Heart of England NHS Foundation Trust

Birmingham Chest Clinic

Quality Report

151 Great Charles Street,
Queensway,
Birmingham, B3 3HX
Tel: 0121 424 1950
Website: http://www.heartofengland.nhs.uk

Date of inspection visit: 20 October 2016
Date of publication: 02/08/2017

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

Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Birmingham Chest Clinic is located in Birmingham City centre, and is part of the Heart of England NHS Foundation Trust. The clinic forms part of the trusts respiratory medicine directorate, providing specialist outpatient services and imaging services.

We conducted this inspection as part of the comprehensive short notice announced inspection of the Heart of England NHS Foundation Trust on 20 October 2016.

We rated Birmingham Chest Clinic as good overall.

- Staff were appropriately skilled and had completed mandatory training.
- Premises were clean and tidy, cleaning schedules were available which staff followed, ensuring all areas were appropriately covered.
- Medicines were stored and administered safely
- Incidents were recorded, reviewed and learning was shared.
- The trust participated in national clinical audits. We saw how staff used audit outcomes to review their performance and policies. Although the trust performed well in the chronic obstructive pulmonary disease (COPD) audit when compared with other providers; they reviewed the results and identified areas where they could make further improvements. They had created and implemented an action plan.
- Tuberculosis services had introduced systems and working practices, which increased engagement with patients; reducing the number of Did Not Attend (DNA) appointments.
- We saw compassionate and caring attitude displayed by all staff. This included support staff who we observed during telephone conversations with patients.
- Patients told us they had wonderful service from staff and felt like a visit to the clinic was like a visit to family.
- Staff had the training and skills to support patients who might be given bad news about their condition.
- Tuberculosis staff, helped patients understand that TB was simply a disease, reducing the stigma which some patients felt.
- Tuberculosis (TB) services had provided satellite sites where patients who found it difficult to access the city centre could attend for treatment or screening.
- TB staff followed up patients who had missed appointments by phone or by personal visit to encourage continued engagement with the service.
- Adult and paediatric clinics were timed to allow families to attend together reducing the need for multiple appointments and multiple journeys for families with children.
- Imaging services provided a very efficient service with little or no waiting. This included patients using the Chest Clinic and also walk-in patients from other locations in the trust and from GP requests.
- Governance processes ensured that staff were supported to provide services.
- Managers and supervisors were approachable and knowledgeable. Working collaboratively across specialities in managing their staff.
- Executive level managers visited regularly and understood the needs of the service.
- Risks to the service caused by the suitability of the location had been identified and alternative locations were being considered.

However:

- We found that whilst adjustments had been made to accommodate patients with mobility issues; for example the waiting room wheelchair lift, if these were not functioning as was the case on the day of our inspection, there was no safe alternative for patients to use.
- Imaging services throughout the trust, including those at The Birmingham Chest Clinic did not participate in the Imaging Services Accreditation Scheme (ISAS).

Summary of findings

- Specialist clinics only operated on certain days in the week and predominantly during working hours. This meant that some patients had limited opportunity to attend without disruption to their work or personal commitments.
- Patient comments about waiting times were not recorded and no analysis had been done to see if improvements could be made.
- We found some opportunities to review the quality of service and make improvements were not being identified.
- Lack of engagement by diagnostic imaging services with Imaging Services Accreditation Scheme (ISAS); reduced the options available to managers to monitor performance and access comparative information.
- The premises were old and although adapted to meet current legislation in terms of accessibility, left patients at risk when equipment such as wheelchair lifts broke down.

We saw several areas of outstanding practice including:

- Tuberculosis services received national recognition for their work in decreasing the number of failed appointments and improving engagement of patients from certain minority groups.
- The lead nurse had written best practice article, which appeared as best practice guidance on the Royal College of Nursing website.

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

The trust should:

- The trust should ensure that patient comments such as excessive waiting times are recorded and reviewed to enable opportunities for improvement to be identified.
- The trust should consider improving the environment for children in the waiting areas and treatment rooms as these were not child friendly.
- The trust should consider making more activities available for very young children to help distract them whilst waiting to be seen.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Outpatients and diagnostic imaging	Good	• Staff were appropriately skilled and had completed mandatory training. • Premises were clean and tidy, cleaning schedules were available which staff followed, ensuring all areas were appropriately covered. • Medicines were stored and administered safely • Incidents were recorded, reviewed and learning was shared. • The trust participated in national clinical audits. We saw how staff used audit outcomes to review their performance and policies. Although the trust performed well in the COPD) audit when compared with other providers, they reviewed the results and identified areas where they could make further improvements. They had created and implemented an action plan. • Tuberculosis services had introduced systems and working practices, which increased engagement with patients; reducing the number of Did Not Attend (DNA) appointments. • We saw compassionate and caring attitude displayed by all staff. This included support staff who we observed during telephone conversations with patients. • Patients told us they had wonderful service from staff and felt like a visit to the clinic was like a visit to family. • Staff had the training and skills to support patients who might be given bad news about their condition. • Tuberculosis staff, helped patients understand that TB was simply a disease, reducing the stigma which some patients felt. • Tuberculosis (TB) services had provided satellite sites where patients who found it difficult to access the city centre could attend for treatment or screening. • TB staff followed up patients who had missed appointments by phone or by personal visit to encourage continued engagement with the service.

Summary of findings

- Adult and paediatric clinics were timed to allow families to attend together reducing the need for multiple appointments and multiple journeys for families with children.
- Imaging services provided a very efficient service with little or no waiting. This included patients using the Chest Clinic and also walk-in patients from other locations in the trust and from GP requests.
- Governance processes ensured that staff were supported to provide services.
- Managers and supervisors were approachable and knowledgeable. Working collaboratively across specialities in managing their staff.
- Executive level managers visited regularly and understood the needs of the service.
- Risks to the service caused by the suitability of the location had been identified and alternative locations were being considered.

Birmingham Chest Clinic

Detailed findings

Services we looked at
Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Birmingham Chest Clinic

The Birmingham Chest Clinic has occupied the site since 1932 and operated as a purpose built Tuberculosis (TB) clinic by the local authority. In 1948, the NHS took over the service in 1970 expanded the service beyond TB and now offers several other specialist outpatient services. The clinic provides diagnostic imagining such as plain imaging to support the running of the services offered at the clinic. Between October 2015 and September 2016 Birmingham Chest clinics saw 5481 patients. An average of 457 patients per month.

Between January 2015 and November 2016, imaging services saw 2221 patients. This was approximately 100 patients per month.

The service offers the following specialist clinics:

- Allergy services
- Chest X-Ray service
- General lung disease
- Rapid Access for suspected lung cancer
- Occupational lung disease
- Tuberculosis (TB)
- Thoracic surgery
- Sexual health

The location has six consulting rooms, one treatment room and four assessment bays. Clinics operate between 8.30am and 6pm on weekdays. Each speciality has a defined day or half day clinic. Diagnostic imaging services operate between 9am to 12:30pm and 1:30pm to 4:30pm Monday to Thursday and 9:30am to 12:30pm on Fridays.

Our inspection team

Our inspection team was led by Donna Sammons, inspection manager. The service was inspected by a CQC inspector. A specialist advisor with expertise in outpatient services was available for advice.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

How we carried out this inspection

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

Detailed findings

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

We spoke with nine members of staff including managers and nursing staff, we spoke with three patients and we checked five sets of patient notes. We looked at records regarding the general management of the clinics and imaging services and reviewed data and information provided to us by the trust prior to, during and following the inspection.

Facts and data about Birmingham Chest Clinic

Activity:

Between October 2015 and September 2016 Birmingham Chest clinics saw 5481 patients. An average of 457 patients per month.

Between January 2015 and November 2016, imaging services saw 2221 patients. This was approximately 200 patients per month.

The clinic is registered to provide the following regulated activities:

- Family planning services
- Treatment of disease, disorder or injury

Diagnostic and screening procedures

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Outpatients and diagnostic imaging

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

Information about the service

Birmingham Chest Clinic is situated in Birmingham City centre, and is part of the Heart of England NHS Foundation Trust. The clinic forms part of the trusts respiratory medicine directorate, and provides specialist outpatient services for the directorate.

Clinics operate between Monday and Friday and cover a number of specialities including general respiratory clinics as well as specialist occupational lung and interstitial lung disease (ILD) clinics, thoracic surgery clinics, allergy clinics for both adults and children and there is a Tuberculosis (TB) service.

The location has six consulting rooms, one treatment room and four assessment bays.

Between October 2015 and September 2016 Birmingham Chest clinics saw a total of 5481 patients. An average of 457 patients per month.

Diagnostic imaging services were also provided at the location. These include plain film imaging services to support the chest clinic activities. Plain film x-ray services were also provided for patients from other disciplines who had been referred by their GP or other outpatient facilities.

Between January 2015 and November 2016 Imaging services saw a total of 2221 patients. This was approximately 100 patients per month.

Summary of findings

We rated this service as good because:

- Staff were appropriately skilled.
- Premises were visibly clean and tidy.
- Actions were taken to improve some of the services provided and improve patient engagement with services.
- Staff were polite, respectful and supportive of their patients.
- Administration and reception staff expressed genuine empathy with patients when speaking with them on the phone or in person.
- Patients felt engaged and informed about their care and treatment. Patients expressed realistic expectations which they told us were based on honest and adult conversations with staff.
- Staff were supported in their role.

However:

- The building which housed the clinics was old and although adapted to meet current legislation in terms of accessibility, left patients at risk when equipment such as wheelchair lifts broke down.
- Imaging services throughout the trust, including those at The Birmingham Chest Clinic did not participate in the Imaging Services Accreditation Scheme (ISAS).

Outpatients and diagnostic imaging

- We found some opportunities to review the quality of some services and make improvements were not being identified.
- Lack of engagement by diagnostic imaging services with Imaging Services Accreditation Scheme (ISAS); reduced the options available to managers to monitor performance and access comparative information.

Are outpatient and diagnostic imaging services safe?

Good

We rated this core service as good for safe, this was because:

- Staff were appropriately skilled and had completed mandatory training.
- Premises were clean and tidy, cleaning schedules were available which staff followed, ensuring all areas were appropriately covered.
- Medicines were stored and administered safely
- Incidents were recorded, reviewed and learning was shared.

However:

- We found that whilst adjustments had been made to accommodate patients with mobility issues; for example the waiting room wheelchair lift, if these were not functioning as was the case on the day of our inspection, there was no safe alternative for patients to use.

•

Incidents

- The trust used an electronic incident recording system. The same system was used at the Birmingham Chest Clinic, which meant that incidents at the location could be included in and analysed alongside information from the wider trust.
- From July 2015 to August 2016 a total of 15 Incidents were reported relating to respiratory medicine and four incidents related to diagnostic imaging. All but one incident were classified as low or no harm.
- There had been no never event incidents at the location during this reporting period.
- Never events are serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- Staff we spoke with were able to describe incidents which had occurred in their respective department or area. They described how learning from these incidents was shared and discussed during team meetings, more

serious incidents were also circulated with learning points on the trust intranet. Staff were less aware of incidents in other parts of the trust, although they felt confident that trends from incidents were identified and circulated.

- We were told how improvements had been made within diagnostic imaging as a result of incidents being reported. A number of radiology requests from clinics on site had been rejected as they were submitted on the wrong forms. This had meant patients had to return to clinic and request the correct form. Following meetings with staff, systems were put in place to streamline the request system ensuring the correct forms were used and illuminating the inconvenience to patients.
- A major breakdown in the buildings heating system resulted in cancelation of clinics. Managers liaised with the Local authority who owned the buildings and a temporary heating system was erected in the staff car park.

Cleanliness, infection control and hygiene

- We saw that all public areas, treatment and assessment areas appeared clean and free from clutter. We saw that cleaning schedules were followed.
- The service employed its own dedicated cleaners. We spoke with cleaning staff who were able to demonstrate how they followed scheduled cleaning plans with daily, weekly and monthly tasks.
- Cleaning of equipment or treatment areas between patients was completed by nurses or healthcare workers.
- Control of substances hazardous to health (COSHH) information was available to staff. Cleaning equipment and chemicals used were stored securely and clearly marked.
- Gel hand sanitiser dispensers were situated throughout the clinic areas. We saw that dispensers were full, and we witnessed their use by a number of different staff. However, we did not see any patients using the dispensers nor being invited to do so by staff. Signage in the areas of the dispensers was poor.
- We were told that hygiene audits were completed quarterly by visiting staff from the Hartlands hospital. Unfortunately staff were unable to show us local records of these.
- Personal protective equipment in the form of disposable gloves and aprons were available to staff and we witnessed these being used and disposed of between patients.
- Waste management followed the trust guidance with external contractors collecting and disposing of clinical waste in common with the trusts larger sites. Sharp's bins were available throughout the treatment rooms and cubicles.

Environment and equipment

- The Birmingham Chest Clinic had occupied the site since 1932 when it was opened operated as a purpose built Tuberculosis clinic by the local authority. It continues to house Tuberculosis services which were now provided by the NHS trust together with additional specialist chest clinics, allergy services and radiology services.
- The Chest Clinic is situated in the centre of Birmingham City. The buildings remain the property of the local authority and were rented by the trust.
- The building had been adapted over time to ensure compliance with legislation governing accessibility and the needs of patients using the service. This included installation of a patient lift which could be accessed from the side of the building and a wheelchair lift which could also be used by patients using walking aids to assist them move between the treatment rooms and the waiting areas.
- Treatment rooms were large and well lit, however facilities were spread across a number of levels on the ground floor, which meant access was difficult.
- The patient lift was available via a narrow alleyway at the side of the building; this gave access to both the clinic area and the basement radiology services. The alley was dark and uninviting. This access route was obviously established long after the original structure was built, and would have been the best option available to make the site accessible; however it gave a 'below stairs' impression that disabled patients were somehow less welcome or less important. This was clearly not the case once patients had accessed the building.
- The wheelchair lift on the ground floor enabled patients to move between the reception area and treatment rooms; however this had broken down on the day of our inspection. We saw one patient who used walking aids, being assisted by staff to negotiate the steps.

- All portable electrical appliances had been tested and clearly marked to show they were safe to use.
- Radiology staff expressed concern regarding policy for emergency evacuation of the building. Policy required that two trained staff should be available to assist patients out of the building. At the Birmingham Chest Clinic there was only one trained member of staff on duty at any one time.
- The Chest Clinic did not have any dedicated patient parking. There was a patient drop off area at the main entrance which allowed limited parking to enable patients to be escorted into the building, or collected following clinic. There were good public transport links with the surrounding area. Patients who drove to the clinics needed to use the city centre car parks. The clinic had an agreement with a nearby private car park which provided a limited number of spaces specifically for Chest Clinic patients; however the cost of parking was still met by the patient.

Medicines

- Staff followed the trust policies and procedures regarding the storage and administration of medication.
- There were secure storage facilities for medicines used by the TB service, and separate storage for the remaining clinic services.
- We examined documentation relating to the clinic medicines storage. We saw that medicines were stored appropriately in a secure room and in locked cabinets. Temperature sensitive medications were stored in a secure refrigerator. We saw that daily checks of the refrigerator temperature were recorded on all days that the clinics were open. Information was available to staff on what they needed to do if temperatures were found to be outside set limits.
- We checked a random sample of medicines both in the refrigerator and the main drugs cabinet; we found all medicines were within their safe use-by dates.
- We saw nursing metrics information which showed that medication audits were completed by pharmacy staff.
- We saw that Patient Group Directives (PGD's) were in place which enabled qualified trained nursing staff to administer certain medication to defined classes of patient without needing to request individual prescriptions from doctors. We reviewed four PGD's covering different medications. We saw that the forms were properly completed with clear instructions for staff and information which must be conveyed to the patients. The PGD's were correctly signed and showed the period during which they could be used.

Records

- We saw records regarding the general running of services, maintenance of equipment and upkeep of buildings in the clinic managers' office. These were comprehensive and easy to follow.
- The clinic used a paper based system for patient records. We reviewed five sets of patient records; we did this to ensure that information which staff and patients had told us was reflected in the notes. We saw that clinical notes were typed after each visit making information easy to read. Notes contained information which would enable staff to understand the patient's needs including risk assessments and lifestyle information.
- Whilst patient records appeared complete, we did note that in two of the five sets, consultants had not dated the information. We asked administration staff about this who explained that in the two instances they could see from the entries that the consultant had made the entries on the same date as previous entries from nursing staff. However in one instant we noted that the consultant's notes had started on a new page, this had the potential to cause confusion if that or other notes were filed out of sequence.
- We saw records which confirmed the maintenance and calibration of x-ray equipment.

Safeguarding

- The trust had a safeguarding lead; staff we spoke with understood how to obtain support and guidance regarding safeguarding issues.
- Staff understood the different forms of abuse and circumstances which amounted to safeguarding concerns. They were able to give details of safeguarding referrals they had been involved with. Staff working in the TB service had made regular referrals regarding children's safeguarding; the majority relating to children who had not been brought into clinic for treatment or where families had failed to fully engage with the service which could potentially endanger the child's health. Staff had been involved in child protection procedures including attendance at multi-agency risk assessment conferences.

Outpatients and diagnostic imaging

- All nursing and health care staff had received adult and children's safeguarding training to level 2. However, only two nursing staff had received training to level 3 in children's safeguarding, these being the respective clinical leads for TB services and the clinic sister. We asked senior managers if they were assured that sufficient staff were available on site with level 3 training. The group support manager for respiratory medicine undertook to review the training required to ensure that the service was fully compliant.
- Tuberculosis staff described how they were heavily involved with the local safeguarding teams and regularly attended multi-agency safeguarding hub (MASH) meetings. Their main involvement stemmed from parents or guardians of children or young people failing to ensure the child engaged with treatment or screening programmes.

Mandatory training

- The trust target for mandatory training was 85%. The trust provided us with details of 11 core subjects which formed their mandatory training. Not all staff were required to have training in all subjects. The trust figures identified the number of staff required to complete each subject and the percentage of staff who had completed each. Whilst some subjects such as information governance had been completed by 100% of staff, other subjects had completion rates as low as 40% for 'Blood Awareness' by clinic staff, and 30% in safeguarding children level 2 by TB staff. We aggregated the percentages across all subjects which showed that 76% of clinic staff and 75% of TB staff had completed their mandatory training. The only nursing staff who had not completed their mandatory training were on long term sickness absence.

Assessing and responding to patient risk

- Patients attending the chest clinic or imaging services were relatively well. However protocols were in place to refer patients to other services if comorbidities were affecting their health, to inpatient services if their health had deteriorated or if patients required emergency treatment staff would use the 999 system to arrange ambulance transfer to an accident and emergency department.
- Outreach teams operated from the TB services and conducted clinic sessions at the main hospital sites in the trust as well as making home visits where required. This ensured that patients who found it difficult to get to the chest clinic received appropriate care and treatment and any change to their health could be assessed and appropriate referrals made.
- All patients using clinic services were provided with contact details for the service which they were able to ring if they had concerns about their health between clinic appointments. A member of the nursing team was identified each day to monitor and respond to patient calls. The service was only available during clinic open times.

Nursing staffing

- Clinical leads assessed the number of staff required to provide services in consultation with the consultants covering the specialities.
- Clinics operated on a regular timetable which identified the dates and times of the speciality involved, this enabled managers to plan the staff skill mix according to the type of clinic and number of patients.
- Staff shortages were covered from within the teams. This was due to the specialist training involved making it difficult to use agency or bank staff. Approaches had been made to agencies for specialist cover; however these had not been taken up.
- The TB Service had 17 qualified nurses supported by five dedicated administrative staff.
- Respiratory and allergy clinics had three band 6 qualified nurses and two health care assistants.

Medical staffing

- No medical staff were based at the Birmingham Chest Clinic. Consultants and their teams, from the trust's main hospital sites attended clinics in line with their speciality.
- There were no out of hours services at the clinics.
- Detailed information regarding medical staffing is contained in the Outpatients report.
- We were told that relationships with medical staff were excellent. On occasions clinics had had to be cancelled due to the availability of consultants. Sufficient time was usually available to cancel patients and provide alternative appointments.

Major incident awareness and training

- Staff had received awareness training for major incident scenarios.

Outpatients and diagnostic imaging

- Business continuity plans were in place and we saw how these had been used to reduce the impact of a recent heating failure in the building.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain is not rated for this core service.

- The trust participated in national clinical audits. We saw how staff used audit outcomes to review their performance and policies. Although the trust performed well in the chronic obstructive pulmonary disease (COPD) audit when compared with other providers; they reviewed the results and identified areas where they could make further improvements. They had created and implemented an action plan.
- Tuberculosis services had introduced systems and working practices, which increased engagement with patients; reducing the number of Did Not Attend (DNA) appointments.

However:

- Imaging services throughout the trust, including those at The Birmingham Chest Clinic did not participate in the Imaging Services Accreditation Scheme (ISAS).

Evidence-based care and treatment

- Care pathways followed national guidance and best practice. These included Multidisciplinary Team (MDT) working in relation to interstitial lung disease(ILD). Idiopathic pulmonary fibrosis NICE pathway, and the NICE pathway on respiratory conditions, and the NICE Tuberculosis pathway.
- TB services had received national recognition for their work in increasing engagement with the service and reducing the number of failed attendances at appointments. Engagement increased from 28% in 2012 to over 80% at the time of the inspection. The lead nurse for Tuberculosis published a presentation showing best practice and outlining recent NICE guidance. The presentation 'Managing Tuberculosis Today' appears on the Royal College of Nursing (RCN) website.
- Birmingham Chest Clinic TB service was a centre for drug resistant TB. Patients whose condition did not respond to commonly used treatments were referred to the service.

Pain relief

- Clinical pathways followed national recognised practice and where appropriate these included control of pain associated with people's condition.
- Of the three patients we spoke with none suffered from conditions which caused them pain or discomfort so we were unable to ask how well such issues were managed.

Patient outcomes

- Respiratory medicine engaged with the national chronic obstructive pulmonary disease (COPD) Audit published in February 2016. The audit used trust wide data. The trust had a participation rate of 87% which was better than the England average of 85%. Figures included inpatient services and community based services.
- The trust pulmonary rehabilitation (PR) plan was 100% compliant with the respiratory conditions which the guidance suggested should be included. The audit identified that approximately a quarter of other trusts did not meet this standard.
- A large number of patients (approximately 40%) failed to complete their PR plan. The trust identified that long waiting periods of up to 45 days for appointment followed by further waiting of up to 15 weeks to commence a class were the major contributing factors. An action plan to improve documentation, increase exercise prescription at discharge and enhance investment in the service was completed and put into operation.
- An audit of multiple drug resistant tuberculosis patients MDR-TB resulted in a series of recommendations including:
- Develop definitive local guidelines for MDR-TB contact surveillance.
- Create posters aimed at clinicians for clinic rooms to show appropriate management through an MDR-TB surveillance pathway.
- Alerts system on iCare portal for patient's requiring further follow-up so letters or text messages were conveyed to them and their GP.
- Improve patient education about the risks of MDR-TB and non-compliance by creating leaflets or technology such as phone apps.

Outpatients and diagnostic imaging

- We were provided with details of an audit of NICE guidelines for diagnosing and treating extra-pulmonary tuberculosis (EPTB). The outcome of the audit concluded: "Trust practice is good, however, there is room for improvement;
- Increasing use of biopsy rather than reliance on clinical diagnosis, particularly in suspected Gastro Intestinal TB.
- Increasing use of imaging in suspected TB Meningitis.
- Raise awareness of guidelines amongst physicians less frequently exposed to patients presenting with extra-pulmonary disease.
- Create a pathway for suspected EPTB to assist clinicians and re-audit using this tool".
- On going audits within the respiratory medicine directorate included national asthma audit, audit of interstitial lung desease (ILD) multi disciplinary meeting (MDT) decisions.
- Local audits included reviewing checks of the resuscitation trolley and contents, Medication audits, infection control audits, patient observation and assessment audits and communication audits. Nursing metrics showed managers compliance rates and enabled trends to be identified and interventions to be applied if required. We saw how periodic changes to performance had been identified.
- Diagnostic imaging services at the chest clinic were managed from Heartlands hospital. The trust did not participate in the Imaging Services Accreditation Scheme (ISAS). The United Kingdom Accreditation Service (UKAS) has been licensed by The Royal College of Radiologists and the College of Radiographers to manage and deliver ISAS. They describe ISAS as "a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments". Accreditation is encouraged by NHS England and is seen as working towards best practice. When we asked about the trust's accreditation they responded with the statement "The Directorate has not signed up to ISAS, we have however made a start on building evidence working toward ISAS Accreditations".
- Between January and November 2016, diagnostic imaging services saw a total of 2221 patients. These consisted of 222 patients referred by their GP, 11 patients from other HEFT hospitals who chose to use this location, and 1988 patients from the on-site clinics.
- In addition to completing x-rays for patients attending the chest clinic, the radiology staff also assisted the trust by taking general calls for the radiology service and booking them into suitable services at one or other of the locations, and other electronic admin tasks in support of their colleagues at the other sites.

Competent staff

- There were two main service staff groups at Birmingham chest clinic, nursing and support staff who worked in the specialist clinics at the centre and TB nursing and support staff working at or from the centre.
- Clinic staff were line managed by the clinic sister; TB staff were managed by the TB lead nurse. Administrative and support staff were managed by a combination of the clinic sister, TB lead nurse and the clinic manager.
- Each group received regular one to one supervisions or meetings with their managers.
- Appraisal rates for the 16 nursing and support staff in clinics as of September 2016 was 93%. The 22 TB service nursing and support staff had an appraisal rate of 85%. The trust target was 90% compliance.
- Nurses were supported in collecting information and revalidating their registration.

Multidisciplinary working

- The TB service held weekly nurse led multi-disciplinary team (MDT) meetings which included doctors, and regular attendance by representatives of Public Health England and the local authority.
- Respiratory MDT meetings were also held weekly and followed NICE guidelines in relation to interstitial lung disease (ILD) MDT processes. Meetings included consultants, nursing staff, managers and therapists.
- Some MDT meetings involving chest clinic patients took place at the trusts main hospital sites to facilitate the best attendance, this included **interstitial lung disease** (**ILD**) meetings. One of the two ILD specialist nurses from the chest clinic always attended these meetings.

Seven-day services

- Birmingham chest clinic did not provide any seven day services.
- Clinics operated between 8.30am and 6pm on week days. Each speciality had a defined day or half day clinic. This provided a degree of continuity for patients and allowed consultants and their teams from the trusts

main locations to plan their attendance at the clinics. However it meant that there was no flexibility to allow patients who worked or those with other commitments to attend clinics when it was convenient to them.
- An out of hours answer phone service was provided where patients could ring with non-urgent questions. A member of the nursing staff was nominated each day to contact patients and answer any queries.
- Diagnostic imaging services operated between 9am to 12:30pm and 1:30pm to 4:30pm Monday to Thursday and 9:30am to 12:30pm on Fridays.
- Services did link in with other agencies and services such as district nurses and GP practices which meant that patients who required assistance out of clinic hours were able to be supported.

Access to information

- Patient notes were stored on site at the chest clinic. Following consultations doctors notes, letters to GP's and patients were all typed by admin staff. Copies were retained in the notes which meant that up to date information was always available when patients attended clinic.
- Where notes or other internal information needed to be transported between trust sites, this was undertaken by the trust specimen collection drivers.
- Computer terminals were available for staff to access information and guidance in relation to clinical conditions, trust information and personal email accounts.
- Medical alerts and other important information was circulated as news items and as email notifications.
- Appointment booking was managed from the site. Booking clerks were able to access clinic timetables and identify available slots from the online booking system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing staff had all received awareness training in the Mental Capacity Act (2005).
- Staff we spoke understood their obligations in relation to supporting patients who could not understand their treatment or implications of options they were given.
- Staff described how the majority of patients who attended clinic were able to make informed decisions without assistance. They described instances where people with a learning disability had been accompanied by carers who supported them.
- Staff we spoke with could not recall having needed to make formal best interest decisions.
- Patients we spoke with told us that nursing staff and doctors always explained things clearly and ensured they were fully understood. All the patients we spoke with had attended on their own, however they told us that they had been accompanied by family members on some visits and when they had been accompanied their family member had been able to engage in discussions.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We saw compassionate and caring attitude displayed by all staff. This included support staff who we observed during telephone conversations with patients.
- Patients told us they had wonderful service from staff and felt like a visit to the clinic was like a visit to family.
- Staff had the training and skills to support patients who might be given bad news about their condition.
- Tuberculosis staff helped patients understand that TB was simply a disease, reducing the stigma which some patients felt.

Compassionate care

- During our inspection we observed interactions between staff of all levels and their patients. We saw that patients appeared at ease with staff and happy to be in their company.
- Staff greeted patients courteously and professionally. We saw that patients were greeted with a smile and always responded with a smile.
- We heard support staff dealing with patients on the telephone. We saw how they expressed empathy and provided supportive words. During other calls we heard staff being jocular and laughing with patients. There was a friendly and supportive air to the telephone manner which felt like it was a chat between friends, Support staff appeared to go out of their way to accommodate patient's wishes; we heard many comments such as "Okay well if that's no good let me see when we can sort something for you".

Outpatients and diagnostic imaging

- We saw how nursing staff supported a patient with mobility issues when they had to negotiate a small flight of steps. The patient felt confident to negotiate the steps but staff positioned themselves in front and behind the patient, arms ready to provide support but allowing the patient to exercise their independence. A stair lift was present but staff explained to the patient that it had failed that morning and maintenance had been called to repair it.
- We observed radiology staff advising a patient who had used the walk-in x-ray service on the time scales for receiving their results through their GP. The exchange was pleasant and professional.
- Friends and family test results showed that during the three months July, August and September 2016, the number of patients attending clinics was 2003, of which 175 (9%) responded. Of the 175 responses 169 patients said they were extremely likely or likely to recommend the service to friends or family if they required similar treatment. Only one speciality received any negative responses with Thoracic Medicine patients returning 78 responses in July and August with 3 patients saying they would extremely unlikely and 2 patients unlikely to recommend the service.
- During the same three month period diagnostic imaging services at the Chest Clinic achieved an average of 99% of patients who responded would be extremely likely or likely to recommend the service.

Understanding and involvement of patients and those close to them

- Patients told us that they were kept fully informed regarding their medical condition including how they might be affected in the future and how treatment plans could be adopted or amended to help them cope.
- All the patients we spoke with had attended the clinic on their own; however they told us that on previous visits they had been accompanied by family members or close friends. They said that their companions had been involved in discussions with nursing and medical staff and had been able to ask questions and fully support them (the patient) during the consultations.
- One patient said, “I’m in no doubt about the future. I know there is no getting better, but I also know that I’m getting the best treatment available and will stay better longer”. Another commented, “The staff here and the service here are wonderful”.
- Radiology staff explained that they were unable to provide information to patients following x-rays because any results had to be formerly reported by a radiologist (a doctor who specialises in interpreting medical images). However they told us they always explained this to patients, most whom were aware of the system. They always referred patients to their GP or consultant for the results.

Emotional support

- Patients described the support they received from staff as ‘outstanding’. Clinical nurse specialists were able to provide informed information to patients about their treatment and prognosis.
- Pastoral support was not available on site but was available at the trusts hospital sites and patients could be referred to the service if required.
- Information was available for patients regarding support groups and charities which could provide further support.
- Tuberculosis staff promoted the use of advocates and peer support to assist people who due to old fashioned beliefs thought the diagnosis was a stigma and something to be ashamed of.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Tuberculosis (TB) services had provided satellite sites where patients who found it difficult to access the city centre could attend for treatment or screening.
- TB staff followed up patients who had missed appointments by phone or by personal visit to encourage continued engagement with the service.
- Adult and paediatric clinics were timed to allow families to attend together reducing the need for multiple appointments and multiple journeys for families with children.
- Imaging services provided a very efficient service with little or no waiting. This included patients using the Chest Clinic and also walk-in patients from other locations in the trust and from GP requests.

However:

- Specialist clinics only operated on certain days in the week and predominantly during working hours. This meant that some patients had limited opportunity to attend without disruption to their work or personal commitments.
- Patient comments about waiting times were not recorded and no analysis had been done to see if improvements could be made.
- The environment for paediatric patients was not child friendly.

Service planning and delivery to meet the needs of local people

- The tuberculosis (TB) screening and treatment service had diversified over time to meet changes in the local population and address cultural issues of diverse groups.
- As TB services often affected multiple members of the same family including adults and children. Clinics ran back to back services with paediatric clinics in the morning and adult clinics in the afternoon; this enabled all affected family members to be seen on the same day, reducing travelling and multiple visits for families.
- TB services were also provided by the team as an outreach service at the trusts other sites, and home visits were conducted where patients were unable or unwilling to engage with the service at the clinic locations.
- Specialist respiratory clinics, allergy clinics and cancer clinics were all based on the clinical needs of the patient groups. Some specialities attracted patients from a wide area of the country not just the local population.

Access and flow

- Between October 2015 and September 2016 there were 1703 new appointments and 3778 follow-up clinic attendances. These consisted of:
- Allergy – new 428 – follow up 260
- Immunology – new 135 – follow up 69
- Paediatric Immunology – new 190 – follow up 352
- Paediatric Respiratory Medicine – new 170 – follow up 217
- Thoracic Medicine - new 777 – follow up 2880
- Thoracic Surgery – new 3 – follow up nil.
- During the same period there were 1311 appointments which patients failed to attend.
- Allergy – 261
- Immunology - 113
- Paediatric Immunology – 120
- Paediatric Respiratory Medicine – 89
- Thoracic Medicine - 728
- Thoracic Surgery – nil.
- We asked the trust for information regarding diagnostic waiting times for patients who used the Birmingham chest clinic so that we could assess the performance against national targets. The trust responded with the statement “There is no activity at the Birmingham chest clinic which is recorded on the diagnostics return”.
- The Birmingham chest clinic whilst providing services on an ‘out-patient’ basis is managed by the trust as part of the respiratory medicine division. From D
- divisional performance review 2016/17 held on 14-9-16. The respiratory directorate were achieving 89% against the national standard of a minimum of 92%. The directorate had not achieved the standard for over 12 months. A review of the root causes of the issue had identified an over-riding lack of clinical capacity against the increasing demand for the various sub-specialities. A business case had been submitted for the appointment of two additional consultants to enable the division to meet this target.
- The division as a whole were currently treating 83.3% of patients diagnosed with lung cancer within the access standard. The trust had implemented a number of interventions and hoped to meeting access targets by November 2016.
- We asked senior staff about patient waiting times once they had arrived at the clinic for their appointment. We were advised that no reviews of patient waiting times had been completed.

Meeting people’s individual needs

- Tuberculosis services had adapted over time to changes in the social and economic make-up of the area. The West Midlands had the highest incidence of tuberculosis outside London. A number of ethnic minority groups which had grown in the region had brought with them beliefs that tuberculosis was a shameful condition and the sufferer was in some way at fault. Staff used peer support and advocacy services to help people understand the disease. This helped them to increase their screening programme and promoted better engagement and commitment to treatment programmes.
- Historically following initial diagnosis the service had a very poor attendance rate. One example showed that of

60 patients booked to attend screening clinics only 17 (28%) actually attended. A review of the service identified a number of issues for patients, including difficulty accessing the city centre site and multiple visits for children and adults in the same family.

- In order to address the issues the service introduced a number of interventions. They set up satellite clinics at the trusts other locations, arranged back to back appointments for paediatric and adult clinics enabling family members to be seen on one visit, and they introduced home visits for large families or where patients had failed to attend clinic. This had resulted in an increase in engagement and completion of treatment to 80%.
- The dedication and commitment of the TB staff was demonstrated when following an outbreak of TB in a local school, staff screened over 1,000 school children in four days. This was achieved by staff working additional hours and without any additional nursing resources.
- Because the range of clinic activities at Birmingham chest clinic were so specialised, equipment, staff skills and support services were all tailored to meet the needs of the patients who attended.
- Despite the fact that paediatric clinics were held at the location, we found the clinic was not at all child friendly. There were no child friendly toys or games in public areas; no child friendly pictures to brighten the rooms. There was nothing which would distract and entertain children whilst waiting to be seen. We asked staff about this and we were shown a box of toys which was available for children in one of the consulting rooms. Again there were no child friendly decorations or wall art in the consultation, treatment or assessment areas.
- Staff described a number of scenarios where they had supported people with a learning disability when they attended the chest clinic.
- Translation services were available with services for Guajarati, Punjabi, Hindi and Urdu usually available. Additional languages could be accommodated if notice were given. Telephone translation services were available if required.

Learning from complaints and concerns

- There had been no formal complaints regarding the Birmingham chest clinic during the reporting period August 2015 to September 2016.
- Staff told us that the issue most patients raised was with waiting times for ambulance transfers. Ambulances were provided by an external trust and despite direct liaison with the service many patients were left waiting for extended periods of time. Staff described how they mitigated the frustration for patients by offering hot drinks and biscuits.
- Some patients also raised issues about waiting to be seen after arriving for their appointment. Staff advised us that patients usually understood when it was explained that some patients required additional investigations or treatments which led to clinics running behind.
- These issues were not recorded and managers told us that no audit had been conducted into patient waiting times.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Governance processes ensured that staff were supported to provide services.
- Managers and supervisors were approachable and knowledgeable. Working collaboratively across specialities in managing their staff.
- Executive level managers visited regularly and understood the needs of the service.
- Risks to the service caused by the suitability of the location had been identified and alternative locations were being considered.

However:

- We found some opportunities to review the quality of service and make improvements were not being identified.
- Lack of engagement by diagnostic imaging services with Imaging Services Accreditation Scheme (ISAS); reduced the options available to managers to monitor performance and access comparative information.

Leadership of service

- The senior staff on site managed Birmingham chest clinic collectively. A clinic manager worked closely with

the lead nurses who ran the specialist and TB clinics. Each had responsibility for their own teams but also shared the management of administration and support staff.
- Staff told us that they felt supported in their role. Managers understood them and provided the environment and facilities they needed to support their patients.
- Links into the senior trust management had improved with the appointment of a respiratory medicine group support manager who shared their time between sites including the chest clinic.
- Monthly board rounds also took place with executive level managers visiting the site to meet with staff.
- Senior staff and managers told us that they were supported by the executive team.
- Diagnostic imaging staff told us they felt supported by senior staff at the chest clinic, but felt isolated from their own managers who were all based at the main hospital sites. They received supervisions and had regular meetings, but did not feel they had the clinical support, which their colleagues enjoyed when working in a larger department where there were more staff and to seek advice from and share issues with.

Vision and strategy for this service

- All the staff we spoke with told us how proud they were of the service provided to patients. Staff believed they made a positive difference to people's lives and in doing so supported the trust in its vision and strategy.
- The Birmingham Chest Clinic had operated from its current location for over 80 years and the buildings had been adapted over time to keep pace with modern medicine and the needs of patients. Senior staff were confident that the service would continue to be provided by the trust and that a city centre location was favoured.

Governance, risk management and quality measurement

- Systems and processes were in place which enabled local managers and senior managers in the trust to monitor activity and service provision at the Birmingham chest clinic. Although we did see areas where opportunities to monitor quality of service were being missed, for example; failing to record patient dissatisfaction with waiting times meant that it was not possible to assess if improvements could be made. No patient surveys had been conducted regarding clinic times and patient availability.
- Team meetings took place within the individual staff groups, we were able see minutes of these minutes which showed how incidents, and issues were discussed within teams and messages were cascaded from managers.
- Managers of the different services in the chest clinic met informally on a daily basis which enabled a constant flow of information between the services.
- Staff told us that senior staff visibility and engagement had improved since February 2016 with the appointment of the respiratory group support manager. They shared their time between the chest clinic and other hospital sites.
- Quality assurance meetings took place each month involving consultants, managers and service leads.
- Respiratory medicine held directorate meetings at monthly intervals. We were told that historically meetings had been very poorly attended due to availability of staff on different sites. On some occasions only three or four members of staff had attended. Following a review and the introduction of a video link system attendance had risen to over forty.
- The respiratory matron attended at least once per month to meet with staff and conduct one to one interview with the clinic Sister.
- Diagnostic imaging services had not engaged with the Imaging Services Accreditation Scheme (ISAS). Accreditation with the scheme is seen as a measure of excellence or striving to attain excellence through the different levels of accreditation. Services are encouraged but not compelled to join the scheme to help them assess and monitor their performance. Not being accredited reduces the availability of comparative performance data which can assist managers identify areas for improvement.

Culture within the service

- All staff we spoke with described a friendly and relaxed working environment. Nursing staff told us that they were treated with respect by consultants and doctors, and that managers were approachable and fair.
- Patients told us that visiting the clinics was like visiting friends.

- Staff told us that they were aware of the need to honest and open with patients, they told us that they felt they always were and always had been. We witnessed how staff apologised to patients when they assisted a patient with mobility problems down a flight of stairs due to the stair lift being out of use.
- Staff we spoke with had a basic knowledge of their responsibility in respect of duty of candour. No incidents had occurred at the clinic which had triggered a formal duty of candour response.

Public engagement

- Focus groups for some specialist services such as **Idiopathic pulmonary fibrosis** (**IPF**) and **Interstitial lung disease** (**ILD**) took place on a monthly basis. These were attended by staff and patients and family members were encouraged to attend to raise awareness and understanding of the conditions.

Staff engagement

- The trust engaged in national NHS staff surveys.
- Information and news about the trust activities were distributed through the intranet.

Innovation, improvement and sustainability

- There was a realisation within the management team that the premises which housed the service was not an ideal clinical location. The condition of the building and its continued suitability were on the trust risk register.
- We were told that discussions were on going at senior trust level regarding possible alternative locations. Local managers assured us that the service was not under threat, and the trust were keen to ensure the service remained in the city centre.

.

Outstanding practice and areas for improvement

Outstanding practice

Chest Clinic

- Tuberculosis services had received national recognition for their work in decreasing the number of failed appointments and improving engagement of patients from certain minority groups.
- The lead nurse had written best practice article, which appeared as best practice guidance on the Royal College of Nursing website.

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

Chest Clinic

- The trust should ensure that patient comments such as excessive waiting times are recorded and reviewed to enable opportunities for improvement to be identified.
- The trust should consider improving the environment for children in the waiting areas and treatment rooms as these were not child friendly.
- The trust should consider making more activities available for very young children to help distract them whilst waiting to be seen.