This included anaesthetist and neonatal doctors.
- We reviewed the trusts information about time lapse between the decisions to perform a caesarean section before it was conducted. We found that from October 2013 to July 2014 the risk had gone from green to amber (fully met to not-quite met). This meant some women had a delay in receiving a caesarean once the decision had been made that they require one. Obstetricians identified the need for a second surgical team to reduce the number of delays. This was reviewed by the trust leadership team at the risk management committee and the Clinical leadership Executive on 2nd October 2014 and it was accepted that that a second team was not feasible.
- Within theatres we reviewed patient records and observed safer surgery checklists. This confirmed that staff were diligent at completing the five steps to safer surgery. The trusts audits of the use of this safety check also showed that between March 2014 and July 2014 the maternity theatres scored 'green' and 'fully met' because all checks had been carried out in full.

Midwifery staffing

- The trust were working towards providing the maternity services with the approved safe staffing levels in line with Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour recommendations Royal College of Obstetricians and Gynaecologists (RCOG 2007).
- Safer Childbirth recommended the use of Birth-rate Plus as a tool for workforce planning.
- The trust produced a Briefing Paper – 'February 2014 Maternity and Perinatal Medicine: Nursing and Midwifery Staffing' which provided a detailed description of staffing and rational for current staffing levels. This briefing paper did not include definitive action to be taken in respect of staffing however it did include figures for the absolute minimum staffing levels required to deliver safe care and stated that numbers below those levels should be escalated to senior staff.
- We saw that the trust had started to recruit additional midwives because adverts for fixed term Band 5 community midwives were placed on the NHS Jobs website on 15 October 2014.The audit completed by the trust showed that for seven months in 2014 the ratio of midwife-to-woman on duty was 1 midwife to 29 women and is better than the staffing in many other trusts though slightly below the average for England.

- The maternity roster showed a good skill mix of staff available for mothers and babies, having had Band 5 and 6 midwives and a midwifery unit manager was available at all times during the day. Band 7 shift coordinators were on-duty night and day and each was aware of the needs of women and babies throughout the unit and in the stand alone maternity unit.
- Midwifery health care assistants were on duty in all areas to provide additional support according to their training and designated responsibilities.
- We saw that breast care nurses and infant feeding advisors were a constant presence on the postnatal ward.
- The trust had an escalation policy if the service was below the required safety ratio.

Medical staffing

- The consultant hours on the labour ward at the time of the inspection was 66 hours per week, the trust board has approved an increase in consultant cover to 98 hours per week which would meet best practice guidance Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour Royal College of Obstetricians and Gynaecologists (RCOG) (2007).
- Handovers were completed three times a day and we observed the major morning handover which involved the consultant obstetrician leads; all grades of doctors coming onto shift; the risk manager; head of midwifery; midwifery matron and senior midwives.
- The doctors under graduate tutor described positive working relationships between consultants and midwifery staff which promoted safe practice.

Major incident awareness and training

- The trust had completed risk assessments and contingency plans were in place to identify and mitigate potential major incidents before they occurred. Monthly skills and drills training took place in relation to major incidents and the outcomes of these events were audited and learning needs identified to ensure the processes were as smooth as possible.
- Training and policies included obstetric emergencies; missing babies and loss in mains electricity power.
- Policies and procedures were in place for transferring women in labour from the free standing midwifery led unit Halcyon to the maternity unit at City Hospital. The transfer process was well understood by the midwives we interviewed. The midwife in attendance remained with the women until transferred onto the labour ward.

Are maternity and gynaecology services effective?

Good

The maternity services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.

Standards were monitored and outcomes were good when compared with other maternity services and midwives received appropriate supervision and training to maintain their skills.

Care was planned and delivered in a way that took into account the wishes of patients and women received the pain relief they required.

Evidence-based care and treatment

- Sandwell and West Birmingham maternity service completed Commissioning for Quality and Innovation (CQUIN) checks. The CQUIN scheme linked successful delivery of specific outcomes and actions to additional payment to the service. We reviewed the overall results of the data collected by the trust between October 2013 and June 2014 and found that the maternity service provided safe care by achieving the agreed targets. For example the numbers of perineal tears were consistently less (better) than the best expected of 4% and performance was fully met.
- Most of the policies, procedures and guidelines we viewed were based on the most recent best practice guidance and so the best clinical outcomes were promoted.
- Midwives recorded that they based their observations during labour on the 'Bishop Score'. This is the standardised measurements used to determine whether a woman may have a successful vaginal delivery and whether labour should be induced.
- There were detailed risk assessments, plans of care and observational guidance to ensure that women who

wanted to have a vaginal birth following a previous caesarean section received care in line with the Royal College of Obstetricians and Gynaecologist (RCOG) best practice guidance.

- We reviewed the plans of care, risk assessments and birth records and found evidence that all risks had been discussed with the women. The birth plans developed with the women were multidisciplinary and involved the lead obstetrician; neonatal consultant; consultant midwife; midwives responsible for the care of the women and other specialists as required.
- The Serenity and Halcyon Birth centres progress and clinical outcomes report 2011- 2013 confirmed that all support for low risk women was based on the NICE (2007) 'Intrapartum care: management and delivery of care to women in labour. Clinical Guidance (CG) 55'. The trusts antenatal screening guidelines and activities are in keeping with National Institute for Clinical and Social Care Excellence (NICE) Clinical Guidelines (CG62) which also encompasses the NICE Quality Standards (QS) 22 in relation to foetal monitoring, record keeping; risk assessment and prevention of veno-thrombosis.
- In the introduction to their policy 'Antenatal screening tests and management of results' approved February 2014, the trust makes reference to the NICE Guidance 2003 instead of CG62 which is the most up to date guidance.
- Plans for service improvement were aimed at achieving standards and outcomes in line with guidance provided by the National Institute for care and social excellence (NICE) or the Royal Colleges for the specialism such as obstetrics and gynaecology; midwifery, anaesthetics and nursing. The results for audits and the maternity specific risk register confirmed that all aspects of the effectiveness and compliance with local and national guidance were monitored.
- The trust provided confirmation that maternity and perinatal medicine completed thirty audits to check the effectiveness of the service and compare the level of compliance against local and national targets.
- The number of babies admitted to the neonatal unit immediately after birth between October 2013 and April 2104 varied was sometimes more than expected however in April, May and June 2014 the number of babies admitted were consistently less (better) than the lowest expected threshold of below 10. These findings meant that the maternity service trended towards providing safe care.

Pain relief

- An anaesthetist was on the Delivery Suite at all times so that appropriate anaesthetic could be administered in an obstetric emergency.
- Epidural pain relief was only available on the Delivery Suite at the maternity unit and the data showed that 2% of women transferred from the Serenity midwife led unit (MLU) to the Delivery Suite for an epidural.
- We saw gas and air (Entonox) machinery in the units we visited.
- The trust also provided birthing pools on all sites for women to use during labour to ease labour pains.
- The medication policy described the midwife exemptions legislation and policies pertaining to the administration of medicines by midwives which included pain relief medication that could be delivered by intramuscular injection during labour. This meant that low risk women giving birth at Halcyon the stand-alone midwifery led unit (MLU) or the MLU at City Hospital had ready access to appropriate pain relief.
- We talked with seven women who had recently given birth either on the Delivery Suite, at one of the MLU's or who had experienced caesarean sections. All said that pain control had been well managed and they had received the pain control they needed.

Nutrition and hydration

- Information about the trusts effectiveness in promoting breast feeding was incomplete because the trust data supplied only went up to March 2014. The Sandwell and West Birmingham trust was one of the trusts which had not provided statistics to NHS England - Maternity and Breastfeeding 2013/2014 or 2014/2015 data collection. The UNICEF Baby Friendly breast feeding promotion website showed that the trust had achieved level 1 baby friendly accreditation and so had created policies and procedures which had been approved as adequate to support the implementation of the baby friendly standards. The trust also informed us that they had achieved level 2 accreditation in 2013.
- We saw that the trust employed an infant feeding team and that volunteer breast feeding buddies also worked with mothers using the service. We talked with three women were breast feeding post-delivery. Mothers we talked with stated that they had received breast feeding encouragement and advice during their antenatal check-ups and visits.

- The trust stored one type of formula milk and we saw that mothers were provided with this on request.
- Women were well cared for in relation to food and drinks and able to choose from a varied choice, which also met their cultural needs.

Patient outcomes

- Following the trust being identified as an outlier for perinatal deaths the trust have adjusted practice which early indications show an improvement. The percentage of women who experienced normal births was better than the England average at the trust which meant that medical intervention was kept to a minimum which promoted a good experience and fast recovery for women and babies from labour.
- The overall results of the data collected by the trust between October 2013 and June 2014 found that the percentage of maternal unplanned admissions to intensive treatment unit was consistently below (better) than the lowest figure expected.
- The overall results of the data collected by the trust between October 2013 and June 2014 found that the percentage of admissions to the Neonatal Intensive Care Unit (NICU) of babies 37 weeks gestation at birth was consistently below (better) than the lowest figure expected.
- The trusts results in the National Neonatal Audit Programme (NNAP) - Annual Report 2013 National Neonatal Audit Programme Published October 2014 showed that they performed within average expectations.
- The NNAP audit looks at a number of outcomes such as how quickly premature babies had their temperatures checked and whether mothers received the correct medication during their pregnancies.

Competent staff

- The trust had a well organised maternity training department which coordinated all training for midwives, nurses and medical staff working on the unit. We saw a clear detailed training plan which ensured appropriate courses were offered and a system in place for following up staff who failed to attend training.
- The clinical educators met regularly to discuss staff development issues and records confirmed that topics discussed included improving take up of mandatory training, plans for courses and training to improve and maintain skills. Discussion about the effectiveness and staff satisfaction with the training provided was also recorded.
- The meeting records for the 'action plan education meeting' on 01 September 2014 identified that courses completed included: medication management, blood transfusion, infant feeding and new methodologies such the change in the tool used to measure foetal growth when women attended antenatal appointments. This was confirmed by staff we interviewed.
- Sufficient numbers of supervisors of midwives (SoMs) were available to promote good practice amongst midwives employed by the trust.
- SoMs are experienced midwives who have had additional training and education to enable them to help midwives provide the best quality midwifery care. They oversee the work of the midwives and meet with them regularly to ensure that high standards of care are provided. They also guide and support midwives in developing their skills and expertise.
- We talked with Supervisors of Midwives (SoM) who confirmed that midwives had access to up to date information and competency checks were recorded.
- Midwives described a comprehensive process for one to one supervision from senior midwives.
- Monitoring by the trust showed that 85% of midwives had completed appraisals.
- The trust employs teams of specialist midwives with additional training and expertise in the following areas: diabetes; foetal medicine, young people, infant feeding and bereavement.
- Student midwives were complimentary about the training and support provided and confirmed that they were supernumerary and able to attend in-house training; study sessions and meetings.
- Newly qualified midwives told us that training and support provided during their first (preceptorship) year was well planned and thorough which helped their transition from a newly qualified band 5 to confident band 6 midwives.
- We reviewed the preceptorship training plan and workbook and found that the contents covered were comprehensive.
- In the information provided by the General Medical Council to the CQC there were no concerns raised by foundation and trainee doctors on rotation in obstetrics and gynaecology at City Hospital.

- One doctor commented that "training is easily available and opportunities for further training and updates are provided on a regular basis."

Multidisciplinary working

- Policies and guidelines were in place for transferring women between specialities and sites these had been developed with working parties which involved all of the relevant allied health professionals. For example the development of the transfer of women from the midwifery led unit into the labour ward had included midwives, obstetricians, anaesthetists, and the supervisors of midwives.
- Midwives and general practitioners could refer pregnant women to specialist antenatal clinics to ensure the most up to date and relevant care was offered.
- Detailed contact records demonstrated internal multidisciplinary team working between specialities and with allied health professionals. For example staff described an event when a women attended the day assessment unit in a distressed state, the midwife documented that they had quickly accessed sonographers, bereavement counsellor and senior midwife to support the family through a difficult process in a timely manner.
- The community maternity team rotated between working in the community, clinics and the midwifery stand-alone units. All midwives stated that there was a good relationship between the community and hospital based staff which meant they worked as a team with a common purpose of promoting the well-being of women and babies. Midwives felt that because health visitors were not allocated to general practitioners (GPs) there was no single method of communication to update GP's about births and discharges from the maternity service.
- On checking we found that the process included the midwives completing a form which was sent to the midwife community office clerical staff were then responsible for informing GPs. This procedure had been strengthened as a result of learning from incidents and now staff from the community office also contacted the senior midwives daily for an update of births and discharges to ensure information was complete. The community midwives attended the GP's monthly patch meetings.
- We saw that midwives had ready access to paediatric nurses for advice and guidance.

Seven-day services

- We saw that out of hours sonographers and imaging were on duty so that women did not have to wait over the weekend if they had concerns.
- Midwives were rostered 24 hours and day 7 days each week.
- Discussion with the consultant midwife confirmed that if women rang the unit more than once stating that they were in labour they were supported to attend the midwifery led unit or preferred choice of birth. If they attended the hospital women were only allowed home if they wanted to go. The trust continues to monitor these occurrences.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records reviewed identified through either signatures or written confirmation from staff that procedures had been explained to women.
- Surgical records for women who had caesarean sections showed that consent had been gained or the procedure had been explained in full to the woman and her supporter prior to the procedure. One mother told us that she had asked for her husband to give consent and it was explained that this was not allowed.
- The trusts consent and deprivation of liberty policy was not service specific.

Environment

- The facilities at all sites were suitable and fit for the purpose, providing private space and areas for women and their supporters to walk around and have refreshments as required.
- It was viewed that the facilities and décor at the Halcyon birthing centre provided an exceptionally comfortable and pleasant environment for low risk women to use during their labour.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good

Services were delivered by a hard-working, caring and compassionate staff. We observed that staff treated mothers and their partners with dignity and respect and planned and delivered care in a way that took their wishes into account.

We found clear systems in place to offer emotional support to women as required and counselling support was available for patients undergoing investigations for foetal abnormality concerns.

Compassionate care

- The trust was participating in the Friends and Family test (FFT) for maternity and perinatal services and the data for July 2014 were reviewed. The take up response was low at 16% although this was an improvement on March 2014 of 12%.
- The vast majority of respondents 256 out of 264 stated that they were extremely likely (171) or likely (85) to use the service again.
- We observed health care assistants supporting women to complete the FFT survey on the postnatal ward using IPads.
- We observed the interactions between staff and women and saw that staff were respectful and thoughtful in respect of preserving the privacy and dignity of women.
- We found that women who had experienced a miscarriage were given single rooms adjacent to the antenatal unit or on the gynaecology unit so that they could remain private and avoid the company of women who had just given birth.

Emotional support

- Trust protocols included a detailed timeline of the information and support that had to be offered to women and their families at the different stages of their pregnancy. This included information about support and advocacy groups.
- Specialist support included input to deal with bereavement and post natal depression.
- We saw that women could choose who they wanted to support them whilst in labour and had chosen parents, siblings or their life partners depending on their situation.
- All the women we talked with told us they had felt emotionally supported throughout the pregnancy.
- The initial antenatal assessment identified women who may be prone to postnatal depression and the pre-discharge assessment included an assessment the woman's emotional wellbeing.
- We interviewed a worker from an independent and private pregnancy support service called Doula. A doula is a nonmedical person who assists a woman and her family before, during, or after childbirth by providing physical assistance, and emotional support. The Doula worker stated that the trusts maternity services involved her in discussions in accordance with the wishes of her clients.
- The worker told us that in her experience of the trust maternity services were interested in listening to women and providing person centred care. Fully accepting a women's choice to use a doula as a means of additional support during their pregnancy.
- We talked with ten women using the service. The majority of women stated they had received compassionate and considerate care throughout their pregnancy.
- Three women had previously given birth at City hospital and chosen to return to the unit and six stated that they would use the service again.

Are maternity and gynaecology services responsive?

Good

Complaints were handled in line with trust policy and patients and staff were aware of the trusts complaints policy. Information provided to women about complaints investigations needed to be more detailed.

Staff had access to support for vulnerable women or children and had close links with the safeguarding team.

The maternity service had worked to develop a number of specific care pathways and protocols for both high and low risk women.

Maternity and gynaecology

Patients had individual assessment of needs for both their medical, social and emotional needs.

Communication for women who did not speak English needed to be improved.

Service planning and delivery to meet the needs of local people

The Director of Midwifery put forward the proposal for additional staffing based on professional expertise and guidance from Birthrate Plus. This staffing uplift was agreed by the Trust.Recruitment has commenced. An agreement to an increase in staff has been approved although it was difficult to confirm that the skill mix of staff would be appropriate or the time scale by which the increased staffing would be achieved.

Access and flow

- Women were discharged after an average one and a half days post birth and although this was not the shortest stay when compared nationally the trust felt that because of the socioeconomic and cultural background of many women they and their babies would benefit from having more input from the infant feeding team and ward midwives before discharge.
- The admission pathways into the maternity service were flexible and women could refer themselves into the service at any stage of their pregnancy.
- The trust ensured that women who presented to the service were provided with the best possible antenatal and postnatal care including screening and guidance regardless of their stage of pregnancy.
- Women we talked with said they had not experienced a delay in seeing a midwife.
- The service policy required that the on call consultant must be able to attend within 30 minutes.
- Women who gave birth at the midwife led units were routinely allocated at least one midwife during labour. Visiting was at set times and only children of women on the unit were permitted to enter the wards.

Meeting people's individual needs.

- The trust runs a number of specialist clinics to support women with complex needs through their pregnancy for example the psychological wellbeing during childbirth clinic which provides assessment, advice and support and consultancy for women who are screened to need this service.
- The service employed midwives with the appropriate specialist training to support women and their families through different events including screening results which indicated problems with the pregnancy, still birth or termination of pregnancy due to foetal abnormality.
- The trust had developed pictorial visual aids to help explain the process of giving birth to women who did not speak English.
- We saw that midwives had ready access to telephone translation services during the postnatal period.
- We found however that people who did not understand English were not provided with information about promoting good health during pregnancy or how to find their way around the unit as independently as possible because information was only provided in written format and in English.
- There was a female genital mutilation (FGM) and vulnerable women specialist clinic which looked after all women who had experienced this procedure and resources such as discreet pictures to help communicate their experience had been made available.
- Midwives confirmed that they had received training about FGM and the safeguarding and support needs of vulnerable women including those with learning disabilities.
- Some parents stated dissatisfaction with appointment times offered by midwives.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. The routes included direct to staff to be handled in keeping with the complaints policy, or women were advised to go to the Patient Advice and Liaison Service (PALS) if they did not want to discuss their concerns with maternity staff.
- PALS produced a report about the complaints they had been involved in and identified learning from the outcomes of investigations.
- We reviewed the data held by the trust for all formal complaints received about the maternity service. There had been 45 complaints in all; 13 were 'not upheld' 16 were 'partially upheld' and 16 were 'fully upheld'.
- We raised issues of concern with the trust told to us by two women during the inspection visit via the senior

management team. We found that although the issues had been investigated the complainants did not appear aware of the outcomes. This was dealt with at the time of the inspection.
- Trust publications confirmed that staff were updated with learning from individual complaints and staff had received customer relations training which meant they had been informed about how to handle difficult situations and so promote a sense of satisfaction and wellbeing for people accessing the service.

Are maternity and gynaecology services well-led?

Good

The maternity service had governance and quality systems in place and risk issues were monitored and detailed within regular governance meetings.

The reports we reviewed lacked detail however this did not impact at on patient outcomes at the time of the inspections. Publications such as annual reports of clinical outcomes were comprehensive and demonstrated effective leadership.

The maternity service had key leadership roles in place across different clinical groups. We saw examples of staff displaying effective leadership and professionalism across the maternity services.

Staff told us that they felt well supported both by the trust as a whole and at a local team level.

Vision and strategy for this service

- All levels of staff working in the community and on the units were satisfied with the progress made in relation to the development of the midwife led units that had taken place since 2010.
- Senior staff had a clear vision about some of the areas that required development, such as additional beds and another theatre team but identified that the main priority was full implementation and successful rollout of the new IT record keeping system.
- Midwives felt there had been a lack of effective consultation with them with regards to the new IT system.

Governance, risk management and quality measurement

- The maternity service had governance and quality systems in place which included a patient safety walkabout by the Chair and non-executive director.
- The risk and governance issues for the sub divisional area of maternity were reviewed at governance meetings however these records did not include information about the record keeping system. The non-executive directors had completed a walkabout of the postnatal unit in September 2014 at which they made observations and talked with staff and patients.
- The summary report identified good practice and areas for review which included the key issues with regards to the new record keeping system and patient flow issues.
- Actions to support improvement had also been proposed.

Leadership of service

- The maternity service had key leadership personnel in place across different levels of the division. We saw examples of staff displaying leadership and professionalism across community, theatres and midwifery services.
- Information cascade was through a variety of communication platforms and managers adopted an open door policy for staff. This meant all staff was given an opportunity to learn about new developments and share their ideas about proposed changes.

Culture within the service

- Staff described an open culture and felt opportunities were given to engage with senior managers and also learn about plans about the organisation through twitter, blogs and weekly articles on the trusts intranet.
- Trainee doctors told us about their experiences of the culture and told us that the unit was “very friendly and supportive to work in”.
- Senior consultants and midwives described relations between all staff as ‘harmonious’ and ‘well integrated.’

Public and staff engagement

- We saw links with local voluntary groups such as a volunteer breastfeeding support group and the consultant midwife described a close working relationship with a Somalian Women’s group.

- Staff said they had ready access to the senior manager for the maternity services whose offices were based on the unit. This enabled them to share their views. We saw this 'open door' policy in operation.
- Staff said they would or had used the service during their own pregnancies. The trust has launched 'Your Voice' a monthly online staff survey. Its purpose is to provide opportunities for staff to comment about the trust and share for ideas about improving services. The management report for the 'Your Voice Staff Engagement Survey in July 2014' showed that the response rate from obstetrics, community and hospital midwives was extremely low.
- 235 surveys had been distributed between these teams and 19 surveys in total were returned which meant the trust could not be sure that the results were representative of the midwives they employed.

Innovation, improvement and sustainability

- The provision of the refurbished and redesigned maternity service which began in 2010 was seen to have resulted in positive changes by staff.
- Staff felt that they were continuing to focus on sustaining the improvement in care and patient experience for mothers, partners and their babies.
- The trust has a growing number of births and had produced a business plan which when completed and implemented would result in an improved service able to meet demands in the medium term.
- The trust has a growing number of births and had produced a business plan which when completed and implemented would result in an improved service able to meet demands in the medium term.
- In 2013, the maternity service won the Promoting Natural Birth category at the Royal College of Midwives' national awards.

Services for children and young people

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

Information about the service

The children's service is managed as a single integrated service across the Sandwell and West Birmingham Hospitals NHS Trust and is the largest paediatric department in the West Midlands.

The main children's wards are situated at Sandwell Hospital.

Children's services at City Hospital include a 12-bed assessment unit called D19 and a level 2 neonatal unit. In addition 11 day surgery beds, five day unit beds and children's outpatient services are located in the Birmingham Treatment Centre. A children's five-bedded day surgery ward is also based at the Midland Eye Centre on the City Hospital site.

The neonatal service provides a full range of medical services required by infants born at 27 weeks' gestation and above. The unit offers short-term intensive care for less mature babies to stabilise them while a transfer to a level 3 unit is arranged. Infants with major cardiac or surgical problems will be stabilised before transfer to an appropriate specialist facility.

During our inspection of City Hospital we visited the following areas: the neonatal unit, the children's outpatients department and children's day surgery ward, D19 (the paediatric assessment unit) and the children's ward in the Midland Eye Centre. We spoke with 4 medical staff, 18 other staff, 2 children, 21 parents and a student nurse.

Summary of findings

Services for neonates, children and young people at City Hospital were caring and effective and accommodated people's needs. However, improvements are needed for the services to be safe and responsive; improvements are also needed in the leadership of the service.

Parents told us their babies and children had received compassionate care with good emotional support.

A clear leadership structure was in place within the Women and Child Health Clinical Group. The trust did not have a formally nominated non-executive director to champion children's rights at board level. Staff did not always feel supported and described an 'autocratic' management style within the paediatric nursing management team.

Neonatal services were well led. A culture of openness and flexibility was observed, which placed the infant and family at the centre of decision-making processes. The Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future' standards for staff had not been fulfilled, because the trust did not provide paediatric consultant on site cover between the hours of 5pm and 10pm. However, since the inspection the trust has provided additional information identifying that this has been risk assessed and the risk mitigated. The consultant lives within 20 minutes travelling time of the hospital. There have been no reported serious incidents or near misses related to the lack of consultant presence out of hours. The children's services nursing

Services for children and young people

establishments were reviewed in 2014, which resulted in staff roles being redesigned. The trust had not followed the Royal College of Nursing (RCN) guidance identified in 'Defining staffing levels for children and young people' (2013). Staff also told us that the staffing levels within the neonatal unit did not follow the 'British Association of Perinatal Medicine (BAPM) service standards for hospitals providing neonatal care (August 2010)'. Since the inspection the trust have informed us that there have been no adverse outcomes / incidents on the neonatal unit related to staffing issues. The latest trust data indicates that they are at 79% when compared to the BAPM guidance.

Since the inspection the trust has informed the CQC that strategies are in place for both the neonatal and children's services. Governance processes were in place and known clinical risks had been monitored. Improvements made to care and treatment were identified by audit findings or in response to national guidelines. Public and staff engagement processes captured feedback from both groups.

However, we found some gaps in the monitoring process in that we were not assured that incident management and learning on the children's wards were robust at City Hospital. We found checking systems for resuscitation equipment ineffective on the children's wards.

The neonatal and children's service provided good access and flow to their services. The reconfiguration of children's services had resulted in improved service provision and access. Good transitional arrangements were in place for young people. However, staff identified concerns about long waits for internal transfers to D19 and for external transfers to Sandwell Hospital.

Concerns had also been raised about the lack of beds and support for children and young people with mental health problems. However, we do recognise that the trust had recognised this risk and as such had identified them on the trust risk register. During the inspection, we raised concerns about CAMHS provision with the trust at executive level. Following the inspection the trust informed us that the specific issue raised on the day was resolved within 3 hours, and on investigation met the risk assessment standard we have set. The patient was being cared for by an agency RMN.'

Are services for children and young people safe?

Requires improvement

We were not assured that incident management and learning at ward level was robust because staff told us they had not always received feedback about incidents they had reported. We observed that there had been some long-standing risks identified within the neonatal service which was still under discussion at departmental and trust level. However, the trust did share learning from incidents in a number of ways including during monthly neonatal in-service days.

In two of the children's areas we found checking systems for resuscitation equipment ineffective. This was because resuscitation equipment checks had not identified expired, undated equipment and equipment that should have been in individual packaging. We also checked the adult resuscitation equipment trolley used by the neonatal unit, should a mother collapse. No resuscitation equipment checks had been documented since 11 October 2014.

The children's services nursing establishments were reviewed, resulting in staff roles being redefined. The trust had not followed the RCN best practice staffing guidance. We observed shortfalls in nurse staffing and staff told us they had not received the necessary training and support needed to care for some categories of children admitted to the service.

Staffing levels within the neonatal unit did not follow best practice guidance.

The Royal College of Paediatric and Child Health (RCPCH) standards had not been fulfilled. This was because the trust did not provide paediatric consultant cover from 5pm until 10pm on each site. Following the inspection the trust informed the CQC that they had risk assessed this situation and a consultant is available within 20 minutes.

We observed a number of shortfalls in record keeping within seven sets of neonatal notes. This meant that the full information about the baby was not available to inform medical and nursing decision making in relation to the baby's care.

Services for children and young people

Incidents

- The hospital had systems in place to make sure incidents were reported, investigated and learnt from. Incidents had been discussed at monthly matron and paediatrician risk meetings, and a monthly risk newsletter was circulated within the paediatric service across the trust. Staff demonstrated an awareness of how to report incidents; however, staff told us that they had not always received feedback from the incidents they reported. We were told that, when learning had been identified from incidents, this had been communicated to neonatal staff at handover sessions there had been no serious incidents or never events reported in neonatal or children's services. Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.
- Unexpected infant and child death guidance was available for staff, parents and carers. Staff were given the opportunity to discuss and evaluate unexpected deaths of children to ensure that learning took place. The minutes of the 'Paediatric Directorate Mortality Report' (Sept 2012-Aug 2013) confirmed that discussions relating to morbidity and mortality had also taken place at trust level.
- Each clinical area had a 'Confident & Caring Board' which displayed information such as staff sickness, hand hygiene audit results, clinical incidents and mandatory training attendance.

Cleanliness, infection control and hygiene

- An integrated infection prevention and control service is led by a director of infection prevention and control. Staff told us that the infection control team nurse visited the wards and gave advice where needed which meant appropriate professional advice was available. Neonatal staff told us that management plans had been developed with the microbiologist when babies had an identified infection. We were told that these plans were kept in a baby's notes and that weekly reviews were documented after the Friday ward round.
- The areas we visited had infection prevention measures in place, such as infection prevention and control guidance, hand sinks, wall mounted hand gels and containers containing aprons and gloves. However, we observed that one wall mounted hand gel was empty on D19 (the paediatric assessment unit). We alerted the staff to this and saw that the hand gel pump was changed.
- Neonatal staff told us of the 'Pinney at the point of care' practice: each baby had its designated colour pinney that staff would wear when giving care to that baby. This was a visible indicator that assured staff that effective infection prevention precautions were being adhered to when caring for each baby.
- The neonatal unit had two isolation cubicles. A business case for more cubicles had been put forward in 2014, but this had been rejected. However, it had been recognised that the neonatal unit did not have enough nurses to staff any extra cubicles. Staff told us that this lack of cubicle provision had not caused any problems, and preventative measures included 2-weekly screening of babies for infections such as MRSA and E. coli.
- We saw that infection control monitoring had taken place on D19 and in the neonatal unit. The outcome was that parents were generally satisfied with the cleanliness of the ward, bed space and bathrooms.
- Staff told us that they received infection prevention and control training at induction and as part of the mandatory training programme. However, we observed a shortfall in training attendance, which meant that patients could be put at risk if individual staff's infection control knowledge was limited.

Environment and equipment

- We checked the neonatal and paediatric resuscitation equipment in each clinical area. On D19 and the children's day surgery ward in the Birmingham Treatment Centre we found equipment with no expiry dates, not stored in individual packaging and some equipment was missing from the resuscitation trolley. We alerted staff and asked them to replace these items.
- There was no defibrillator on D19. We were told that the defibrillator would be collected from the intensive care unit and the trust resuscitation officer was aware that the ward did not have its own defibrillator. We also observed there was only one paediatric defibrillator pad on the resuscitation trolley; no pads were available for use on babies. This meant that babies could have been at risk if the equipment including the correct sized defibrillation pad was not immediately available.
- We also checked the adult resuscitation equipment trolley used by the neonatal unit, should a mother

collapse. We found the handle for the laryngoscope out of date (18 July 2014). We looked to see how often this equipment was checked, and observed that no resuscitation equipment checks had been documented since 11 October 2014. We were told that this trolley should be checked daily, but we saw only one check documented for October 2014.This meant that staff may not have been familiar with the equipment used and whether it was safe to use.

- We saw equipment suitable for babies, children and young people in all clinical areas. We undertook random checks of the clinical equipment throughout the neonatal and children's units and found that equipment had been serviced.
- Two staff raised concerns about the environment not being suitable for children and young people with mental health needs. One staff member also identified a lack of training available when caring for this group of children and young people. This meant that trust policy had not been followed.
- Since the inspection the trust has identified that they agree that the paediatric assessment unit is not designated as a mental health facility, children with a requirement are transferred to Sandwell Hospital. Transfer data demonstrates that this happens. In early December 2014 the trust opened with winter funding new units in both A&E departments to try to address this issue. Prior to that our risk judgement is on a patient by patient basis between emergency department cubicles and other locations.
- Following the inspection the trust identified that staff were supported by the Clinical Psychologist employed by the Trust and by the CAMHS team who undertake the mental health care of these children. Those children requiring admission are transferred to the Sandwell site as City site operates solely as an assessment facility.

Medicines

- The trust adheres to National Institute for Health and Care Excellence (NICE) guidance in relation to medication management.
- Trust auditing of medication errors had taken place. The audit excel report 'Medication Errors – April - September 2014' identified a total of 87 medication errors recorded for the women's and children's health directorate. We saw that communication of drug errors had been included in the trust monthly 'Risk-E-News' newsletter. The October 2014 newsletter identified actions for staff to take should medication be omitted. Additional discussions had also taken place at the clinical effectiveness committee meeting on the 9 October 2014 and at a children's services quality improvement session on the 19 September 2014. The outcome was to re-audit after one year after the introduction of the new paediatric drug chart.
- Doctors' induction programmes included a 30 minute training programme on paediatric prescribing.
- We observed that pharmacy controls were in place. Daily checks of the drug fridges had taken place; we saw records of checks confirming this on D19 (the paediatric assessment unit). Reviews of children's and babies drug charts confirmed they had been completed correctly.

Records

- The children's and neonatal services had both paper and electronic patient records. In clinical areas records had generally been locked away in a lockable cupboard and/or cabinets. However, we observed on D19 during a ward round, which lasted over an hour, the records trolley had been left outside children's cubicles while the doctors were in the cubicles. At times the trolley was left unattended for 20 minutes. This meant that children's records were not secure.
- We reviewed a total of 12 sets notes in the children's and neonatal areas. We were unable to identify the roles of the medical staff against some medical entries in the children's notes. Pre-printed, standardised care plans were in use throughout the children's service. These care plans identified limited (if any) nursing interventions and evaluations. We saw limited evidence of the use of patient specific-risk assessments forming part of the patient care package. This meant they were not personalised to individual patients and we were unable to determine children had been seen by a paediatric consultant within 24 hours of admission.
- We observed a number of shortfalls in record keeping within seven sets of neonatal notes. For example, admission sheets were not fully completed, nursing entries had not always been signed or timed, and some growth and medical charts had not been completed. Pre-printed, standardised care plans were in use. We saw no evidence that the care plans had been reviewed. This meant that the full information about a baby was not available to inform medical and nursing decision making.

- A paediatric records audit had been reported within some undated minutes of learning in action patient experience action plan. The outcome of this audit was recorded as "Data input largely complete. Good results compared to the rest of the trust." The date of the next meeting was 6 August 2014. The staff we spoke with from the Birmingham Treatment Centre had not been involved in any records audits.

Safeguarding

- The chief nurse is the trust executive lead for safeguarding. Clear safeguarding governance reporting arrangements are in place which meant that children's safeguarding and associated processes had been monitored closely by the trust.
- Child protection systems and partnership working arrangements were in place with Sandwell Local Safeguarding Children's Board (LSCB) and the Birmingham Local Safeguarding Children's Boards. We were also told that named leads represented the trust on some LSCB sub-groups.
- The trust's safeguarding child protection policy had recently been reviewed, and was awaiting ratification. This policy is used in combination with other trust policies, such as the whistleblowing policy, responding to domestic abuse, and child death overview guidelines.
- The trust met the statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All staff employed at the trust undergo a DBS check prior to employment, and those working with children undergo an enhanced level of assessment.
- Referrals to the children's safeguarding team are via telephone Monday to Friday between 9am to 5pm. The trust policy contains guidance for staff who need to make a referral out of hours.
- Staff told us that child protection plans for neonates had been flagged up on the perinatal alert register. Child protection issues had also been discussed in the combined foetal medicine meeting. We tracked one case of a child that involved child protection issues, and found a clear management plan in place.
- NICE safeguarding guidance recommends that permanent staff be trained to a level three standard in safeguarding. We were told that clinical staff who worked with children had been trained to level three. The trust's training statistics identified that 74% of nursing and midwifery staff and 67% of medical and dental staff in the women's and children's health directorate had completed level three training in safeguarding children. This meant there were training shortfalls in level three safeguarding training within the directorate.

Mandatory training

- We talked with members of staff of all grades, and confirmed they had received a range of mandatory training and training specific to their roles. We observed there had been a shortfall in staff attendance at some mandatory training sessions such as moving and handling and paediatric basic life support training. This meant that staff had not updated their skills and knowledge in this area, which could affect their responses in an emergency situation or when performing these tasks.
- Training statistics were not available confirming how many trained staff had completed paediatric intermediate life support or advanced paediatric life support (APLS) training. This could put children and young people at risk because the trust were unaware of how many staff were suitably qualified.
- Following the inspection the trust provided additional evidence which confirmed that 100% of medical staff on the on call rota had attained advanced paediatric life support training.
- Staff told us that the neonatal unit had a good education budget, which ensured that staff could complete neonatal training and the teaching and assessing course. However, we observed from the four sets of perinatal medicine governance meeting minutes dated from 21 January 2014 until October 2014 that, although there had been a recognition that mandatory training compliance had reduced, no formal action plan had been developed by the group to address these shortfalls. This meant that the overall response of the group to staff mandatory training shortfalls had not been effective.
- The trust had a corporate induction, which included information in areas such as equality and diversity, NHS counter fraud, customer care and governance. Trust middle grade doctors attended a separate induction programme. We saw a copy of the September 2014 programme. An induction programme was offered on the City Hospital site.
- New staff to the neonatal unit had an identified unit induction and received a new starter pack. The induction included a supernumerary status for 4 weeks;

3 months in SCBU; and a fourth month in neonatal intensive care, during which the first 2 weeks were supernumerary. We were told that during the induction period staff would complete their foundation neonatal course. We spoke with a newly qualified member of staff who confirmed that this had been the induction they had completed. This meant that new staff had been inducted to the unit, and that their personal needs had been taken into account as part of the induction process.

Assessing and responding to patient risk

- Two risk registers were seen. The Sandwell and West Birmingham Hospitals NHS Trust Risk Register: Women and Children's' identified four risks relating to children's services. Whilst, the 'Appendix A: Trust Risk Register (version dated 27 August)' identified two risks relating to children's services. This meant that the higher level risks in children's services had been identified at board level on the trust risk register.
- The trust had identified guidelines and protocols to assess and monitor in real time, and react to changes in risk level.
- Staff told us that four staff on D19 had completed a children's high dependency course. We were told that other nursing staff had completed trust high dependency competencies. Neonatal staff had attended training in recognising and caring for the deteriorating infant. Staff told us that 'live' skill drills had taken place to ensure staff skills and competencies were satisfactory in emergency situations. We were told these skill drills had been minuted. This meant that systems were in place to regularly assess and test staff competence in emergency situations.
- The children's service had no formal agreement with the local children's and adolescent mental health services, although joint working did take place. Concerns were raised at the lack of tier four beds for children and young people with mental health concerns. The team were unanimous in that they felt the paediatric service was not the right place to care for this vulnerable group of children and young people. During the inspection we raised these concerns with the trust at executive level.
- Trust wide the children's service used an early warning system called the 'paediatric early warning score' (PEWS) which is a system used to monitor children and to ensure early detection of deterioration. We reviewed a sample of paediatric early warning score observation charts and found these were completed in detail by members of the nursing team.
- We saw that the trust had safe transfer arrangements in place for children and neonates. The 'Kids Intensive Care and Decision Support (KIDS) Retrieval Service' transferred sick children whilst the South West Midlands Maternity and New-born Network (SWMMNN) is used when transferring neonates.

Nursing staffing

- We observed that best practice staffing guidance had not been fully implemented within the City Hospital children's or neonatal services and that senior nurse cover at band 6 or above was not always in place within each area. For example, there were occasions when there had been shortfalls in band 6 and band 7 staff in the neonatal intensive care unit (NICU). We observed from the special care baby unit rotas that these staff grades had been identified to work. However, this meant that there could be limited senior nurse support within the NICU area due to this shortfall of senior neonatal nursing staff. We were told that they did not comply with the neonatal staffing guidance. Staffing shortfalls had been exacerbated because the neonatal staff who had left the trust had not been replaced due to staff posts being frozen. However, we were told that, since October 2014, all vacant neonatal posts were released. The neonatal risk register identified the non-compliance with BAPM standards for nursing staff because the shortfall could compromise care in times of high activity.
- Feedback from one mother and father on the neonatal unit identified concerns that their babies' needs, and their own, had not been met because staff "seem to be too busy" and "were always in a rush to get to the next baby". This meant that the individual needs of the baby and its parents had not always been met, and this could pose a risk to the care the baby received.
- Staff told us the neonatal unit was short staffed. We were told that staffing shortfalls had been recorded as incidents. We saw one such example which had been reported on 6 July 2014. One nurse had been allocated to care for nine babies in the big cot nursery from

7.30am until 9.15am when the shift lead came to offer some help. This meant that both babies and the staff member had potentially been put at risk due to a lack of trained staff.

Medical staffing

- The lead clinician told us there were 12 consultants providing acute care for children's services across the trust. In addition 33 junior medical staff, which included 12 specialist registrars formed part of the medical team.
- A consultant anaesthetist told us that the trust had up to nine anaesthetic consultants with a paediatric interest, who are confident in treating children over the age of one year. For babies less than one year of age, neonatologists assisted with the care of these babies. Anaesthetic cover was provided from 8am until 6pm weekdays. We were told that there was always an anaesthetic consultant available out of hours to provide anaesthetic advice and support for children's services.
- Trust wide, the RCPCH standards had not been fulfilled because the trust did not provide paediatric consultant cover from 5pm until 10pm, on each site. However, we were told that out of hours consultant staff would arrive at the hospital within 20 minutes of being called. Since the inspection the trust has identified that there is an experienced Registrar on site to ensure that the child's care is not affected in the event that consultant presence is required. The consultant is available for verbal advice 24 hours. There have been no reported serious incidents or near misses related to the lack of consultant presence out of hours.
- Staff identified concerns about the limited night medical cover, which comprised one registrar and one senior house officer to support both paediatric and neonatal specialities. This resulted in one clinical area being left without senior medical support whilst the registrar saw children or babies in the other clinical area. This could potentially pose a risk to the ongoing care of children and babies because consistent senior advice and support is not available in both clinical areas at once. Since the inspection the trust has informed us that in the event that the registrar is required in another area, the escalation policy would be activated and the Consultant on call would be called to attend, thus preventing children being left without senior medical input.

Major incident awareness and training

- A trust major incident plan is in place. Winter and summer management plans were in place. We were told that the ward capacities would be increased by opening additional beds.

Are services for children and young people effective?

Good

Children's and neonatal services improved care and treatment where need for this had been identified by audit findings or in response to national guidelines.

Children and neonates were provided with pain relief when they needed it.

We saw that 100% of staff had received their annual appraisal for 2014. Staff had a mixture of views about the support and personal development they had received.

There was evidence of multi-disciplinary working across various disciplines and specialities.

Evidence-based care and treatment

- Clinically endorsed guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) was used to inform children's and neonates care. We were told that Royal College guidance had been used to develop local policies. The children's outpatient clinics followed NICE guidance, for example, guidance on asthma.
- The children's service had designated lead consultants for each condition. Some transition services were in place for young people. These services included: allergy, haematology, rheumatology and neurodisability services. The first joint endocrinology transition clinic will start in October 2014. The trust identified that some gaps existed in its transition services which included the improvement of the holistic aspect of the transition process.
- We were told that there had been an increase in babies with neonatal jaundice. The review into this identified that incorrect coding had been the issue. The outcome had been to recommend that the community breastfeeding team be strengthened. Initial interim audit results have shown a positive impact.

Services for children and young people

Pain relief

- Babies, children and young people had access to a range of pain relief, including topical, oral and intravenous analgesics (painkillers) when needed. We were told that, if babies were unsettled or appeared to be in pain, this observation would be discussed with the doctor to determine whether pain relief was needed to settle the baby.
- The trust had a dedicated pain management team. We were told by staff that the team would provide support when necessary.
- We were told a pain audit had been completed which found that 90–95% of pain episodes had not been accurately recorded. This resulted in the pain documentation being changed. We did not see any information confirming when a re-audit was due to take place.
- The service used an evidence-based pain scoring tool to assess the impact of pain. We were told that the pain management team had recently started using a new pain management tool which we saw displayed in two clinical areas. We were told that staff were aware of this new tool but no formal training had been identified in its use. The staff we spoke with did not identify how successful the new pain tool had been or whether there had been any negative outcomes for patients.

Nutrition and hydration

- A variety of food choices was available to children. The children's notes we reviewed contained no evidence of completed nutritional assessments.
- We saw guidelines in place for managing referrals to the paediatric dietetic service and to assist staff when 'monitoring feeding and fluid balance in the healthy term normal infant' (approved September 2014) and 'formula feeding guidelines' (approved April 2014).
- We saw there was specific information available, in leaflet and book form, for children and young people who were required to fast because of their recommended treatments. Both documents were informative and had been directed at children's and young people's level of understanding.
- Stage 2 Baby Friendly accreditation (16 October 2013) had been achieved. Stage 2 involves the assessment of staff knowledge and skills. The Baby Friendly initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the 'Ten steps to successful breastfeeding' and to practise in accordance with the International Code of Marketing of Breast Milk Substitutes. The neonatal unit has since applied for stage 3, which is the final Baby Friendly accreditation to be awarded.

Patient outcomes

- The trust had a system of audit to ensure good patient outcomes. The trust's audit dashboard identified a list of the audits that had been completed in children's services and the progress they had made against them. From the 16 audits submitted, the trust identified that 14 recommendations had been effectively implemented. The neonatal audits trust included the national maternal, newborn and infant review programme, the national neonatal audit programme and the NICE quality standards 4 – neonatal care audit.
- Minutes from the monthly paediatric speciality meetings, clinical effectiveness and paediatric and maternity and perinatal medicine governance group action plan meetings confirmed that patient outcomes and clinical effectiveness issues had been discussed and improvements noted. We also saw that quality, safety and performance were standing agenda items on the trust board report.
- Additional audits that had taken place in paediatrics across the trust included a 'Re-audit of parental satisfaction with pre-operative anaesthetic information' and a 'Review of epilepsy related admissions.' Both audits had conclusions and/or made recommendations. The lead clinician told us that a business case had been put together following this audit to recruit an epilepsy nurse specialist.

Competent staff

- Formal processes were in place to ensure staff had received training and an annual appraisal. We saw that 100% of nursing and midwifery, and medical and dental staff had an appraisal in 2013–14.
- We were told staff skills had been enhanced through a three-month rotation programme every three years and that some nursing staff on D19 (the paediatric assessment unit) had completed high-dependency competency assessments. Staff told us they had received no training in children's and young people's mental health conditions. This meant that children could be put at risk if staff had not had training in the mental health condition the child presented with.

- Neonatal staff told us that they rotated through the neonatal unit to ensure that their clinical and technical skills were maintained. A neonatal unit training matrix created in February 2014 identified high shortfalls in training compliance in areas such as resuscitation of the newborn, basic life support and information governance. This meant that some staff had not been updated their skills in these areas.
- Since the inspection the trust has identified that 91% of neonatal nursing staff had completed and are in date for either in-house mandatory training or advanced neonatal life support training.
- Since the inspection the trust has identified that 91% of neonatal nursing staff (inclusive of new starters, long term sick leave and Maternity leave) had completed and are in date for either In house mandatory training or Advanced Neonatal Life Support training (external provider).Staff told us that clinical supervision took place on D19. Positive changes had resulted from these meetings, for example, when staffing concerns were raised, additional staff had been sourced from within the children's service. Monthly discussions about the supervision of junior medical staff by consultant staff take place.
- Staff told us they attended a monthly neonatal in-service day that provided updates on unit issues, incidents and training sessions, and was also a forum where information was shared. We saw that topics on some of these days had included record keeping, developmental care planning and an update on the care of intravenous and central venous lines. Regular attendance by staff at these training sessions meant that their knowledge and skills was kept updated.

Multidisciplinary working

- Staff told us how they worked in partnership with other healthcare professionals such as diabetic community nurses and health visitors to improve outcomes for children and their families.
- The lead paediatrician told us there was effective cross-speciality working. Every quarter, a paediatric surgical meeting took place and was chaired by the urology department. The meeting was used as a forum to discuss services, guidelines, protocols and measurements against joint royal college guidelines. Governance and risk had also been discussed.
- The lead consultant paediatrician and neonatal managers told us that multidisciplinary working existed between City Hospital and Birmingham Children's Hospital. There had been yearly meetings in which learning and issues affecting children's care had been discussed.
- We were told that 14 neonatal units which included this trust had agreed regional neonatal clinical guidelines. Before this guidance went live, a guideline awareness week took place. The guidelines included information on local contacts and agreed template documents which could be used.
- The children's service employed one play specialist. There had previously been more play specialists, but after the services reconfiguration these roles had been made redundant. The remaining play specialist told us that they split their time between the City and Sandwell hospital sites. This reduction in play staff meant that children's play and psychological needs could not be fully provided for.
- Following the inspection the trust told us that they employed 4.09 WTE play therapists /specialists; some are ward based and some rotate around the outpatient departments

Seven-day services

- There was 24-hour paediatric and neonatal consultant support at City Hospital. Junior medical staff and nursing staff said they could access consultants out of hours and described the consultant team as supportive. We were told that out-of-hours consultant staff would arrive at the hospital within 20 minutes of being called. Additional medical cover over night comprised of one registrar and one senior house officer.
- We were told that there were no problems accessing out-of-hours investigations, for example, imaging and urgent laboratory tests. We were also told that pharmacy access and support was available. Services such as CT scans and ultrasound scans could also be accessed after discussion with radiology and after a consultant referral had been made.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- The trust's consent policy included guidance on children and young people and neonatal consent. The neonatal service operational policy also noted that the South West Midlands Maternity and New-born Network consent guideline should be used to obtain consent.

- Staff explained that the consent process was completed by surgeons for children requiring surgery and that verbal consent would be obtained for investigations in the children's outpatient clinics. We reviewed one child's notes in the medical day clinic and noted that the consent form had been signed by the child's mother before their investigation.
- A letter dated 29 May 2013 had been sent to trust medical staff from the trust medical director identifying the importance of obtaining of consent for the provision, withholding or withdrawing of a medical intervention. These actions demonstrated that the trust recognised the importance of consent processes before medical intervention.

Are services for children and young people caring?

Good

Children, young people and their parents told us they had received compassionate care with good emotional support. Parents felt they were fully informed and involved in decisions relating to the babies and child's treatment and care.

Compassionate care

- Throughout our inspection we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers.
- Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.
- We spoke with 15 parents using the neonatal and children's service at City Hospital. They told us that they had been happy with the medical and nursing care received in the inpatient and outpatient areas. They told us that clinical teams liaised well and had kept them informed about treatment plans. One comment made by a parent was, "Staff work together as a team and understand how parents feel." Another mother said she had been treated with respect in the way staff had interacted with her, and they had respected her feelings.

Patient understanding and involvement

- We were told that access to interpreters or a language line could be arranged. During the inspection of the children's outpatients department we observed that an interpreter and a sign language expert were available to assist children and their parents at the hearing clinic.
- We spoke with two parents about their experiences in the children's outpatients department and five parents about their experiences on D19. Parents told us that they had been involved in and were happy with the care their children had received. One parent told us they and their child had received really good quality care and had observed how well staff had related to children and parents.
- We spoke with another 15 parents about their experiences. They told us that the medical and nursing care their child or baby had received had been satisfactory; treatment plans had been explained and clinical teams liaised well.

Emotional support

- Paediatric specialist nurses such as diabetic and child protection nurses were available for parents and staff to access for support and explanations if needed.

Are services for children and young people responsive?

Good

The neonatal and children's service provided good access and flow to its services and met neonates and most children's, parents and / or carers individual needs. The trust had good support from tertiary centres such as Birmingham Children's Hospital and from within the neonatal network. Close links had also been formed with other neonatal and children's services throughout the region.

The neonatal service had limited administrative support which had resulted in some 'near misses' in relation to the booking of babies' appointments.

The children's service has recently reconfigured its services, which has resulted in some improvements in service provision and access.

Services for children and young people

The children's service had no formal written agreement with local children and adolescent mental health services. Staff raised concerns about this vulnerable patient group during the inspection; we raised these concerns with the trust at executive level.

Good transitional arrangements were in place for adolescents.

Service planning and delivery to meet the needs of local people

- The children's service had recently reconfigured its services, which has resulted in improvements in service provision and access. A paediatric department strategy away day had been held on 16 May 2014. Medical and nursing staff discussed outpatient improvement, improving the acute wards and the day unit, community services and improving the urgent care service and support for GPs.
- BLISS (a charity organisation) funding had been obtained to improve the neonatal transition rooms used by parents before their discharge home.

Access and flow

- The neonatal and children's services provided good access and flow to their services. The paediatric assessment unit accepted referrals from the emergency department, midwives, the Childrens Out Patient Department (COPD) and general practitioners. Children on open access to the service were also seen on D19. However, ophthalmology and ear, nose and throat patients were accommodated overnight on D19 because access to specialist support is only available on this site.
- We spoke with two families in the children's medical day unit who described the service they had received as ''Fantastic – couldn't be better'' and a ''really helpful service.'' We observed that one child received their follow-up appointment immediately, therefore assuring continuing access to the service.
- The service reconfiguration had resulted in a number of initiatives to improve service provision and access to the service. One example was the 'Keep it moving' action plans, the aim of which was to streamline processes and systems to facilitate effective patent flow and assist with early discharge. We did not see evidence of a follow-up review, which would have identified the success of the initiative.
- We were told by staff that the City COPD service had no administration support, whilst the neonatal service had limited support. This meant that the nurse's attention was directed away from their clinical role. However, we have since received information from the trust who have told us that reception and clinic administration support had been provided by the general administrative team and that back office support had been provided by paediatric administrative staff.
- Staff from the Birmingham Midland Treatment Centre identified concerns about delayed transfers of children from the theatre recovery area to D19 when children had to stay overnight. In the last 12 months there had been three delayed transfers. Staff on D19 also reiterated the same concerns when children needed to be transferred to the inpatient children's ward at Sandwell Hospital. This meant that children's needs may not have been fully met because access to other parts of the paediatric service had been delayed.

Meeting people's individual needs

- We observed a situation where a mother who spoke limited English had not been offered the support of a translator. We reviewed the child's documentation, which said the mother did not need a translator. We spoke with the mother who told us she would like an interpreter because they could not understand everything the doctor said. This meant that staff had not recognised the additional support needs of the mother.
- Staff had received training to help with their understanding of people's needs. For example, staff had attended training sessions in equality and diversity, safeguarding and managing conflict.
- Transitional arrangements were in place for adolescents. The trust told us they were especially proud of their young people's diabetes service, allergy management and the way acutely ill children were cared for. We saw that joint consultant working within the trust had enabled further expansion of transition arrangements with adult specialities to the benefit of the young person.

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints either locally at ward level, through the Patient Advice and Liaison service (PALS) or the trust complaints department. We saw that the trust had also

responded to concerns through individual patient surveys. Seven parents told us they had no knowledge of the trust's complaints procedure. However, we were told that they would raise concerns if there was a need.

- The trust had captured patients', families and friends 'comments and concerns. We observed that the majority of informal complaints related to process and communication issues. We saw that actions had been produced to address the issues raised.
- The trust complaints data for 2013 – 2014 identified nine complaints in total for all of children's services. The complaints report dated 2013–14 was incomplete: information about date of reply, and action taken were not complete. We were unable to judge how effective the complaints process had been due to this missing information and because not all action plans were completed.
- The acting head of services told us that parent's feedback and complaints had been reviewed monthly and trends fed back to staff. Minutes from quarterly unit meetings, paediatric clinical governance and the maternity and perinatal medicine governance meetings confirmed complaints had been discussed.

Are services for children and young people well-led?

Requires improvement

A clear leadership structure was in place in the Women's and Children's Health Group.

Neonatal and children's services were well led at ward level. However, we recognise that staff felt they had not been supported or involved in decision-making about new ways of working. Staff did not always feel supported and some staff described an 'autocratic' management style of senior managers. The managers were aware that staff morale was low.

Medical cover was an identified risk which at the time of the inspection was not present on the risk register, although, it had been identified within the department. Since the inspection the trust has told us that there is an experienced Registrar on site to ensure that the child's care is not affected. The consultant is available for verbal advice 24 hours and lives within 20 minutes travelling time. There have been no reported serious incidents or near misses related to the lack of consultant presence out of hours. In the event that the registrar is required in another area, the escalation policy would be activated and the Consultant on call would be called to attend, thus preventing children being left without senior medical input.

Nurse shift leadership was also an issue with not every shift being led by a suitably experienced nurse of band 7.

We saw effective governance processes and saw that known clinical risks had been monitored.

Public and staff engagement processes captured feedback from both groups. However neonatal feedback from parents needed to be improved to give staff the opportunity to learn from trends and complaints.

Vision and strategy for this service

- The children's services have a five year strategy and a two year plan; whilst, the neonatal service has an annual plan in place. The acting paediatric matron had been involved in developing the annual plan and the ward managers had been given the opportunity to feed in ideas to this annual plan. This plan fed into the trust business plan which had been discussed at board level. We asked if we could have a copy of this plan and some minutes confirming the progress made against the plan, but had not received them in time to include in the report.
- We were told that changes identified by senior management had been cascaded down to the ward areas. Staff told us that these changes had been implemented; however, the style of senior management leadership was described as autocratic. This was because there had been no staff engagement when the nursing establishments had been reviewed, which had resulted in staff roles being redefined. Staff said they were told, "This is what you have to do. This is what is happening."

Governance, risk management and quality measurement

- The trust had a clear decision-making pathway in place for governance, risk management and quality measurement. Meetings took place which enabled clinical staff and management staff communications, for example, monthly paediatric directorate meetings and directorate operational meetings and departmental risk and governance meetings.

- The ward manager on the paediatric assessment unit (D19) was the paediatric clinical governance coordinator for the service. Discussions with staff and minutes from the ward meetings confirmed that staff had been kept informed of issues and updates, for example on patient safety, clinical effectiveness, and area-specific quality issues.
- A new risk was added to the women's and child health directorate risk register in September 2014 which identified a lack of ward clerks. This had been identified as a risk on the register due to an increase in incidents (for example, 'near misses' where baby cardiac appointments had not been made when there was insufficient ward clerk cover to support the delivery of care).
- Neonatal staff also told us of a second risk, which had not been identified on the risk register but had been escalated and would be discussed at the next risk meeting. This risk related to middle-grade medical cover at nights. The impact was that the registrar could be covering the PAU for most of the night which resulted in a junior senior house officer covering the neonatal intensive care cots, or vice versa. We were told that discussions had taken place about separate medical cover; however, there was currently insufficient staff to provide this cover. We were told that this had been going on for the past 5 years and, as yet, no serious outcomes had resulted from this lack of medical support. However, nursing staff and junior medical staff had been left stressed and feeling unsupported. Since the inspection the trust notes that this risk was recently reviewed again in the context of the Deanery visit. It was concluded that the combined workload of PAU and Neonates with Consultant, Registrar and separate SHO cover – fulfilled the deanery training requirements and standards. Training accreditation was retained.

Leadership of service

- A clear leadership structure was in place within the Women's and Children's Health Group. The clinical group comprised of four directorates which was led by a head of service and a clinical director. The community children's directorate has no clinical director as there are no medical staff employed within this directorate. The leadership team for neonatal and children's services included Neonates has one Acting Matron and 1 Head of Service (Director of Midwifery). Paediatrics has 2 matrons (1 of which is currently acting) and 1 Acting Head of Service.
- Staff told us there had been a lack of recognition of the neonatal service by the trust's senior management and executive teams, which had resulted in a lack of support.
- There was a clear leadership structure within the paediatric assessment unit (D19) and children's outpatient department. For example, on D19 the band seven ward manager was supported by band six sisters. Staff we talked with on all children's clinical areas told us they had felt supported by their immediate line manager. A ward manager told us they were supposed to have two non-clinical days each week for management tasks. We were told they rarely had the opportunity to take them.
- Shift leadership – we were told that the neonatal unit aimed to allocate at least one band 7 nurse for each shift. However, we were told that this was not always possible. When there was a shortfall in cover by band 7 nurses, senior band 6 nurses led the shift.
- Neonatal staff told us that leadership development was encouraged. At least two nursing staff had completed leadership modules and staff had also been able to access in-house management development training. Several staff had completed Master's level training, which included advanced neonatal nurse practitioner courses.

Culture within the service

- There was a culture of openness, flexibility and willingness to help among all the teams and staff we met in the children's and neonatal clinical areas. Staff spoke positively about the service they provided for babies, children, young people and parents.
- Staff were very honest about their current feelings. Conversations with them confirmed that morale was low. They told us they had not been engaged in the changes to the nursing establishments which had resulted in staff roles being redefined and staff roles had changed as a result. Some staff told us they did not feel supported and as a result felt vulnerable.
- We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of acute health services. We were told that

paediatricians and the nursing staff from the neonatal and children's service had supported staff in other areas, for example, the adult intensive care unit, when a child was admitted to that area.

- The acting head of service told us that they recognised that staff morale was low. They did not identify how they were going to improve this during our discussions. This meant that the impact of these changes on staff had not been fully recognised, as support systems did not appear to be in place.

Public and staff engagement

- A paper-based feedback survey was used to ask parents and children about the service. Thirteen surveys had been completed on D19 between February and May 2014. The survey results identified that care received had been rated good or excellent. Other questions with high scores related to being treated with dignity and respect and generally answering all questions. Therefore, the survey response identified a high level of satisfaction with service provision.
- Feedback from parents on the neonatal unit had been obtained informally and through informal complaints. We were told the informal complaints had been investigated. However, structured feedback to staff about issues raised through complaints needed to improve.
- Feedback had been captured from staff through the staff survey. We saw the results for January, April and July 2014 and observed a reduction in percentage scores for engagement, advocacy, involvement and motivation.
- Neonatal staff told us that staff meetings, which had previously been separate monthly events, were now held on monthly in-service days.
- Staff told us that the last visit to the unit by the executive team had taken place in December 2013. This meant that limited presence on the neonatal unit by the executive team could have resulted in neonatal issues not being fully recognised, because the team would not have seen the impacts that policy decision making had had on service delivery.
- The trust has since informed us that the Chief Nurse had been to the unit throughout 2014 and in particular to see first-hand the flooding issues which arose leading to temporary closure of the unit. Similarly both the CEO and COO have been on the unit during the prior six months.

End of life care

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

Information about the service

End of life care was delivered where required by staff throughout the hospital. There was a specialist palliative care team who provided support and advice for those patients who had complex care and/or complex symptom management. Support was also provided to relatives of end of life patients. The specialist palliative care team consisted of 1.4 whole time equivalent (WTE) consultants and seven WTE nurses (one vacancy). In addition there were two WTE occupational therapists. The team was accessible 24 hours day, providing support and advice across the two trust acute sites; Sandwell General Hospital and City Hospital. Ward staff understood how to make a referral to the specialist team and reported the team responded promptly.

We visited seven wards and two specialist departments at City Hospital. We met five patients, spoke with eight relatives and reviewed 13 care records. We talked with 14 staff about end of life care. These included the specialist palliative care team, ward nurses and doctors, allied health professionals, the chaplaincy team and bereavement and mortuary staff. We observed care being provided to patients and relatives. Before and during our inspection we reviewed the trust's performance information.

Summary of findings

The specialist palliative care team had developed tools, processes and training for generic staff in order to deliver, monitor and evaluate care in line with current best practice. They regularly reviewed the complex care needs of patients to promote coordinated, safe and effective end of life care and clinical practice. Ward staff were familiar with the trust's end of life care plans. Records showed potential problems for patients were identified and planned for in advance.

The patient and relatives we were able to speak with told us they had been involved in decisions, care was good and staff were respectful and kind. End of life patients were not always able to be in their preferred place of care as the discharge planning process was not fully effective. We were told recent reviews of the chaplaincy service would impact on the ability to be fully responsive to patient needs. We reviewed 15 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in patient records and found one third had errors or information missing. Ward staff said they valued the support, expertise and responsiveness of the specialist palliative care team.

End of life care

Are end of life care services safe?

Requires Improvement

On one ward we identified a medicine error for an end of life patient. Senior staff confirmed this and other similar incidents were not routinely recorded as incidents. We reviewed 15 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in patient records and six had errors or information missing. Equipment, medicines and other resources were available and used to assess and manage patients' pain and other symptoms safely.

The specialist palliative care team provided safe care and advice for patients, relatives and staff throughout the trust. The team demonstrated how they learned from incidents and shared learning with others. There was damage to flooring in the mortuary which had been poorly repaired which may have presented an infection control risk.

Incidents

- There had been no Never Events in the specialist palliative care service (a serious, largely preventable patient safety incident which should not occur if the available preventative measures have been implemented).
- The specialist palliative care team reviewed incidents relating to end of life care as a standing agenda item at their quarterly business meeting. Staff said this ensured feedback and learning was shared and understood by the whole team.
- We looked at records of the last specialist palliative care governance meetings held during December 2013 and May 2014. These documented discussions, learning and action plans regarding general risks identified across the trust and specific incidents reported. For example; through incident reporting the team discussed actions taken to improve staff communication and terminology used with families during a patient's last hours of life.
- We visited seven wards. On one ward we saw a medicine error had been identified in an end of life patient's records. We spoke to three senior ward staff about this to establish if this had been recorded as an incident. Reporting incidents is necessary to identify patient safety issues and make any necessary practice or policy changes to reduce similar future harms to patients. This medicine error had not been reported as an incident and one senior staff said 90 per cent of errors of this type were not reported. This was contrary to the trust's incident reporting policy.

Cleanliness, infection control and hygiene

- In one room in the mortuary we saw two examination tables had been removed. One table remained which staff confirmed was still used with deceased patients. The floor where there previously fitted tables had been removed had been filled in with concrete. This concrete was rough, uneven and cracked in places. This surface was not easy to effectively clean. This presented an infection control risk. This did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

Environment and equipment

- The National Patient Safety Agency recommended during 2011 that all Graseby syringe drivers should be withdrawn by 2015 (a device for delivering medicines continuously under the skin). The Graseby syringe driver had been withdrawn from the hospital and staff throughout the trust had been retrained to use the McKinley syringe driver.

Medicines

- Written guidance was available for doctors to prescribe appropriate end of life medicines to manage patients' pain and other symptoms.
- Staff on the wards we visited all told us they routinely kept stocks of palliative medicines for symptom and pain relief
- Records showed those patients referred to the specialist palliative care team had their medicines reviewed by the team. This was done in consultation with other medical staff involved with the patients' care.

Records

- We reviewed 13 sets of patient records. We saw detailed discussions between clinical staff and patients and relatives were recorded sensitively. Records were legible and illustrated clear plans detailing current and planned care which was regularly reviewed.
- We looked at 15 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. We found six of these were incorrectly completed or had information missing. Five of the forms had errors specific to resuscitation. For example, one form had written information stating the

patient did not wish to be resuscitated but the form was ticked to confirm the patient was for resuscitation. On another, the form had been ticked to confirm the patient was for resuscitation and ticked to say they were not for resuscitation. The way this form had been completed was not in line with national guidance published by the General Medical Council.

- During the unannounced inspection visit at the hospital we saw nurses given a safety handover and a handover sheet which incorrectly identified 2 patients as DNACPR. We shared our findings with the senior nurse on site at the time, who agreed to check all of the DNACPR documents on the ward.
- We saw clinical staff used the trust's 'end of life care tools'. These detailed actions for staff to follow once active interventions were considered inappropriate and emphasised comfort and quality of life. These included, stopping unnecessary tests, observations, non-essential medicines and documenting the patient's preferred place of care.
- The trust's end of life care plan included risk assessments of patients' nutrition, mobility and skin integrity. The 13 patient care records we looked at showed these risk assessments had been regularly reviewed.
- A modified version of the trust's end of life care plan was being piloted for use in the emergency department. The purpose of this was to apply the principles of good end of life care to rapidly dying patients and their families. When we spoke to staff from acute departments about this not all of them were aware of this pilot and the alternative records to complete.
- A patient transport DNACPR form was completed for patients being discharged via hospital transport. This was completed and signed by a doctor and ambulance crew. This meant the ambulance crew understood the care required before the patient was formally discharged.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt.
- Relatives told us they had been involved by staff with decisions when patients were no longer able to make decisions independently.

Safeguarding

- Staff were knowledgeable regarding their role and responsibilities to safeguard vulnerable adults and children from abuse and understood what processes to follow.
- Most of the specialist end of life team were in date with the trust's mandatory safeguarding training.

Mandatory training

- The specialist palliative care team provided records of mandatory training completed by the nurses in the team. This training included health and safety, infection control and safeguarding children and vulnerable adults. The records showed seven nurses were in date with more than 90% of the mandatory training. No mandatory training information was available for the two palliative medicine consultants.

Assessing and responding to patient risk

- The trusts end of life care tool incorporated regular reassessments of patients needs to minimise risks and maximise symptom control. We saw risk documents had been reviewed.
- The management of deteriorating patients' care was documented in care records. These showed patients and their relatives were involved with decisions about care.

Nursing and medical staffing

- The specialist palliative care team provided support, advice, training and care to patients and staff trust-wide. The team consisted of 1.4 whole time equivalent (WTE) consultants and 7 WTE nurses (one vacancy). In addition there were two WTE occupational therapists. The team said this was adequate staffing and were reviewing skill mix as vacancies arose.
- The team responded to all referrals from clinicians throughout the trust for adult patients who had complex support and/or complex symptom management needs during end of life care. This included support to families of patients referred.
- The specialist palliative care team screened and allocated all new referrals on a daily basis. Current work and new allocations were reviewed every morning by the team and work was allocated based on patient need and urgency.

Major incident awareness and training

- Mortuary staff had additional facilities available in the event that the mortuary became full.

End of life care

- The specialist palliative care team had not received any major incident planning or training.

Are end of life care services effective?

Good

End of life care was provided in line with national guidance. Patients identified with end of life care needs had their needs assessed and reviewed and had pain and other symptoms managed effectively. Wards had identified end of life champions who received additional training by the specialist end of life team. Ward staff recognised end of life care related to a range of conditions and had training and additional resources to respond appropriately to patients' individual needs.

The specialist end of life team was valued by ward staff. The team were reported to be accessible, responsive and effective in supporting patients with complex end of life care needs and staff training needs.

Evidence-based care and treatment

- The specialist palliative care team had developed an end of life tool/pathway based on the recommendations in the Department of Health End of Life Care Strategy 2008. This provided a framework across the trust for non-specialist end of life practitioners to structure care for patients during the last year of life. This included guidance on end of life medicines and symptom management and where and how patients could be supported in their preferred place of care.
- End of life care followed other national guidance; for example, the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013. For example standards were being met with the provision of a specialist palliative care team who provided seven day working and could be contacted in person or by telephone during all out of hours. Staff on the seven wards we visited said the accessibility of the specialist team had improved the consistency and effectiveness of end of life care for patients
- The specialist palliative care team provided written audit evidence relating to end of life tools developed by the team. These included continued evaluation of action plans related to the five year end of life strategy. For example, a retrospective audit of deceased patients' records (December 2013) had been completed to ascertain how optimum end of life care had been achieved.

Pain relief

- We spoke with the relatives of five patients who told us pain relief had been provided in a timely manner.
- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to promptly manage any changes in patients' pain or symptoms.
- We visited seven wards and on each staff told us they always kept stocks of commonly prescribed end of life medicines. Staff said they did not experience significant delays getting alternative or additional stocks from pharmacy.

Nutrition and hydration

- Patients' records showed those identified as being in the last hours or days of life had had their nutrition and hydration needs evaluated and appropriate actions followed. These records documented subsequent discussions with relatives. Three relatives of patients we spoke with confirmed ward staff had clearly explained all changes in care, including those related to nutrition and hydration.
- The trust's end of life tool included ongoing medical review of patients' nutrition and hydration needs. We looked at five patient care records and saw individual nutrition and hydration needs had been assessed and reviewed and actions clearly recorded.
- We observed patients had drinks and snacks available. Relatives and staff said these were replenished throughout the day.

Patient outcomes

- City hospital contributed to the National Care of the Dying Audit, Royal College of Physicians, 2014. This scored participating trusts against seven organisational and key performance indicators. The hospital had fully met three of the indicators, almost met two indicators, partly met one indicator and not met one indicator. The specialist palliative care team had identified actions,

responsible clinicians and timescales required to improve levels of compliance. This included working with other colleagues to develop shared practice guidelines and training.

- The specialist palliative care team audited records to see if patients had achieved their preferred place of care (Palliative Care Team Annual Report 2013-2014). During October, November and December 2013 the percentage of patients who achieved their choice was; 72%, 78% and 79%. The figures for January, February and March 2014 showed the percentage of patients who achieved their preferred choice of care had decreased to 67%, 49% and 53%. The specialist palliative care team had documented a range of training and education events for trust staff in order to improve these patient outcomes.

Competent staff

- We saw evidence the specialist palliative care team provided regular and ongoing training to different professional groups. These included medical and nursing staff, allied health professionals, medical, nursing and occupational therapy students and nursing assistants. Training subjects included end of life care, anticipatory and end of life medicines, organ donation and the role of the coroner's office.
- All wards had identified end of life care champions for the benefit of patient care. The specialist end of life team provided a rolling programme for identified staff to develop eight core end of life care competencies. These included; diagnosing dying, care plans, communication, comfort, modifying care, symptom control, meeting spiritual needs and care after death. Evaluation records showed staff who had already attended, valued the programme, reporting information was relevant, clear and well delivered.
- Ward staff knew who their end of life champion was and said the additional advice and support given by this person helped to maximise patient care and gave staff increased confidence with sensitive situations.
- The specialist palliative care team said they felt well supported by each other and used the daily team meetings and weekly multidisciplinary meetings for formal and informal supervision, learning and support.
- Four of the specialist palliative care nurses showed evidence of advanced continued professional development in end of life care.

Multidisciplinary working

- The specialist end of life team had a weekly multidisciplinary meeting to discuss end of life patients in more detail and depth and review care and treatment plans.
- The specialist palliative care consultants attended four different condition-specific multidisciplinary meetings every week to advise on end of life care during patient reviews. One consultant said they regularly attended 70% of meetings.
- The specialist palliative care team said they would attend other multidisciplinary meetings on an ad hoc basis when requested by other teams.
- The specialist palliative care team said they supported other health professionals to recognise and consider when patients may be approaching the need for terminal, end of life care.

Seven-day services

- The specialist palliative care team provided a seven day service. The nurses worked Monday to Sunday 8am to 4pm. The nurses provided on call telephone advice from 4pm to 8am. The consultants worked 8am to 4pm Monday to Friday and provided out of hours telephone advice during the weekend.
- All ward staff we spoke with said the palliative care team responded promptly to referrals, with many patients being seen the same day or within 24 hours.
- Care records documented end of life patients had care anticipated to meet needs during the night and weekends. This included medicines and equipment.

Are end of life care services caring?

Good

Compassionate end of life care was provided to patients by ward staff. The patient and relatives of end of life patients we spoke with told us they felt involved with care and were treated with dignity and respect. However, relatives said they were given limited practical support when visiting end of life patients for extended periods of time. The specialist palliative care team had action plans in place to improve the experiences of end of life patients and their relatives.

End of life care

Compassionate care

- Five patients we spoke with said staff had been nice and kind and they had no complaints about care they had received. We observed patients and relatives were treated with compassion.
- Ward staff told us where possible, end of life patients were accommodated in side rooms to increase dignity and privacy for them and those visiting.
- Relatives of end of life patients told us ward visiting restrictions had been lifted and drinks were occasionally offered to them.
- Relatives of end of life patients said limited practical support was available when visiting for long periods. For example, relatives were offered a pillow and blanket but slept in high backed chairs and were not routinely offered any food. Also, despite accessing reduced car parking fees, parking costs had mounted up when it had been necessary to stay at the hospital for extended periods.
- The National Care of the Dying Audit, Royal College of Physicians, 2014 identified quiet spaces were not available in all areas for relatives and friends of dying patients. The specialist palliative care team had action plans to encourage the trust with the development of new quiet spaces.

Patient understanding and involvement

- We spoke with five patients and eight relatives of end of life patients who told us they felt involved and informed with decisions and care.
- We reviewed 13 care records and saw detailed recordings of discussions with patients and relatives. This included discussions relating to medical treatments, prognosis and actions staff should take in response to patients' and relatives' wishes.
- The specialist palliative care team provided written resources for patients and families which were provided by the team or accessible via the trust website. This included information about a range of end of life medicines and information and advice about the last days of life.

Emotional support

- Emotional support for patients and relatives was available through the specialist palliative care team, ward based nurse specialists, the chaplaincy team and patient affairs offices (bereavement services).
- Training by the specialist palliative care team was available to ward staff on communication and end of life care.
- The trust had a dedicated bereavement service. Staff provided support and guidance to the families. Condolence cards were sent to bereaved families.
- Once a year there was a critical care unit memorial service for families of patients who had died. This was a multi-denominational service held within the hospital chapel.
- Families gave positive feedback regarding the bereavement service provided.

Are end of life care services responsive?

Requires Improvement

We assessed this domain to be requires improvement. The discharge process was not effective as staff reported frequent delays, with assessments, planning and transport, including for those patients identified for fast track discharge.

The chaplaincy service was being reviewed. The chaplaincy staff said any reduction in the service could impact on their ability to be responsive to patient needs in an appropriate and timely way.

Patients' individual needs were effectively responded to by ward staff. The specialist palliative care team were responsive to requests to support patients with complex end of life symptoms and care needs.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team had established links with community palliative care services and the clinical commissioning group (CCG). Staff said this promoted shared learning and expertise and enabled complex patients who switched between services to have consistent care.
- One consultant from the specialist palliative care team was part of the end of life strategy group for the local CCG. A key function of this group was to develop service planning and delivery to meet the needs of local people.

End of life care

Access and flow

- End of life care was delivered where required by ward staff throughout the hospital. The specialist palliative care team was accessible 24 hours a day for support and advice regarding patients who had complex care and/or complex symptom management.
- Referrals to the specialist palliative care team were made by ward staff using the trusts IT system or by telephone. The specialist palliative care team met every day to review current work and allocate new referrals, which were prioritised and allocated based on urgency and need.
- Ward staff understood how to make a referral to the specialist team and consistently reported the team responded promptly, usually seeing patients the same day or following day from referral.
- Patients receiving end of life care, who wished to transfer their care home or to an alternative service and, patients identified for fast track discharge, had their individual needs assessed by the discharge liaison team. The team said the service was always busy and unpredictable. Recent reorganisation of these services had resulted in reduced staffing levels. The discharge liaison team said this had resulted in delays in assessments for end of life patients wishing to be discharged from hospital. No audit or evaluation information was available regarding the effectiveness of the service. We spoke with the specialist palliative care team and ward staff who confirmed end of life patient discharges could be delayed for days or weeks.
- Ward staff said further discharge delays of days or weeks impacted on end of life patients. Staff said this was due to the time taken by the local authority to arrange the appropriate care packages for patients.
- Staff said end of life patients with completed hospital discharge assessments and plans in place, did not always get transferred home for their preferred place of care. This specifically affected end of life patients being discharged home via ambulance. Patients whose home included steps or stairs required three ambulance crew. Ward staff said if the ambulance crew assessed the steps or stairs as having health and safety implications the end of life patient was taken back to the hospital A&E department. Staff said the patient would then be admitted to a ward where there was a bed vacancy.
- Planning and effectively responding to an end of life patients' choice for their preferred place of care and death is part of national best practice guidance. This includes; One Chance to Get it Right, Department of Health, 2014 and the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013.
- There was a policy in place for the rapid release of a deceased patient from the mortuary. Medical and mortuary staff demonstrated an understanding of the processes to follow. This enabled the cultural wishes of families to be respected.

Meeting people's individual needs

- The specialist palliative care team was accessible 24 hours a day for support and advice for patients who had complex care and or complex symptom management.
- The chaplaincy service responded to the spiritual needs of end of life patients and their families. This included providing last rites services. The chaplaincy service had a multi-faith prayer room and provided multi-faith services and individual spiritual support and guidance as required
- The chaplaincy service said recent reviews meant the service could be reduced. The chaplaincy team said they were considering how to manage any potential service or staff reduction and the subsequent impacts on patients needs. The team were concerned changes would impact on their ability to meet the standards set in the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013.
- Translation services were available for end of life patients and relatives.
- We saw patients and relatives had been frequently consulted and their wishes had been clearly recorded in care plans.

Learning from complaints and concerns

- End of life complaints were reviewed as part of the quarterly specialist palliative care governance meetings. Minutes from the last meeting dated May 2014 showed complaints and patient feedback had been discussed and actions planned to make end of life service improvements.
- The specialist palliative care team said any patient concerns or issues were dealt with at the time they were reported. Staff said concerns were also discussed during

the team's daily morning meeting and if necessary were discussed in more depth and detail at the monthly multidisciplinary meeting. Staff said they learnt how to improve practice by sharing experiences.
- Information was available throughout the hospital to inform patients and relatives how to make a complaint.

Are end of life care services well-led?

Good

The staff we spoke with on wards valued the expertise and responsiveness of the specialist team. The specialist palliative care team was enthusiastic and passionate about the quality of end of life care provision and developing the skills of others. There were governance processes in place to monitor the quality of end of life care strategy. The specialist palliative care team demonstrated learning and changes in practice as a result of audits and complaints.

Vision and strategy for this service

- We spoke with 14 staff on seven wards at City hospital. This included doctors, nurses, allied health professionals and health care assistants. Staff demonstrated a good understanding of the trust's end of life care pathway and how and when it should be used with patients.
- The specialist palliative care service had clear strategy and work plan priorities for the present and future. Palliative care priorities were discussed and recorded by the specialist team during their monthly business meetings.
- An end of life strategy group had also recently been coordinated by the specialist palliative care team. One meeting had been held during June 2014 with further meetings planned on a quarterly basis. The trust's chief nurse was nominated as chair and membership was being extended to include other disciplines and services. For example; a geriatrician, patient and carer representatives, a surgeon and district nursing lead. Staff said the aim of this group was to monitor, evaluate and plan and progress the trust's end of life strategy. In addition standing agenda items were documented to include; audits, key performance indicators, complaints and incidents, education, communication, the Mental Capacity Act and ethics. The last meeting minutes documented the intent to share outcomes from the meetings with different hospital directorates, GP's and the local clinical commissioning group (CCG).

Governance, risk management and quality measurement

- The specialist palliative care team reviewed clinical standards and risk and quality indicators as standing agenda items during the monthly business meeting. These included incidents, audits and quality improvement programmes. Staff said they adjusted practice as a consequence of incidents and complaints. This included the way in which they shared their learning and clinical practice with others. This information was documented in meeting minutes. For example, how to improve the transfer of end of life patients to alternative services during out of hours.
- End of life patient care was monitored by senior staff on wards. If staff learning needs were identified they requested support or training from the specialist palliative care team.

Leadership of service

- The senior specialist palliative care staff were described by colleagues as knowledgeable, supportive and passionate about end of life practice. Several staff members of the palliative team said the team was the best they had ever worked in because of team's good communication and excellent peer support. The specialist palliative care team had regular informal and formal supervision during daily and weekly meetings.
- Staff throughout the trust said the specialist palliative care team were visible, approachable and accessible. Ward staff we spoke with valued the expertise and responsiveness of the specialist team and said patient outcomes and clinical practice improved as a result of the support provided.

Culture within the service

- The specialist palliative care team was passionate about the quality of end of life care for patients and relatives. The team said they felt supported by the trust board.
- The specialist palliative care team promoted a culture of sharing knowledge and developing the skills of others. This was done on a 1:1 basis, small groups or during larger training or end of life awareness events.

End of life care

Public and staff engagement

- The specialist palliative care team was evaluating ways to more effectively collate the views of patients and bereaved relatives.
- Staff who attended training courses facilitated by the specialist palliative care team were asked their opinions of both content of the training and style of presentations. The majority of this feedback was positive. The specialist palliative care team said feedback was used to plan and improve future training sessions.
- The specialist palliative care team worked collaboratively with other services to improve end of life care for patients. This included community end of life and primary care services including district nurses and hospices.
- The specialist palliative care team conducted a bereavement survey using a questionnaire with bereaved relatives between May 2013 and November 2013. This resulted with the completion of 165 questionnaires. Most relatives of deceased patients were satisfied with the end of life care provided. For example, 77% of relatives felt the patient's wishes had been considered and 78% felt they were given enough information after the death. An action plan was in place to address areas identified as requiring improvements. This included staff communication skills and how information should be collected in future from bereaved relatives.

Innovation, improvement and sustainability

- The specialist palliative care team was using national guidance to plan, improve and sustain the end of life services provided in the hospital.
- The emergency department was piloting a different end of life form/pathway which had been developed by the palliative care team. It was developed to identify and support patients who were dying within the emergency department. It had been use for a few months. However, we were aware that communication of the initiative needed to be improved because not all the stakeholders were aware of its implementation. The specialist palliative care team provided a range of ongoing end of life training programmes for staff. This had been done and continued to be planned for the future in order to skill up increasing numbers of staff throughout the hospital to be able to provide good end of life care for patients.
- One of the specialist palliative care consultants was a member of the end of life group for the local clinical commissioning group (CCG). This included engaging with local people and planning end of life services.
- The specialist palliative care team said their ability to follow and deliver on action plans identified within the trust's end of life care strategy was dependent upon maintaining the current skill mix.

Outpatients and diagnostic imaging

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

Information about the service

Sandwell and West Birmingham NHS Trust run a range of outpatient services from Sandwell Hospital, City Hospital, and in community settings. At Birmingham City Hospital, the outpatient clinics are sited in the Birmingham Treatment Centre. They are located on the ground and first floor, with reception desks located on the ground floor and in waiting areas. There is a main reception area on the ground floor, with additional reception desks on the first floor. During our inspection, we observed a range of outpatient clinics, including haematology, breast, orthopaedic, respiratory, children's, oncology, chest and chemotherapy.

The trust operates a diagnostic imaging department across both sites, which undertakes X-rays, CT (computerised tomography) scans, interventional imaging, fluoroscopy, ultrasound and nuclear medicine. Management and staffing rotate across both acute hospital sites (City and Sandwell General).

We met with 33 staff, including receptionists, nursing staff, health care assistants, radiology staff and consultants. We spoke with 26 patients and relatives. We looked at the patient environment, and observed waiting areas and clinics in operation.

Summary of findings

We observed that patients were cared for in a clean and hygienic environment. There was a system in place for reporting incidents, but this was not always being used in a consistent manner.

In one area, the safety of patients was being compromised. In some areas we saw practices that did not ensure the privacy and dignity of patients.

The trust was struggling to meet the demand for outpatient appointments, so overbooking of clinics was commonplace, causing delays for patients. The impact of this was not being monitored locally.

Staff were well regarded by patients, who were positive about the care they received.

The managers of outpatient departments were accessible, and the majority were respected by staff.

Within diagnostic imaging services, there was a breach of the Ionising Radiation (Medical Exposure) Regulations 2000. There were issues regarding the lack of staff training records.

Reporting times for completed imaging were delayed. There had been service changes within imaging service, which had put pressure on an already short-staffed department.

Management was still under development, with some managers recognising their limitations. Forward

planning was not in place either, but the trust had recognised this, and were using an outsource consultancy to produce a toolkit to improve service in the future.

Are outpatient and diagnostic imaging services safe?

We observed patients being cared for in a clean and hygienic environment. There was a system in place for reporting incidents. Staff were aware of how to report an incident, but rarely received feedback. Repeated incidents had not been effectively responded to.

Staff had an awareness of the Mental Capacity Act, but did not have a working knowledge and confidence to implement the requirements of the Act. Training on the Mental Capacity Act was only provided for senior members of the nursing staff.

Staff had received safeguarding training, and were familiar with reporting systems.

Patient records were not held securely.

Within the imaging department we judged that they were in breach of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000. The CQC IR(ME)R inspectors will contact the trust regarding regulatory action. Incidents had occurred and been reported appropriately. Training records had not been adequately maintained for staff. There was long-term sickness, which was impacting on staffing levels.

Incidents

- An electronic incident recording system was in place, which the senior nurse was trained to use. Staff informed us that they reported any concerns or issues directly to the senior nurse.
- We were informed by staff that there had been five incidents reported over the last 12 months. All of these incidents related to the escalator in the main outpatients area. There had been no change as a result of the reporting of the incidents, resulting in a continued risk to patient safety. Following the inspection the trust told us they responded and arranged repairs each time the incident was raised regarding the escalator.
- Staff were aware of how to report an incident. The manager received feedback from trust-wide incidents, and would feedback to staff if it was relevant to their work. However, some staff reported not receiving feedback.

Outpatients and diagnostic imaging

- There had been no 'never events' reported in the outpatients department. (A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.)
- Patients told us that they felt safe in the hospital.
- During our visit we witnessed a patient fall in the reception area. Emergency treatment was provided, but we were told that the resuscitation team "only do transfers if there is a risk to life". After an initial assessment, an ambulance was called (this was supplied by a different provider), but did not arrive until over one hour after the incident had first occurred. During this time the patient was cared for on the floor, screens were used to provide some privacy. No pain relief was given during this time, despite the patient being in some discomfort .

Diagnostic Imaging Department

- 58 radiation errors were recorded across Sandwell General and City Hospital in the past year, this was about average when compared to other trusts.. Over half were due to incorrect/unnecessary referrals and lack of robust identification procedures by the imaging staff. Where required under the IR(ME)R (Ionising Radiation (Medical Exposure) Regulations 2000), exposures reaching a nationally-agreed threshold for external reporting were notified to the inspection team, and appropriate investigation was being carried out. These included firm action plans and a governance structure surrounding the wider learning brought about following incidents.
- Across both sites all staff spoken to were aware of the need to report incidents, concerns and near misses. These incidents were investigated, and staff involved were included in this process. All incidents were documented on the trust software system for reporting, and outside organisations were informed when applicable.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Clinical areas appeared clean, and there were systems in place to monitor checks of cleanliness.
- Toilet facilities were clean.
- Hand-hygiene gel dispensers were located at the entrance to each clinic, and were prominently signposted. Checks were in place to monitor hand hygiene.
- Patients told us that they considered that the hospital was clean.

Environment and equipment

- The environment was relatively new and was bright and airy. It was well designed for its purpose.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment available in most outpatient areas.
- Resuscitation trolleys were located in the outpatients department. All resuscitation equipment, including oxygen, should have been checked on a daily basis; this had been the case up to the day of inspection when responsibility was transferred to a different member of staff. This transition was not successful and there was a short gap in checks.
- All staff have basic life support training, and some had received intermediate life support training.
- Checks were in place to monitor the safety of the environment.

Diagnostic Imaging Department

- Equipment was regularly maintained, and records of maintenance were kept. These records were in relation to medical physics equipment servicing and maintenance.
- Radiographer additional quality assurance was not undertaken on a regular basis. This was confirmed by the trust's Radiation Protection Adviser (RPA), who informed us that there were actions surrounding closer work with radiology staff, in order to improve compliance in this area. However, the equipment always met its annual maintenance and safety checks, and therefore there was no concern that equipment may be faulty or unsafe in any way.

Medicines

- All drugs used by the department were stored in a locked cupboard. No controlled drugs were stored in the department.

Records

- In outpatients, we observed patients' notes on trolleys outside consulting rooms. Staff were not always in the

vicinity, so records were vulnerable to theft and unauthorised access. This issue was not identified as an information governance risk in the departments risk register.
- In the oncology unit, space for notes was, at times, limited, with some notes observed on the floor in the corridors.
- Staff told us that when they did not have the full set of a patient's notes they made up temporary sets of notes by obtaining copies of recent letters that are stored on the database; but these did not contain all of a patient's records. When doctors or nurses do not have access to complete patient records it can compromise their ability to make robust decisions about care and treatment.

Diagnostic Imaging Department

- There were no staff training or development records available to view, except in CT. This included no IR(ME)R update training, or equipment competencies, for any operator throughout all other modalities. The understanding was that all staff were adequately trained in the safe use of X-ray units, but there was no documentary evidence to substantiate this. This applies to all duty holders as cited within IR(ME)R.

Safeguarding

- There was a good awareness of adult and children's safeguarding. Staff stated that they were well supported by the trust's safeguarding team, who they could contact for advice.
- Information on safeguarding was displayed in some clinic areas.
- No safeguarding referrals had been made by general outpatients in the last 12 months.
- Safeguarding training was included as part of the mandatory training package. All staff received level 1 & 2 safeguarding children training. All staff received level 1 adult safeguarding training, but only the senior nursing manager (band 7 and above) received level 2 adult safeguarding training. The trust have recognised that 'band 6 staff, with their managers, should consider the relevance of the training (level 2) to their working environment' (Safeguarding Adults Policy Aug 13). Due to the level of autonomy that the trained and untrained staff have within the department, level 2 training should be offered to staff.
- All staff we spoke to were aware of their responsibilities in safeguarding children and adults.
- The safeguarding policy was available for staff via the intranet.

Mandatory training

- The training records for general outpatients identified who was up to date with their training, and where there were gaps.
- Not all mandatory training was up to date. Fire safety awareness, infection control, information governance, and basic life support were areas of particular concern. The manager was aware of these shortfalls, but staff could not undertake training due to the impact that this would have on staffing levels.

Diagnostic Imaging Department

- We saw records which demonstrated that mandatory training of all imaging staff was currently at 90.9% for the previous 12 months. This was below the trust standard, but considered to be good in comparison to other hospital departments. Of the radiographic staff, 86.8% had undertaken a personal development review, which is a 12 month rolling programme. This is below the trust's recommended level of 95%, however following the inspection the trust made us aware that this was a year to date figure
- Medical appraisal and revalidation rates were 100% for medical radiologists. This meant that staff had the required skills and qualifications to maintain their registration.

Assessing and responding to patient risk

- General outpatients had a risk register; however, information governance and mandatory training risks were not included.
- Despite five accidents whilst patients had been using the escalator, no action had been taken to address the risks, resulting in a continued risk to patient safety.
- The fracture clinic did not have sufficient appointments to meet British Orthopaedic guidelines, of seeing all patients with fractures within 72 hours of their diagnosis. We saw evidence that patients were not being seen up to 10 days after their fracture had been diagnosed.

Diagnostic Imaging Department

- No exposure factors or diagnostic reference levels were listed in any X-ray room, apart from computerised tomography (CT); it is viewed as best practice that these are available and used clinically for guidance. Automatic

exposure factors were used in all X-ray rooms we viewed. It is acceptable practice to use automatic exposures, as long as the exposure parameters have been optimised, which they were in this instance. This was discussed with various members of staff, who informed us that they were aware of the correct range of exposures required for each examination, and the expected dose for standard patients and projections.

Nursing staffing

- In general outpatients all staff reported that staffing levels were insufficient to cover all the clinics adequately.
- Staff were frequently required to work in excess of their contracted hours. Overtime was not paid. It was difficult to take time back in lieu due to staff shortages.
- Over the last month, the department had required at least one bank staff member to be used on a daily basis, but no agency staff were being used at the time of the inspection.
- Not all clinics had trained nurse cover. This was decided by the nurse manager, and was determined by the level of clinical intervention required in each clinic
- The manager of general outpatients had reported concerns about staffing to senior managers. They had responded that staffing was currently being looked as part of the outpatients workforce review which was due to be concluded on November 17th 2014.
- Staff from the oncology unit reported that patient safety could not be assured due to severe staffing shortages.
- The unit was currently running only as a result of staff working additional hours. Staff regularly came into work early, and worked over their normal hours at the end of the day, but they were not allowed to claim overtime. Staff reported that it was very difficult to take time back due to the shortage of staff.
- Volunteers were not used in outpatients.

Diagnostic Imaging Department - Staffing

- There is a 4.45% sickness absence recorded for imaging staff across both sites, which was considered high within the trust. At the time of the inspection, no actions surrounding this were seen.
- There had been an increase in agency nursing usage across both acute hospital sites during this financial year, due to long-term sickness.
- At the time of the inspection, there were three vacant radiographer posts and two vacant radiologist posts. These had not been advertised, as senior management within the department had stated that there was a need to make substantial savings, and the biggest spend was staffing. The current impact of this decision was not fully known. However, we did see that a recent decision to extend the hours of the service had resulted in a reduction in the number of rooms able to be staffed to undertake imaging.
- Due to the five outstanding posts and long-term sickness rate of 4.45%, we considered that the additional pressure on the remaining staff could not be maintained long term, without reorganisation of the service. Both imaging departments were undergoing a staff review at the time of the CQC visit. Also, patient safety could be compromised if this situation was allowed to continue long term.

Major incident awareness and training

- The outpatients manager stated that they were involved in major incident planning when necessary.

Diagnostic Imaging Department

- We noted that there was a major incident procedure for imaging, which was also part of the whole hospital major incident procedure.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There was good multidisciplinary working in the hospital and community settings, to provide joined–up patient care.

The diagnostic imaging department were not working within guidelines regarding reporting timescales. This had resulted in the department having to use third party organisations to decrease the backlog, and their own staff were being paid a premium to reduce the backlog of unreported examinations.

Staff had a good system in place, enabling them to compare previous images with the most recent for reporting purposes.

Within the imaging department, the backlog of reporting had meant that the department had had to seek the

support of a third party contractor, to help reduce the backlog of accumulated work. All radiologist reporting sessions cover examinations undertaken at both hospitals within the trust.

Evidence-based care and treatment

- The respiratory outpatients used the NICE quality standards on chronic obstructive pulmonary disease (COPD) as their model of care.

Diagnostic Imaging Department

- The national two week wait timeframe for cancer patient examinations was also adhered to. However, the reporting of these examinations did not comply with usual report turnaround times, which should be five days. Instead, there was a four to five week turnaround time for routine reports.
- All ultrasound examinations were reported within 24 hours by the advanced practitioner sonographers and radiologists.
- All interventional imaging was reported within 24 to 48 hours by the radiologists.
- Extra reporting sessions were being undertaken by the radiologists as part of waiting list initiatives, and they received extra payment for this work. This meant that they could reduce the backlog.
- Standards of reporting were discussed with senior management, as were the number of examinations reported per session. We were told that the number of exams reported was low, and the management was trying to increase the number of reports to reduce the backlog. The additional consequence would be a reduction in spend on the extra sessions.
- The radiologists were not completing the recommended number of reports per four hour session. For example, they reported on 45 X-rays, when the Royal College of Radiologists (RCR) suggests a standard of 75 exams in a four hour session. An outsource company were being used to undertake some of their plain film reporting.
- The outsource company was not being used for CT and MRI (magnetic resonance imaging) reporting. This enabled staff to maintain their skills in these two modalities.
- The trust utilised the services of another provider to review all of the complex head examinations undertaken. These were discussed during a twice weekly multidisciplinary team meeting. There was no radiologist representation from the trust at these meetings. This meant that any changes to reports were not discussed with the Sandwell or City radiologists, or changed on their radiology computer system. No learning and development was therefore currently taking place at this level. Also, any report changes made by the other provider, were only made in patient notes.
- All A&E, ultrasound, nuclear medicine and interventional exams were reported within 24 to 48 hours.
- Two weeks after the inspection, the trust informed us that some of the reporting times had reduced, namely CT and MRI scans. Of unreported CT and MRI scans, 6% and 8% remained unreported at five weeks. The trust had identified that by November, they would have improved further to a two week maximum time to report for non-urgent work.
- Electronic vetting of all request forms was in place throughout imaging, and worked well. Standard procedure was that previous images were viewed during justification, and this was routinely undertaken.

Pain relief

- Staff told us that they could give Paracetamol to patients if they were in pain, but all other painkillers were required to be prescribed.

Patient outcomes

- Patients we spoke to were positive about the outcomes of their treatment. Patients told us that treatment was effective and met their needs.

Competent staff

- There was a structured induction programme in place for new staff; however, no new staff had been recruited to general outpatients for some years.
- In general outpatients there was an appraisal system in place, and records showed an appraisal completion rate of 98%.
- In general outpatients the last team meeting had taken place three months ago. Notes of staff meetings were available to staff who did not attend.
- Staff were kept up to date by trust-wide communications. The nurse manager sent out emails when key messages needed to be communicated.
- In general outpatients clinical supervision did not take place. Senior managers had suggested that a trust-wide 'governance day' would be arranged, when individual staff and teams could have dedicated time to reflect on their practice; however, this had not yet happened.

Outpatients and diagnostic imaging

- Staff in general outpatients reported that access to training was difficult due to staffing levels.
- Allied health professionals reported that access to training was good, apart from speech and language therapists.

Diagnostic Imaging Department

- There were three advanced practitioner radiographers, who undertook reporting of A&E generated exams, and staff spoken to told us that they were encouraged to develop their skills. The trust was unable to demonstrate that training or competency checks had been undertaken, because they had not maintained records of them. This was the situation across both sites as the advanced practitioner radiographers worked across both sites.
- There was no clear guidance for new staff available in the X-ray rooms regarding exposure parameter guidance, or information surrounding expected dose values. It is a regulatory requirement that diagnostic reference levels are established, and audited with regular review; although a dose audit programme was established, the reference levels were not displayed, and therefore not available to staff to refer to within the X-ray department.
- There was little sub-specialisation amongst the radiologists. They were all general radiologists, although two or three of them were willing to increase their knowledge of neuro-radiology, as they were performing complex head CT and MRI examinations.
- Some senior managers admitted a lack of knowledge surrounding the radiation regulations, and were aware that they needed to familiarise themselves with IR(ME)R.

Multidisciplinary working

- Some clinics were jointly run by consultants and nurses, and some only by clinical nurse specialists.
- Patients told us that where they received care from different services in the hospital, staff were aware of this.
- All staff reported good working relationships with community teams.
- We saw examples where staff engaged with allied health professionals, general practitioners and community teams.
- Allied health professionals stated that effective integrated working took place across departments.
- In the lung clinic there was an effective patient pathway between hospital and community services.

Seven-day services

- All clinics were held on weekdays, with some additional out of core business hour clinics organised to meet demand and waiting time targets.

Access to information

- Patients we spoke with stated that they felt they had been involved in decisions regarding their care.
- Patients told us that they had received information about their conditions.
- A patient support centre was located on the ground floor of outpatients. The centre was open to the public between 10am and 4pm. It provided a wide range of patient information, alongside responding to patient and visitor queries. The centre responded to between 180 and 200 queries a month.
- There was a wide range of appropriate leaflets available in the breast unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Some staff had an awareness of the Mental Capacity Act, but did not have a working knowledge and confidence to implement the requirements of the Act. Staff were aware of how to seek help and support. This could result in staff not ensuring that patients had either a best interest assessment, or persons appointed to act on their behalf involved in their care, if a patient did not have appropriate capacity.
- Training on the Mental Capacity Act was only provided for the senior nurse manager in general outpatients, who cascaded this to other staff.
- Allied health professionals had a good understanding of the Act and its implications to their work. They were aware of how to access support if required.

Are outpatient and diagnostic imaging services caring?

Good

Patients were treated with dignity and respect.

Staff were well regarded by patients, who were overwhelmingly positive about the care they received.

Outpatients and diagnostic imaging

Compassionate care

- Throughout our visit we witnessed patients being treated with compassion, dignity and respect. One patient spoken with said that staff "are very good here, always helpful".
- All outpatient departments had suitable rooms for private consultations. Clinic consultations took place in rooms with the door closed.
- In general outpatients there were measurement rooms, but at busy times some weight and height measurements were undertaken in the corridors, which compromised patient's dignity and confidentiality.
- Patients we spoke with all felt that the outpatients department was very caring and were complimentary about the service.
- Patients we spoke with told us that they felt they had had their treatments and procedures explained to them.
- Chaperoning arrangements were in place. Doctors and nurses decided if chaperoning was necessary. When patients requested a chaperone, one would be provided, but patients were not informed of their right to a chaperone, either before or during a consultation. Due to the nursing staff shortages, the provision of chaperones often led to additional waiting times for patients.

Diagnostic Imaging Department

- The radiographic staff interaction with patients, which we observed during this visit, was professional, informative and compassionate at all times.

Understanding and involvement of patients

- Patients we spoke with stated that they felt they had been involved in decisions regarding their care.
- Patients told us that they had received information about their conditions and medications.
- Patients also told us that relatives or carers were included when they wanted them to be. This included joining them in the clinic rooms.
- One patient spoken to said "they always ask me if it is ok to do the treatment, they explain things and answer questions".

Emotional support

- Many staff had worked at the hospital for some years, and were known to some of the patients. This helped them to build a trusting relationship with staff.
- We observed staff supporting patients in a compassionate manner.
- We saw examples across most departments where patients were referred on to clinical nurse specialists. A number of clinical nurse specialists regularly held their own clinics across the outpatient departments.
- Patients told us that relatives or carers were included when they wanted them to be. This included joining them in the clinic rooms. A relative spoken to said "my wife comes here, she gets worked up but they always say I can go in to see the doctor with her".

Are outpatient and diagnostic imaging services responsive?

Inadequate

We judged this domain to be inadequate. The outpatient environment was modern and well planned. However recliner chairs were available in the oncology outpatients, but only four of the 18 were in usable order.

Patients were happy with the treatment and care they received, but were often kept waiting beyond their appointment time. The trust were struggling to meet demand for appointments. There was no mechanism in place to measure the access and flow in the department.

The trust did not always fully respond to patient complaints. There was no structured support in place for people with dementia and learning disabilities.

Within imaging, changes had been made to improve access to the service, but due to staffing, this had not been fully achieved.

Service planning and delivery to meet the needs of local people

- Patients received written notice of their appointment that informed them of where to go when they arrived at the hospital. Contact numbers were provided if patients were uncertain of anything before their visit. It also informed them as to what they would need to bring with them, or if they were required to visit another department for tests.
- The respiratory physiology clinic had changed its operating times to accommodate earlier appointments following poor attendance levels and feedback from patients.

Outpatients and diagnostic imaging

- There was no use of pre-booked X-rays to reduce the length of waiting times in the X-ray department and in outpatients.
- The number of patients who were seen within 18 weeks of referral was above the national average.
- The planning of clinics was mainly based on historical practice, and on the availability of consultants and the drive to achieve the 18 week referral to treatment target. There had been no recent review to assess current and future capacity. The trust was aware of this, and planned to undertake a review in the future.
- To ensure that each clinic had a limit on the number of patients booked in, a template was used for booking appointments. However, staff reported that this was not always used, and that clinics often exceeded the prescribed numbers. This often resulted in clinics over-running, resulting in patients experiencing long waiting times, and staff working over their prescribed hours.
- Senior managers had been frequently informed about the over-booking of fracture clinics. No action had been taken in response to this matter.

Diagnostic Imaging Department

- Staff hours had been changed recently, to improve accessibility to the service for patients. The working days had been elongated to a 12 hour shift pattern during the day. Staff told us that this resulted in rooms needing to be closed due to staffing level safety issues. This was because there were gaps in the number of staff available during the core hours of the working day. This put more pressure on staff to undertake the same workload in fewer rooms across both sites, but more often at Sandwell. Evidence of staff rotas, and room capacity and demand were seen as part of the inspection.
- All A&E patients were X-rayed in separate X-ray rooms next to the A&E department, so no major trauma patients were taken to the main imaging department.

Access and flow

- Patients told us that they were happy with the treatment they received, but were usually kept waiting beyond the time of their appointment. Most patients we spoke with were tolerant, and accepted if they were not seen at their scheduled appointment times.
- In the entrance of the oncology clinic there was a notice stating 'we apologise for any delays, your patience would be appreciated, thank you'.
- In the oncology clinic up to 28 patients were brought in between 9am and 10am. This can lead to some patients waiting up to three hours for their treatment. The trusts non-compliance with acute oncology standards was recorded in the corporate risk register, and plans were in place to address this issue.
- Access and flow within the outpatients department was not being adequately measured. The numbers of clinics that started late or over-ran was not known by senior staff within the outpatients department. Waiting times in clinics were not systematically measured.
- The trust provided patient transport services. Staff reported that appointments were sometimes cancelled due to patient transport issues, such as a patient not being ready for transport. There were also examples of excessively long waiting times to take patients home.
- Outpatient clinics were made up from the separate directorates within the trust, such as oncology and children's, alongside general outpatients, including surgery and medicine.. A meeting chaired by the CEO was undertaken fortnightly where outpatient's performance was discussed.
- In the neuro physiotherapy clinic, concerns had been raised with the trust regarding the length of time that patients had to wait for follow-up appointments after joint injections. The three month follow-up target was regularly missed, with eight patients waiting six months. The trust had not yet responded to this concern.
- The number of patients who did not attend their appointment was lower than the national average.

Diagnostic Imaging Department

- There was a backlog of routine computerised tomography (CT) scan reporting of examinations which were between four to five weeks old. The usual turnaround times for reporting is five days.
- Within the staff rota, we were able to confirm that there were two general radiographers, plus one CT-trained radiographer, working through the night, from 8pm to 8am. There was also a radiology registrar on-site for reporting CT exams throughout this timeframe. The staff worked across sites but the scanners were not always available on both sites simultaneously due to staffing shortages.

Outpatients and diagnostic imaging

Meeting people's individual needs

- Overall, there was good access to interpreters. The trust had its own bank of interpreters who could be accessed by outpatients. If GPs flagged the need for an interpreter in their referral letters, then one could be booked in advance.
- Allied health professionals reported some difficulties in accessing interpreters across the hospital.
- Staff informed us that patients with complex needs were fast-tracked through the department to avoid any delays.
- The trust had a network of dementia co-ordinators and champions. Staff contacted the trust dementia leads if they had any concerns. Dementia awareness training was not mandatory.
- There was not a routine process for screening for dementia.
- Staff told us that there was no learning disabilities awareness training.

Diagnostic Imaging Department

- There were a number of information notices for patients in different languages in the waiting areas. All staff were aware of the interpreter service offered within the hospital, which was used frequently when required.
- There were separate changing cubicles for male and female patients in computerised tomography (CT), and patients in other areas were provided with dressing gowns, and were encouraged to remain in the changing cubicles until called into the imaging rooms.

Learning from complaints and concerns

- Over the last 12 months there had been one formal complaint about the general outpatients department that was currently under investigation.
- The manager informed us that any issues were dealt with at the time that they arose. No record was kept of these incidents. Patients were referred to the Patient Advice and Liaison Service (PALS) if necessary.
- There were complaint leaflets available in outpatient departments.
- Staff were aware of how to support patients if they wished make a complaint.
- Most patients we spoke with were not familiar with the complaints process, but said that they would raise any issues directly with staff.
- Some of the patients we spoke to were not happy with the response from the trust to their complaints.
- Conflict resolution was included in the mandatory training programme, which nearly all staff in general outpatients had completed. Most staff spoken with had experience of managing confrontations in the centre.
- Only the senior manager in general outpatients had completed investigation of incident, complaints and claims training.

Diagnostic Imaging Department

- All incidents were discussed at clinical governance meetings, and changes were made to the service if necessary. Action plans, review, and revision of policies and procedures were seen during the inspection, and minutes of IR(ME)R governance, and clinical governance meetings, were also inspected.

Environment

- Birmingham Treatment Centre has been in operation for eight years. The building is modern in design, creating a light and spacious environment.
- Drinking water was available for patients in all clinic areas.
- All signs in the centre were clear, and signs in languages other than English were seen.

The patients in the oncology unit frequently had extended waits for their treatment. There were 18 reclining chairs in the department, but only four worked safely.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We assessed this domain to be inadequate. There was a lack of vision or strategy. The service was part way through a change programme but staff felt the targets were unrealistic and did not take into account the complexity of the service.

Service governance systems were not strongly established. Incident and risk management processes needed to be improved.

A workforce review had had a negative effect on staff morale within the service.

Communications across the trust had recently improved.

Outpatients and diagnostic imaging

Communications regarding the change programme had not always been timely and effective. Managers in the outpatients department were accessible and well regarded by staff.

Within the imaging department, leadership needed to be developed further to enable all staff to be supported to deliver the service effectively. The management needed to develop their analysis of service delivery, to ensure future plans met the needs of patients and staff.

Vision and strategy for this service

- Not all staff were able to describe the vision and strategy for the future of the trust. Allied health professionals had a good understanding of the trust's vision.
- A change programme was currently in place for outpatients, called 'The Year of the Outpatient'. This project aimed to improve patient experience of using outpatients, by modernising the systems and processes currently in place. A survey of patient opinion had been completed. Progress on the subsequent targets within the change programme had not been achieved. Senior managers reported that the rate of change was not always realistic, and plans did not fully reflect the complexity of the outpatients service.
- Progress on the first targets within the change programme had not been achieved. Senior managers reported that the rate of change was not always realistic, and plans did not fully reflect the complexity of the outpatients service.
- Not all staff in outpatients were aware of the change programme. This is in spite of the Trust newspaper reporting the aims and work streams of the project.
- Alongside the change programme, a workforce review had also been undertaken. The outcome of this review had identified the need to reduce the number of trained nurse posts by two in total across the City and Sandwell hospitals. The number of health care assistants would also be reduced. Staff reported fearing for their jobs, which was adversely impacting on the morale of some staff.

Diagnostic Imaging Department

- There was no clear vision or strategy in the imaging department. The senior managers were waiting for the productivity review report, which was being produced by a outsource consultancy to bring about changes in the departments.

Governance, risk management and quality measurement

- Incident reporting was inconsistent. When incidents had been reported, the trust did not always respond.
- Some staff were not familiar with the mental capacity policy and how to implement it.
- There were no governance procedures to monitor the frequency of overbooked or late-running clinics, or waiting times. Therefore, the impact was unknown, and no actions were taken to address the issues.
- The general outpatients risk register did not capture all risk issues, such as information governance and mental capacity.
- During April and December 2014, the trust had asked all patients attending outpatients about their experience. The majority reported that their experience had been very good.

Diagnostic Imaging Department

- One senior department manager stated that there was currently no forward planning in the department; this meant that room lists could be cancelled at the last minute, due to radiologists taking planned leave. It was also stated that this was being examined by an outside consultancy firm, as the department was undergoing a productivity review, and they expected to receive an imaging toolkit, which incorporated forward planning and standards of working as a result of the review.

Leadership of service

- Most staff we spoke with told us that their immediate line managers were approachable. The outpatient nurse manager told us that there was an open door policy.
- Most staff reported feeling well supported by their managers. Some staff did not feel well supported by their managers, particularly when managed by staff from other specialties, due to a lack of knowledge and understanding about profession-specific issues.
- Staff stated that the workforce review had not been handled sensitively, with confusing messages and changing timescales. This had adversely impacted on morale.
- Allied health professionals reported that changes were sometimes made very quickly, without sufficient time to reflect and fully consider implications of the change.
- Some staff recognised that new ways of working could open up positive opportunities.

- No member of the trust board had visited the centre, despite the implementation of 'The Year of the Outpatient' programme.
- Some staff reported not feeling valued by the trust.

Diagnostic Imaging Department

- Some of the managers were newly in post, and described an absence of leadership in the department for 18 months prior to their employment. One of the managers told us that they thought that this was the main reason for the current position of the department lacking in any leadership or direction.
- Some senior managers stated that they could benefit from training and support to improve their management styles. They felt this was required if they were to make the service more responsive to the needs of the patient and other clinical colleagues. Following the inspection the trust informed us that a leadership development programme was in place and representatives from imaging were represented.
- During the group discussions with the radiographers, leadership was one of the topics raised, and the staff felt that they were not well-led. Although they had good working relationships with the radiologists, they did not feel that the clinicians took responsibility for the service.
- The staff stated during the focus group that the managers were not visible on the 'shop-floor', but were approachable in offices. They felt that the band 7 radiographers ran the departments, producing the working rotas, and were around for advice and support when needed.

Culture within the service

- We observed staff culture that was respectful and advocated for patients. Staff offered a caring service.
- Staff in outpatient departments spoke positively about the service they provided for patients. They were proud of their customer service and the way in which doctors and nurses worked as a single team.
- Staff we spoke with were aware of the whistleblowing procedure. They told us that they would report any concerns they had.
- Staff in general outpatients were not receiving clinical supervision, so there was no formal monitoring of their practice.
- Staff were receiving annual appraisals that included a review of completed training.

Public and staff engagement

- Staff reported that overall communications across the trust had been improved over the last 12 to 18 months. However, communications about the workforce changes had often been confusing and contradictory.
- Allied health professionals reported that they were well informed through their manager, and through the regular newsletter, 'Hot Topics'.

Diagnostic Imaging Department

- A token system, for patients to describe their experience within imaging, was in use. The various imaging departments had different coloured tokens, which were given to patients prior to their examination; patients then placed them in the relevant sections of the wall boxes provided which best described their experience in the department. The distribution of the tokens were analysed weekly, and any required changes to the service and/or department which had been identified by patients, were put into action.
- We saw documentary evidence that information within the radiography department was relayed at weekly staff meetings by the band 7 staff. Staff stated that the morale of the departments was low, but the staff tried hard not to show this to the patients. This was evidenced during the walk around the department.

Outstanding practice and areas for improvement

Outstanding practice

The maternity services at Sandwell and West Birmingham Hospitals NHS Trust provided a significant number of specialist clinics in response to the needs of the local population. These were run by midwives and consultants with extra training and expertise these areas. This meant that women were given advice and care that was current and promoted their wellbeing as much as possible.

Areas for improvement

Action the hospital MUST take to improve

A&E

- The trust must put in place an effective system for learning from incidents and errors, and address the risk of 'less serious' incidents being under-reported by doctors, and trends being missed.
- The trust must follow through from findings of safety audit data and follow-up absence of safety audit data.
- The trust must address systemic gaps in patient assessment records.
- The trust must take steps to improve staff understanding of isolation procedures.
- The trust must provide a consistent system for safe medicine storage.
- The trust must review its governance arrangements in relation to supporting the accident and emergency (A&E) department to more consistently achieve the national 4-hour target.
- The trust must improve its management of governance arrangements in the A&E department.
- The trust must improve its management of inter-professional relationships within the A&E department.

Medicine

- The trust should ensure all medicines are stored in accordance with trust procedures.
- The trust should ensure all care documentation, including food balance charts, are completed accurately and in a timely fashion

Surgery

- The trust must take action to ensure that hand hygiene is carried out appropriately by all members of staff across the trust at all times.
- The trust must take action to ensure that a suitable system is in place to ensure that patient records are kept secure at all times.
- The trust must take action to ensure that a suitable system is in place to regularly assess and monitor the quality of postoperative surgical care.

Children &Young People

- The trust must ensure that the nurse staffing skill mix reflects the appropriate national guidance for staffing the specialty reviewed. Staffing skill mix and support on some shifts within the clinical areas were not always meeting national best practice guidance.
- The trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.
- The trust must ensure that staff receive appropriate training including mandatory training updates and supervision.
- The trust must ensure that there is an accurate record in respect of each child that includes appropriate information and documents in relation to the care and treatment provided to each child.

OPD & Diagnostics

- The trust must maintain adequate records regarding the qualifications and training of imaging department staff.
- The trust must ensure guidance be available for imaging staff regarding exposure parameter guidance or information surrounding expected dose values.

Action the hospital SHOULD take to improve

A&E

Outstanding practice and areas for improvement

- The trust should consider ways of improving multidisciplinary communication within the A&E department team.
- The trust should consider what the systemic gaps in the use of patients' early warning score records are indicating about usage of this tool.
- The trust should consider some analysis of staff practice of relying on patients' relatives for language interpretation, and what impact this has on the accuracy of assessment of a patient's condition.
- The trust should consider how to better promote its complaints policy and procedure in the A&E department.

Medicine

- The trust should take action to improve the compliance with staff's mandatory training targets
- The trust should ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.

Surgery

- The trust should ensure that a safe system is in place, which all surgical staff have received appropriate training in, to safely book patients into the theatre suite and record same.
- The trust should ensure that the World Health Organisation (WHO) surgical safety checklist and preoperative briefing follow the WHO guidelines. The trust should ensure that staff know what is expected of them and that the checklists are assessed and monitored for quality.
- The trust should consider improving the environment in the pre-assessment unit at City Hospital because it is not patient friendly, has inadequate staff facilities and does not promote patients' dignity.
- The trust should consider reviewing its process for booking bank and agency staff. The current system does not flow as the trust expects it to, and it obstructs staff in ensuring that shifts are staffed safely.

Maternity and Gynaecology

- The trust should display the results of safety checks prominently so that the information is accessible to staff, patients and visitors.
- The trust should take active steps to ensure that all staff consistently follow best practice guidance in relation to hand cleansing and infection control dress code.
- The trust should ensure that resuscitation equipment is checked daily in keeping with best practice guidance provided by Resuscitation Up 2010 in all areas.
- The trust should ensure that all medication on the maternity unit is securely stored at all times.
- The trust should consider placing the record keeping on the trust risk register to ensure that monitoring occurs at the highest level of the organisation.
- The trust should consider separating out the number of hospital-acquired pressure ulcers into specific wards so that action can be targeted accordingly.
- The trust should consider updating all midwifery staff about the rationale and outcomes for 'high-risk' women who choose to give birth at the midwifery-led units, so that all staff can be confident that the maternity service promotes the best emotional and physical outcomes for women and babies.
- The trust should investigate further ways of improving communication for women who do not understand English.
- The trust should ensure that staff who are expected to translate are provided with the skills required to carry out this function well.
- The trust should consider improving how the outcome of an investigation and resulting action are communicated to complainants.
- The trust should consider ensuring that all risks and issues of high concern are included on the corporate risk register to ensure that senior directors are aware of the progress in reducing and managing the risk.
- The trust should find a way of increasing feedback about working for the trust from obstetric and midwifery staff.

EOLC

- The trust should review flooring in the mortuary where there is cracked concrete. This presented an infection control risk and did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

Outstanding practice and areas for improvement

- The trust should ensure processes are in place to ensure that doctors consistently complete 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms correctly in line with national guidance published by the General Medical Council.
- The trust should review the hospital discharge processes. These have an impact on patients' ability to achieve their preferred place for end of life care and fast-track discharges. This is contrary to national best practice guidance including One chance to get it right, Department of Health, 2014.
- The trust should review how the reduced chaplaincy services can continue to provide a caring and responsive service to patients when required. The reduction in these services is contrary to national guidance including the NICE Quality standards for end of life care, 2011, updated 2013.

OPD & Diagnostics

- The trust should provide safeguarding adults level 2 training to all staff who run clinics and are likely to have contact with vulnerable people.
- The trust should improve staff understanding and knowledge of responsibilities regarding the Mental Capacity Act 2005.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services (1) The registered person must take proper steps to ensure that each service users is protected against the risks of receiving care and treatment that is inappropriate or unsafe, by means of- (a) the carrying out of an assessment of the needs of the service user and (b) the planning and delivery of care and, where appropriate, treat in such a way as to- (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers (1)The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to- (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control (2) (a) The registered person must, so far as reasonably practicable, ensure that the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for this purposes of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records (1) The registered person must ensure the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of maintenance of- (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; (2) (a) kept securely and cane be located promptly when required.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified and skilled and experienced person employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff (1) The registered person must have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by- (a) receiving appropriate training, professional development, supervision and appraisal.