

# Heart of England NHS Foundation Trust

# Good Hope Hospital

## Quality Report

Rectory Rd  
Sutton Coldfield  
B75 7RR

Tel: 0121 424 2000


Website: [www.heartofengland.nhs.uk](http://www.heartofengland.nhs.uk)

Date of inspection visit: 20 October 2016

Date of publication: 01/08/2017

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

Urgent and emergency services	Requires improvement	
Medical care (including older people's care)	Good	
Surgery	Requires improvement	
Outpatients and diagnostic imaging	Good	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The trust had undergone significant changes in senior and executive management due to the trust not meeting nationally identified targets. We used the intelligence we held about the hospital to identify that we needed to undertake a responsive inspection of the Emergency department (ED), Medicine, Surgery, and Outpatients and diagnostic imaging.

The inspection took place with an unannounced inspection on 06 September 2016 and on that day we gave the trust short notice of our return on 18 to 21 October 2016.

We did not inspect Maternity and Gynaecology, the trust had commissioned an independent review of the service, this was taking place at the same time as our announced inspection. We decided that it would be too onerous on staff to have two inspection teams at the same time. We also did not inspect critical care, children and young people and end of life services.

We have not aggregated the rating for the hospital, but for the core services only. We did not inspect all the core services or the same core services as previously. You can see the rating comparison of services in the provider report.

- During the inspection we saw both ED and surgery medication management needed to improve. The storage of and checking of medications did not ensure the efficacy of medicines and ensure patient safety.
- Infection prevention control needed to improve in both ED, surgery and outpatient department. There were bloodstains seen in some areas and on some resuscitation equipment in the ED. In addition, screening for infections prior to surgery was not consistent. We saw that hand hygiene audits were not completed in outpatients. Although we did observe good handwashing and gel use appropriately.
- The ED was not meeting national targets to admit, transfer or discharge within four hours.
- Staffing was an issue in medicine services, being consistently below planned numbers.
- Sepsis management needed to improve, as staff were not following the guidance.
- Discharge arrangements for some patients were not always effective leading to delays. This did include lack of provision in the community, but also the planning and management within the hospital needed improvement.
- Within surgery, we noted that some national audits demonstrated that they were performing below the England average.
- The patient flow within surgery had delays at every point, including the return to the ward following surgery.
- Services for vulnerable people did not meet their needs in surgery. For example, the records relating to deprivation of liberty safeguards, were not well completed.
- Feedback to staff relating to incidents and outcomes was not always delivered in outpatients.

However;

- Incident awareness and reporting was good within the hospital.
- The handover process in ED was excellent, this included education development by senior staff.
- A safe patient protocol was in place and being used when patients were being cared for in corridors when the department was full.
- Junior members of staff were well supported, staff told us about the positive teamwork.
- The ED had employed a flow coordinator, to improve the time that patients were seen.
- Within the medicine directorate, surgery and outpatients the safeguarding awareness in staff was good, in line with the trust policy.
- There was good clinical leadership seen in surgery. Medical assessments and risk assessments were completed and reviewed effectively to inform patient care.
- Friends and family test results were above the England average in surgery. Feedback from patients mostly described the compassionate care they received.

# Summary of findings

- Within the outpatient department, we saw that the 'I am clean' stickers were used effectively.
- Medications and prescriptions were stored safely.
- Staff within diagnostic imaging complied with the policies relating to the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME)R.

We saw several areas of outstanding practice including:

ED:

- The trust employed a nurse educator for the ED specifically to ensure nursing staff are competent practitioners. Newly qualified staff had a local induction and a period of preceptorship. Newly qualified staff that we spoke to told us that they received very good support.

Outpatients and diagnostic imaging:

- We saw some excellent examples of innovation. In diagnostic imaging an induction pack had been introduced for the radiographer to reflect on their practice. Following completion of the induction, a discussion took place between the radiographer and the on-site lead. This would provide the radiographer with the opportunity to reflect on their role and ensure they had the knowledge to practice safely.

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

Importantly, the trust must:

**ED:**

- The ED at Good Hope Hospital must ensure they follow policies and procedures about managing medications; including storage, checking medications are in date, and safe disposal of medications.
- The ED must ensure that cleanliness standards are maintained throughout the department in order to ensure compliance with infection prevention and control requirements.

**Surgery:**

- The trust must consistently maintain medicines within their correct storage conditions to ensure medicines are suitable for use.

In addition the trust should:

**ED:**

- The ED should continue to monitor the management of complaints for Good Hope Hospital, ensuring these are investigated and managed within trust timescales.
- The ED should ensure that all appropriate patients receive a risk assessment relevant to their individual needs upon entering the department; for example falls risk assessments.

**Surgery:**

- The trust should ensure compliance with the Mental Capacity Act (2005) is documented.
- The trust should take action to improve adherence to infection prevention and control procedures
- The trust should ensure patients have timely access to pressure relieving equipment suitable for their needs.

**Outpatients and diagnostic imaging:**

- The trust should ensure local rules for lasers are signed and in date.
- The trust should ensure service records for lasers in ophthalmology are up to date and accessible for relevant staff.

Please note the full list of 'Must' and 'Shoulds' can be found at the end of the report.

# Summary of findings

Professor Sir Mike Richards

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Requires improvement

### Rating



### Why have we given this rating?

We rated the service overall as requires improvement:

- The department breached the Department of Health waiting time target to either admit, transfer, or discharge patients within four hours of arrival and was worse than the national average between August 2015 and July 2016. Performance in meeting the target
- Staff within ED reported that due to a lack of capacity within the ED, some patients were cared for outside of cubicles around the nurses stations repeatedly.
- There was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes and in July 2016 this had increased to 51%.
- The department did not meet the trust target of responding to complaints within 30 days. On average, it took 123 days to investigate and close complaints.
- We saw large quantities of medicines that were out of date still stored in the medicine cupboards and fridges throughout ED.
- We saw inconsistent checking of controlled drugs and refrigerator temperatures in certain areas of ED.
- We were concerned about some infection prevention and control procedures; during the announced inspection we saw several old bloodstains on the floor and on equipment within patient areas in the resuscitation area. .

However:

- Staff were aware of how to report incidents and did so routinely.
- Awareness of duty of candour was embedded within the department. Duty of candour relates to openness and transparency and requires

# Summary of findings

providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide support.

- We saw staff undertake excellent handovers which incorporated additional learning from senior members of staff.
- Although patients were located within the corridor at the time of our announced visit, we saw staff using a safe placement protocol to ensure all patients were cared for in a safe manner.
- The department had a plan of audits to undertake in order to measure performance, and took part in national audits.
- Newly qualified or trainee members of staff were well supported both by colleagues and management. All staff we spoke to commented upon the supportive environment and positive teamwork.
- We observed excellent examples of care; whereby staff treated patients with dignity, respect and compassion.
- The trust had recruited a flow co-ordinator to aid the flow of patients throughout the department, and to ensure all patients were treated in as timely a way as possible.

## Medical care (including older people's care)

Good



We rated the service overall as requires improvement:

- The department breached the Department of Health waiting time target to either admit, transfer, or discharge patients within four hours of arrival and was worse than the national average between August 2015 and July 2016. Performance in meeting the target declined during this time period.
- Due to a lack of capacity within the ED patients were cared for in corridors approximately 75% of the time.
- There was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes and in July 2016 this had increased to 51%.

# Summary of findings

- The department did not meet the trust target of responding to complaints within 30 days. On average, it took 123 days to investigate and close complaints.
- We saw large quantities of medicines that were out of date still stored in the medicine cupboards and fridges throughout ED.
- We saw inconsistent checking of controlled drugs and refrigerator temperatures in certain areas of ED.
- We were concerned about some infection prevention and control procedures; during the announced inspection we saw several old bloodstains on the floor and on equipment within patient areas in the resuscitation area. .

## However:

- Staff were aware of how to report incidents and did so routinely.
- Awareness of duty of candour was embedded within the department. Duty of candour relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide support.
- We saw staff undertake excellent handovers which incorporated additional learning from senior members of staff.
- Although patients were located within the corridor at the time of our announced visit, we saw staff using a safe placement protocol to ensure all patients were cared for in a safe manner.
- The department had a plan of audits to undertake in order to measure performance, and took part in national audits.
- Newly qualified or trainee members of staff were well supported both by colleagues and management. All staff we spoke to commented upon the supportive environment and positive teamwork.
- We observed excellent examples of care; whereby staff treated patients with dignity, respect and compassion.

# Summary of findings

- The trust had recruited a flow co-ordinator to aid the flow of patients throughout the department, and to ensure all patients were treated in as timely a way as possible.

## We rated this service as good because:

- All staff clearly understood the safeguarding policies and processes.
- Staff reported incidents and received feedback. There was evidence of learning from incidents across the trust taking place.
- Individual patient risks were identified and managed.
- Staff planned and delivered patients care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Most patient outcomes were similar or better than national expectations.
- Staff delivered compassionate and dedicated care.
- There was an open culture and good team working within the service.
- .

## However:

- Patients were not always safely discharged in a timely manner.
- Staff were not following The Sepsis 6 (Deteriorating Patient Screen pathway) for the patients with sepsis whose notes we reviewed.
- The service was not compliant with recommendations for the safer management of controlled drugs and waste regulations

---

## Surgery

### Requires improvement



We rated this service as requires improvement because:

- Improvements were required in adherence to infection prevention and control practices and medicines management.
- Although staff were aware of the focus on reducing pressure ulcers and falls there was a lack of awareness of other incidents, or any



# Summary of findings

learning which had been identified as a result of incidents. The identification of incidents and risk and the management of risks on the risk register was not always robust.

- The service had below average performance in relation to a range of national measures to assess the effectiveness and responsiveness of care. The effectiveness of care, as measured in national clinical audits, indicated performance below the national average in a number of areas. The risk of an unplanned re-admission following discharge was also higher than the England average for all specialties other than urology. The average length of stay for elective surgery was higher than the England average
- Patients experienced delays at all stages of the patient journey through surgical services. This included delays in scheduling unplanned surgery and delays in returning from recovery to the surgical wards.
- Care provided did not always take account of patients' individual needs, in relation to those living with dementia and those with a learning disability. Access to independent translation services was not promoted. Records of mental capacity assessments and the best interest decision making process was not well completed.

However:

- There was a good awareness and escalation when patients' condition deteriorated and a good awareness of sepsis.
- Initial medical assessments and nursing risk assessments were completed and reviewed appropriately; there was a multi-disciplinary approach to care and clear plans of care for patients. Care pathways were used for routine procedures to ensure a consistent approach to care. Patients' pain was regularly assessed and effectively managed. Patients were aware of the plans for their care and felt involved in decision making.
- Good clinical leadership was in place at ward level. Staff had access to training and development and completion of mandatory

# Summary of findings

training was generally good. They had attended adult safeguarding training and there was good awareness of safeguarding policies and procedures. Staff worked well together; they were supportive of each other and were committed to improving the quality of patient care.

- Patients gave mostly positive feedback on the care and compassion shown by staff and the timeliness of staff responses when they required assistance. Results from the Friends and Family Test (FFT) were above the national average. We observed patients' privacy and dignity being maintained and a professional and sensitive approach by staff when providing care.

## Outpatients and diagnostic imaging

Good



We rated this service as good because:

- We saw staff washing their hands and using the gel provided.
- Incidents were investigated; we reviewed incident reports and root cause analysis documents from outpatients and diagnostic imaging and found these to contain details of concerns, findings from investigations, recommendations and arrangements for shared learning.
- Outpatients and diagnostic imaging departments were tidy, clean, and uncluttered. Equipment had I am clean stickers applied, this showed equipment had been cleaned. In diagnostic imaging, we saw evidence of the cleaning of ultrasound probes before and after use.
- Equipment was maintained and tested in line with trust policy. We saw that labels were applied which identified when equipment had last been checked. Service reports were available to view in diagnostic imaging. There were plans in place to replace or purchase additional pieces of equipment in diagnostic imaging.
- Hospital staff kept medications locked and secure in cupboards. Prescriptions were stored securely.
- Records reviewed were legible, accurate and up to date.
- Staff were aware of their roles and responsibilities in relation to safeguarding and knew how to raise matters of concern.

# Summary of findings

- Nursing, medical and dental staff received mandatory training. The training consisted of 17 modules including infection control, information governance and manual handling.
- Staff in diagnostic imaging adhered to diagnostic imaging policies and procedures. These were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME)R.
- Procedures were in place to ensure that the probability and magnitude of accidental or unintended doses to patients from radiological practices were reduced as far as reasonably practicable.

## However:

- Service records for lasers were unavailable to inspection staff at the time of the inspection; staff were unable to locate these. Local rules for YAG and KTP (types of lasers) were displayed, however they were not dated. Local rules should be signed and dated by the laser protection advisor.
  - Feedback to staff on individual incidents was limited.
  - There was a lack of hand hygiene audits for the main outpatient department.
-

# Good Hope Hospital

## Detailed findings

### **Services we looked at**

Urgent and emergency services; Medical care (including older people's care); Surgery; Outpatients and diagnostic imaging;

# Detailed findings

## Contents

Detailed findings from this inspection	Page
Background to Good Hope Hospital	13
Our inspection team	13
How we carried out this inspection	14
Facts and data about Good Hope Hospital	14
Our ratings for this hospital	15
Findings by main service	16
Action we have told the provider to take	90

## Background to Good Hope Hospital

- There are 445 beds at this hospital at the time of our inspection.
- This trust is a Foundation Trust, this means
- At the time of the inspection the trust was starting the process to seek approval to merge with University hospitals Foundation Trust.
- The Hospital is based in the North of the city of Birmingham; this is an affluent part of the city of Birmingham.
- We used the intelligence we held about the hospital to identify that we needed to inspect of the Emergency department (ED), Medicine, Surgery, Critical care and Outpatients and diagnostic imaging. In relation to Critical Care we inspected this service as it had been rated good previously and wanted to see if it had improved further.
- We have inspected because we needed to be assured that the trust was on an improvement trajectory. Intelligence from the trust and nationally available reports along with information from the public, helped us to identify the services for which we had concerns.

## Our inspection team

Our inspection team was led by:

**Head of Hospital Inspections:** Tim Cooper, Care Quality Commission

**Inspection Manager:** Donna Sammons, Care Quality Commission

The inspection team also consisted of 12 Acute Inspectors, 2 Medicines Inspectors and 2 Assistant Inspectors. We were also assisted by 21 specialist advisors.

# Detailed findings

## How we carried out this inspection

Heart of England NHS Foundation Trust (the trust) was inspected previously in December 2014 as part of an unannounced responsive inspection. The trust was in breach with regulators NHS Improvement,

and we had received intelligence which warranted our response and so we arranged an inspection. The inspection took place between 08 and 11 December 2014 and focussed on A&E, Medicine, Surgery, Maternity and Outpatients Departments on all three sites. The trust was rated as requiring improvement in December 2014.

Due to further undertakings by NHS Improvement in which an interim management team was appointed at the trust and in addition to intelligence gathered by the CQC, we undertook an unannounced inspection on 06 September 2016 which formed part of, and informed a short noticed focussed inspection which took place between 18 and 21 October 2016. The inspection covered medical care, surgery, urgent and emergency services and outpatient and diagnostic imaging services across the trust. We also inspected community services for adults, the Birmingham Chest Clinic, Castle Vale Renal Unit and Runcorn Road Renal unit.

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

- Is it safe?
- Is it effective?

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

Before our inspection we reviewed a range of information we held about the trust and asked other organisations to share what they knew. These included Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

As part of our inspection, we held focus groups and drop-in sessions with a range of staff in the trust including nurses, trainee doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the trust.

## Facts and data about Good Hope Hospital

The health of people in Birmingham and Solihull is worse than the England average. Deprivation is higher than average and about 29% (72,000) children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in Solihull is better than the England average. Deprivation is lower than the England average and about 16% (6,000) children live in poverty. Life expectancy for both men and women is higher than the England average.

The trust's main CCG (Clinical Commissioning Group) is NHS Birmingham Cross City.

This trust has four main locations:

- Good Hope Hospital
- Heartlands Hospital
- Solihull Hospital
- The Birmingham Chest Clinic

Activity and patient throughput For the 2015/16 year the trust had:

- 223,189 A&E attendances.

# Detailed findings

- 232,073 inpatient admissions.
- 2,482,230 outpatient appointments
- 60,525 surgical bed days.

The trust employed 9,120 staff.

Of this there were 3,057 nurses, 1,002 medical staff and 580 allied health professionals

The trust had a budgeted establishment of 10,322 staff.

The financial position 2015/16

- Income £682.9m
- Underlying Deficit of £65.6m

- The trust predicts that it will have a surplus of £19,000 in 2016/17.

In addition to standard specialties at the trust, they also provide the following Specialist services at the Birmingham Chest Clinic;

- Allergy Services
- Chest X-Ray Service
- General Lung Disease
- Rapid Access for Suspected Lung Cancer
- Occupational Lung Disease
- Tuberculosis (TB)




## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Urgent and emergency services</b>	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
<b>Medical care</b>	Good	Good	Good	Requires improvement	Good	Good
<b>Surgery</b>	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
<b>Outpatients and diagnostic imaging</b>	Good	Not rated	Good	Good	Good	Good
<b>Overall</b>	N/A	N/A	N/A	N/A	N/A	N/A

### Notes

# Urgent and emergency services

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Good	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Urgent and emergency services at Good Hope Hospital are provided 24 hours a day, seven days a week. The trust also has an emergency department (ED) at Birmingham Heartlands Hospital and a minor injuries unit at Solihull Hospital. Both of these locations have been reported separately.

The paediatric unit is open between 7am and 3am each day; outside of these hours paediatric patients can attend via the adult ED.

The ED department comprised of an area for major injuries, an area for minor injuries, a paediatric ED unit, resuscitation area and a clinical decision unit (CDU). The major injury area provides 17 cubicles where seriously ill patients can be seen. The minor injury section contains four bays for assessment. The resuscitation area had space for five patients, including one specifically for paediatric patients. The paediatric ED unit was separated by locked doors from the rest of the unit, and contained four bays and a triage area.

The Clinical Decision Unit (CDU) was established for patients with low risk conditions and aims to prevent unnecessary admissions to hospital by offering a short stay placement (12-24 hours). There are four cubicles within CDU.

ED also contains a specific room for psychiatric patients to be seen and assessed, a relatives room, a viewing room and waiting areas for patients and relatives within minor injuries, major injuries and paediatrics.

Between August 2015 and July 2016, Good Hope Hospital ED had 88,486 attendances. The month with the lowest number of attendances was December 2015 with 6983; the highest being May 2016 with 7954. Of the total number of attendances during this period, 25,610 patients were admitted. Activity at this location was calculated as above targets by 3.4% for this time period; as seen within the trust's finance exception report; September 2016.

The inspection took place over two days at Good Hope Hospital; an announced inspection on the 20th October 2016 and an unannounced inspection during the evening on the 29th October 2016.

During the inspection, we spoke with 12 patients, seven relatives, 19 staff members of varying grades, including consultants, middle grade doctors, junior doctors, nurses, healthcare assistants, and student nurses. We looked at 23 patient records, including one paediatric record.



# Urgent and emergency services

## Summary of findings

We rated this service as requires improvement because:

- The department breached the Department of Health waiting time target to either admit, transfer, or discharge patients within four hours of arrival and was worse than the national average between August 2015 and July 2016. Performance in meeting the target declined during this time period.
- Staff within ED reported that due to a lack of capacity within the ED, some patients were cared for outside of cubicles around the nurses stations repeatedly.
- There was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes and in July 2016 this had increased to 51%.
- The department did not meet the trust target of responding to complaints within 30 days. On average, it took 123 days to investigate and close complaints.
- We saw large quantities of medicines that were out of date still stored in the medicine cupboards and fridges throughout ED.
- We saw inconsistent checking of controlled drugs and refrigerator temperatures in certain areas of ED.
- We were concerned about some infection prevention and control procedures; during the announced inspection we saw several old bloodstains on the floor and on equipment within patient areas in the resuscitation area.
- We saw that ED at Good Hope Hospital had outstanding complaints awaiting an investigation and response, although actions had been taken to address this. The trust was not meeting targets of ensuring patients were admitted, transferred or discharged within four hours of attending; and was worse in this area than the England average.

However:

- Staff were aware of how to report incidents and did so routinely.
- Awareness of duty of candour was embedded within the department. Duty of candour relates to openness

and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide support.

- We saw staff undertake excellent handovers which incorporated additional learning from senior members of staff.
- The department had a plan of audits to undertake in order to measure performance, and took part in national audits.
- Newly qualified or trainee members of staff were well supported both by colleagues and management. All staff we spoke with commented upon the supportive environment and positive teamwork.
- We observed excellent examples of care, whereby staff treated patients with dignity, respect and compassion.
- The trust had recruited a flow co-ordinator to aid the flow of patients throughout the department, and to ensure all patients were treated in as timely a way as possible.

# Urgent and emergency services

## Are urgent and emergency services safe?

Requires improvement



We rated safe as requires improvement because:

- The use of the modified early warning score (MEWS) to identify patients whose condition was deteriorating was not consistent and was not completed within the required time periods or frequency.
- We found a significant amount of medications to be out of date within various areas of the department. Furthermore, medicines and medicines storage were not being checked as per good practice guidelines or as per the trust medicine policy.
- We saw old blood stains in patient areas on the floor and on equipment trolleys. We were not assured that infection control practices were embedded.
- We observed that a falls assessment was not completed on a patient who presented at the Emergency Department (ED) as a result of falling.
- During the unannounced visit we observed the psychiatric room to be unfit for purpose and used as a storage room.

However:

- Staff were aware of incident reporting and provided examples of learning from past events.
- We saw excellent handovers which ensured patient care and safety.
- We saw effective use of a safe placement protocol for those patients located in the corridor awaiting treatment.

### Incidents

- Data from the trust showed Good Hope Hospital ED reported 751 incidents for the period of September 2015 to September 2016. Of these, 507 were recorded as 'no harm', 199 as 'low harm', 37 as 'moderate harm' and seven as 'severe harm' and one as 'catastrophic/ death'. Of the seven severe harm incidents; five were related to pressure ulcers which developed prior to admission to hospital and the other two related to delayed diagnosis. The catastrophic/ death incident related to the suboptimal care of a deteriorating patient; at the time of the inspection the root cause analysis had not been completed.

- Between May and August 2016, the highest number of reported incidents were in relation to tissue viability (148 out of 271). Twenty-one incidents were reported for both medication errors and security incidents. In accordance with the Serious Incident Framework 2015, the Urgent and Emergency Care directorate reported four serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016. One of these incidents related to Good Hope Hospital. This was in relation to non-adherence to trust data protection and IT by a locum doctor. We saw that a robust approach had been taken to investigating these and lessons learnt were documented. Staff provided explanations and apologies to patients where appropriate.
- Between August 2015 and October 2016, the service reported no incidents which were classified as Never Events. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Nursing and medical staff told us they were aware of how to raise incidents and gave examples of incidents they would report or had reported. Staff told us they received an automated email response from reporting incidents. Student nurses told us they were not personally able to report incidents, but would ask a nurse to do so on their behalf if required.
- Staff reported that incident feedback was received through managers and senior management through various channels and provided examples to support this. For example, an electronic information sharing journal 'Risky Business' which aimed to highlight incidents and share learning. We saw from band 7 nurse team meeting minutes, that incident reporting and analysis was discussed; and support plans for staff were drawn up.
- Data from the Patient Safety Thermometer showed that there were zero pressure ulcers, zero falls with harm and zero catheter urinary tract infections reported between August 2015 and July 2016 for the emergency department (ED) department.
- We saw minutes from a morbidity and mortality meeting, dated October 2016, for paediatrics detailing a paediatric death at Good Hope Hospital in September 2016. Key points surrounding this death were

# Urgent and emergency services

highlighted; with additional notes to invite further key individuals to these meetings in future. The minutes also contained details of a safeguarding update regarding referrals for further support for parents experiencing mental health problems. Action points were highlighted for band 7 attendees to disseminate learning to staff, and for the updates to be promoted through 'risky business'.

- Regarding morbidity and mortality in adults, a trust presentation dated September 2016 provided an overview of a joint ED critical care meeting about traumatic arrests in March 2016. Relevant deaths were explored with reference to traumatic arrest guidelines in terms of managing future cases.

## Duty of Candour

- From November 2014, NHS providers were required to comply with Duty of Candour regulations. Duty of candour relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide support.
- Between September 2015 and September 2015, the trust reported seven incidents following which the duty of candour was followed.
- We spoke to staff about their understanding of duty of candour. Staff were able to tell us what duty of candour was and how it would be put into practice.

## Cleanliness, infection control and hygiene

- Trust wide ED hand hygiene audits from April 2015 to July 2016 showed 100% compliance with the exception of April 2015 (70%), March 2016 (no results) and July 2016 (90%). Within ED, a specialist infection prevention and control nurse had been appointed to address poor practice and to improve standards of hygiene and cleanliness throughout ED. This member of staff attended specific learning events around infection prevention and control in order to disseminate this learning to the wider team.
- The trust provided us with updated cleaning reports for Good Hope Hospital dated November 2016. Scores achieved during this review were over 98% overall for 466 audits. For the paediatric area, scores were between 98 – 100% for 186 cleanliness audits. The minor injury area of A&E scored an average of over 98% cleanliness across 245 audits.

- We saw that the majority of the emergency department appeared clean. However during our announced visit in the resuscitation area, we saw several old blood stains on the floor and on equipment trolleys both within and outside of a patient cubicle which was not from that patient. We raised this with staff who immediately cleaned these up. Later that day, we saw staff thoroughly cleaning the cubicle.
- We saw an inconsistent approach by staff to washing and gelling hands both prior to and after seeing patients; and when moving between different areas of the department. The majority of staff were seen to observe good hand hygiene practice, in addition to using appropriate equipment such as gloves and aprons. Patient comments also confirmed this. However a small number of staff were not compliant.
- We saw that within one cubicle within the resuscitation area; staff found it difficult to access the sink due to a chair being in the way. Therefore staff used hand gel rather than moving the chair and washing them.
- There was no hand gel available at the entrance to the 'Majors' area.
- We saw that staff generally complied with the 'bare below the elbow' requirements; although one staff member was noted to be wearing a non-wedding band ring. This was removed when CQC staff were present.
- We saw 'I am Clean' stickers on equipment throughout ED indicating that these items had been cleaned on the date specified and were ready for use.
- Within the Ward to Board Assurance Report for emergency care provided by the trust, we saw that no cases of MRSA or Clostridium difficile had been recorded between August 2015 to July 2016.
- The infection control nurse told us they conducted handwashing, catheter insertion and environment audits monthly. The August 2016 audit showed 50% compliance with hand hygiene and 60% compliance with catheter insertion. Hand hygiene was reported at 90% the previous month; however no data was provided for evidence of audit results prior to this. The August result for catheter insertion was a significant improvement on the preceding two months. The nurse provided feedback to staff which incorporated the use of a 'glowbox'; a piece of equipment designed to highlight any unwashed areas of the hands. The ED team were also encouraged to challenge each other if gaps in handwashing or infection prevention were noted. Data provided by the trust did not contain results

# Urgent and emergency services

for September 2016 therefore it was not possible to determine improvement. Other changes included: special trolleys, aseptic wipes attached to sharps bins, isolation boxes made ready, green 'I Am Clean' labels. Furthermore, the sluice was decluttered and a commode audit was carried out.

## Environment and equipment

- We saw that, with the exception of the paediatrics area, it was easy to access all areas of ED without a swipe card. This meant patients and the public could enter ED as they wished which may have impacted upon security. For example, staff told us that their emergency decontamination kit was stolen from the department. The kit was replaced quickly with an alternative, however, we were unable to identify any actions to prevent a similar issue occurring in the future
- We saw that nursing staff regularly checked all resuscitation trolleys throughout ED and associated paperwork was completed fully. The trolleys were located in appropriate places for emergency access.
- We saw that equipment such as swabs, dressings, and syringes were in date and rotated appropriately. Those nearing their expiry date were clearly marked.
- We saw the utility and isolation rooms were clean and fully equipped.
- We observed that electrical equipment safety testing had been completed and all electrical equipment sampled by the inspection team was within date. Equipment check logs were up to date.
- We identified potential hazards in the room allocated for patients experiencing mental health difficulties during the unannounced inspection. The room appeared to be being used as a storage room and contained articles such as a wooden chair, walking frames and a metal stool. The inspection team escalated this concern at the time of inspection; staff told us that the room is not normally used as a storage room. During the announced visit, we saw the furniture had been removed and the room was made fit for purpose.
- The ED had separate areas for paediatric patients and adult patients. However, between 3am and 7am the paediatric area was closed; therefore any children attending would be seen in the adult's area. In addition, one of the five resuscitation beds was reserved for the use of paediatric patients. This was at the end of the bay; therefore paediatric patients could be kept

reasonably separated from adult patients. Appropriate paediatric resuscitation equipment was kept in this area. All staff spoken with were aware of how to manage paediatric patients outside of paediatric opening hours.

- Data from the trust showed that an environmental health and safety audit had been conducted in February 2015, with a review due in December 2016. Several actions were identified as a result of this audit, including exploring the possibility of improving the natural lighting in the department, ensuring quarterly assessments were completed, monitoring the leaking roof and ensuring risk assessments were completed for Control of Substances Hazardous to Health (CoSHH), Display Screen Equipment (DSE), lone working and manual handling.
- The trust provided us with data to report that ward environment audits had been carried out between April 2015 and July 2016. For several months, no audit result was recorded however for July 2016, the result was 84% compliant. This was a drop from 90% reported in April 2016. These results indicated the ward environment was not meeting targets for safety. We saw action plans were in place to improve the environment following the above mentioned health and safety environmental audits completed 2015, due for review December 2016. However it was not clear within the documentation whether all actions had been achieved.
- One resuscitation bed was allocated specifically for children; the area was child friendly, and was located at the end of the area. Death packs for sudden infant death were available; as was neonatal grab bag and blankets and nappies. The area was fully equipped with all articles sealed and in date.

## Medicines

- We found that medicines in the major injury unit, minor injury unit and clinical decision unit were stored securely. However, the paediatrics medicine cupboard and the medicine refrigerator, both located within the resuscitation area were unlocked; therefore allowing free access. We raised this concern on both the announced and unannounced inspection.
- Since the inspection, the trust have informed us that the fridge lock in the resuscitation area was faulty and the lock needs to be replaced. The trust initially raised this issue through the estates department, but have since

# Urgent and emergency services

ordered a replacement from the manufacturers. The trust further informed us that the broken refrigerator lock has been placed on the department risk register until the repair has been undertaken.

- Staff within ED told us that the pharmacy department managed the process for medication stock and date checking, however staff also told us that the process for ordering medications was that night staff would order the required medications via an order book, which was sent to the pharmacy department who would fulfil the order. Therefore night staff should have noticed the out of date medication. When we checked all areas for out of date stock, we found resuscitation and the major injury/ illness department had a significant amount of out of date medication, or medications that had been opened and were now past their use by date. Examples of this were insulin pens, vials and bottles of insulin, medications which formed part of a pre-eclampsia kit. We escalated this concern to the emergency department practitioner and the matron who both immediately took action. We also found out of date glucose in the paediatrics medicine cupboard; the sister immediately removed these when informed.
- The trust provided an update and stated that they immediately returned any out of date medication to pharmacy and requested a member of the pharmacy team attended to fully check all medications in all areas of the hospital ED. The trust reported that this issue has been built into pharmacy ward audits for future maintenance. Furthermore, the matron includes spot checks of medication within her ward rounds.
- We saw in the clinical decisions unit that all medications were in date and appropriately monitored. However there was a packet of a patient's personal medication which had clearly been there for some time and was out of date. Pharmacy department had not collected this.
- We found that all controlled drugs across the department were stored securely and checked twice daily. All controlled drugs checked were within date. However, within the resuscitation order and delivery book, a few entries had not been signed to say the medications had been received.
- Nursing staff told us that they were issued with patient group directions (PGDs) therefore, enabling them to issue set medications without the immediate need for a

prescription from a doctor. Nurses told us they completed specific training to enable them to hold PGDs. Staff told us that the paperwork relating to this was held centrally by the pharmacy department.

- We saw that refrigerator temperatures of the drugs storage refrigerators were within the correct limits; which is between two and eight degrees. Room temperatures were also appropriate at under 25 degrees. Temperature logs demonstrated that staff checked these daily as per best practice guidelines within the resuscitation area. However, according to data provided by the trust from August to October 2016, within ED generally medicines sometimes went days without being checked at all, including the controlled drugs and fridge temperatures. For example, between Tuesday 13th September and Sunday 18th September, no medications were checked, nor fridge temperatures recorded on days which the department was open. Furthermore, where controlled drugs were checked, often this was only by one member of staff, rather than two, and on other occasions controlled drugs were checked just once a day rather than two as per the HEFT medicines policy. Logs provided for the trust were only available between August to November 2016.

## Records

- We looked at 23 records including one paediatric record. The department used both electronic patient records and paper records. The paper records were stored securely, were legible and up to date. Staff signed and dated their entries. Patient notes and observations were paper based. These were easily accessible for different staff to view and interpret; for example if a patient moved from the major injury area to resuscitation. If patients were moved to a different area, such as x-ray, staff could take patient notes with them with ease.
- Records reviewed during the inspection showed completed triage, pain scores, fluids, presenting condition and other key information.
- Staff printed patient wristbands following initial assessment.
- We saw in paediatrics, staff completed a discharge letter to provide to the patient's GP and school if necessary.
- We requested audits of ED records from the trust to corroborate our findings. The trust told us they have not done any audits for the last 12 months.

## Safeguarding

# Urgent and emergency services

- We spoke with staff who reported they had completed mandatory safeguarding training.
- Safeguarding children and adults level 1 and 2 had a trust-wide training compliance of 100% for nursing staff, thereby exceeding the trust target of 85%. Safeguarding children level 3 had a completion rate of 84%; just below the trust target.
- Medical staff had a training completion rate of 100% for safeguarding children and adults level 1. Safeguarding children level 3 had a completion rate of 77%, therefore not meeting the trust target.
- Staff provided examples of when they would raise a safeguarding alert and were able to verbalise how they would do this.
- We saw the trust was implementing female genital mutilation (FGM) training. We spoke with the education lead who confirmed this, and we saw copies of the lesson plans for this session and posters up advertising the training to staff. The trust had an up to date policy for adult and child safeguarding.
- In paediatrics, staff displayed a good level of safeguarding knowledge. Staff gave examples of identifying children who might be at risk in order to check their history. Staff were aware of identifying repeating conditions.
- We observed that staff asked safeguarding questions of patients or relatives, especially in the paediatrics area, and recorded this on the patients' records. Staff also asked questions about contact with social services or any other relevant bodies. We saw these details were also recorded in records.
- We saw that missing patients were flagged for followed up. During the unannounced inspection, we saw the sister in charge report that a patient was missing, to police, security and Rapid Assessment, Interface and Discharge (RAID), using a specific form. A West Midlands Ambulance Service crew returned the missing patient to the hospital.
- Staff told us support and supervision for raising safeguarding concerns was available from colleagues of a same grade, or more senior staff.
- We saw that within paediatric mortality and morbidity meeting minutes (October 2016), meeting attendees discussed safeguarding as an agenda item and to learning disseminated to staff through verbal and electronic communication.
- Staff reported they attended an annual update for mandatory training, both e-learning and face to face. Line managers reminded staff to complete this. This included both nursing and medical staff.
- We looked at training records for all ED nursing staff across the trust. We saw that eight of the 17 mandatory training courses had a completion rate of 100%, and five others met or exceeded the trust target of 85%. However four courses did not meet the trust target. These included blood transfusion administration (68%), waste management (78%), and safer swallowing and manual handling training were both at 83%.
- Medical staff mandatory training data showed ten of the 17 mandatory courses fell below the trust target. However, eight had 100% compliance, and one met the trust target. Courses with lower completion rates included blood transfusion administration (44%) and waste management (36%).
- Several different grades of staff told us that for new staff, a comprehensive induction was provided, which included mandatory training such as basic life support, patient handling and safeguarding. Staff also received information on REACT, the hospital's occupational therapist and physiotherapy services, RAID, the hospital mental health service and relevant information regarding sepsis and identification of this.
- As part of their induction, student nurses were also offered, the opportunity to attend an 'ambulance day' whereby they accompanied a West Midlands Ambulance Service crew for a shift to develop knowledge and awareness of this role.

## Assessing and responding to patient risk

- Between August 2015 and July 2016 Good Hope Hospital reported 198 "black breaches". A black breach is when a patient waits over an hour from an ambulance arriving at the ED until the ambulance staff can hand the patient over to ED staff. Good Hope Hospital reported 11 "black breaches" in August 2015 and 6 in July 2016. There was a downward trend in the monthly number of "black breaches" reported over the period. A high number of black breaches (29) were reported in October 2015 and the lowest number (6) in July 2016. For the remainder of the twelve month period, an average of 16 'black breaches' were reported per month.

## Mandatory training

# Urgent and emergency services

- Data provided by the trust indicated that for the financial year 2016/ 2017 the average time for ambulance handover was 20 minutes. The trust reported in June 2016.
- During the inspection, we saw that ambulances were not queuing to deliver patients; and the ED department presented as calm, controlled and timely.
- We saw all patients received initial clinical assessments by appropriately skilled staff.
- Data from the trust for the months of January to August 2016 demonstrated some areas of patient observations were not meeting required targets. For example, checks of ongoing hourly MEWS (Modified Early Warning Score) showed that May 2016 was the only month of those checked, to meet target of 100%. All other months checked were below target. Checking MEWS within 30 minutes of arrival was slightly better; however again the target was only met in March, May and June 2016. During August 2016, only 60% patients checked had their MEWS completed within 30 minutes of arrival.
- The target for observations being rechecked at regular intervals was achieved at 100% across every month checked.
- We observed that staff did not complete a falls assessment or implement a falls care plan for an elderly patient who had presented at ED following a fall. We saw that staff had seated the patient in such a way they were unable to fall again to maintain the patient's safety.
- We saw that staff could easily monitor the number of patients and their status in the different areas of ED through the use of a live computer database.
- We saw that staff had access to a safe placement protocol and would complete this for patients in the corridor, to ensure safety at all times.
- We saw that the department allocated a nurse to provide cover to any patients in the corridor if required. This was to complete rapid assessments and to conduct further observations. If a corridor nurse was not available or there were too many patients in the corridor or waiting on ambulances, escalation procedures would be followed reporting to the HALO (Hospital Ambulance Liaison Officer; funded through the hospital but employed by West Midlands Ambulance Service) and senior staff.
- We were told the escalation protocol was to inform the 'bleep holder', bed manager, HALO and on call consultant. The escalation policy was due for renewal on 21st September 2016. We saw a note in ED coordinator folder which told staff to continue with current escalation policy. The escalation procedures staff said they followed, were in line with the Good Hope Hospital escalation policy dated November 2015. The trust told us that any overcrowding concerns were discussed during the three bed meetings that took place in ED daily.
- Staff told us frequent attendees to ED were discussed at staff meetings; in particular if those patients could present as a risk to staff or other patients; such as through violence. Staff told us they felt safe in the department as there was sufficient security on site. We saw two security staff enter the department to assist with a patient who had been assaulted.
- We saw that patients with mental health conditions including those sectioned under the Mental Health Act were brought to ED. The staff had access to a specialist mental health team, Rapid Assessment, Interface and Discharge (RAID) 24 hours a day, seven days a week. We saw one patient brought to ED who was awaiting a bed in a secure facility. This patient was immediately located in a cubicle as they were distressed.
- We saw staff put measures in place to monitor risk factors such as allergies; patients were given a red wristband so this information was easily identifiable. We saw staff double check with patients any such allergies before recording this information.
- Of the 23 records we looked at, these demonstrated that MEWS and Paediatric Early Warning Score (PEWS) and repeated observations had been completed appropriately during the time of our visit.
- Patients who reported allergies were given a red wristband for easy identification.

## Nursing staffing

- Data provided by the trust for the time period May 2016 to August 2016 indicated that qualified nursing staffing was between 91% and 93% of planned staff. Therefore there was up to a 9% deficit of nursing staff on average each month. Healthcare assistant staffing ranged from 107% to 117% for the same period, indicating for this grade, overstaffing occurred every month. Therefore the trust presented with the right staff numbers overall, but with a partial incorrect skill mix of the nursing staff.

# Urgent and emergency services

- The trust reported their nursing staffing numbers for August 2016, Good Hope Hospital ED had 8.3 less nursing staff in post than what was budgeted for. For September 2016, the trust reported a vacancy rate of 21% in emergency care nurse management.
- In September 2016, the trust reported a turnover rate of 9% in ED as a whole for nursing care. Between April 2015 and March 2016, the trust as a whole reported a sickness rate of 3% in ED nursing staff and a sickness rate of 9% in ED nurse management.
- The trusts divisional performance report for September 2016, identified that the trust had recruited 17 new nursing staff for September 2016 across Good Hope Hospital and Birmingham Heartlands Hospital.
- We saw from band 7 nurse meeting minutes from 2016 that the skill mix for ED should include one band 7 and two band 6 nurses per shift to provide adequate cover. We saw that staffing and skill mix was a regular item on the agenda; with nurses making plans to manage any shortfalls or problems.
- During the announced and unannounced inspection, we saw that staffing was at planned levels. We were told during the unannounced inspection that bank staff were used on approximately one shift per week, and agency staff are not used.
- Staff told us that staffing specifically for the paediatric unit required two paediatric nurses in order to meet the needs of patients. We were told that should staffing fall below this, a nurse would be supplied from the 'majors' department to cover the shortfall. We saw that paediatric staffing was calculated according to the predicted flow of patients.
- During 2015, the trust's EDs were measured against National Institute for Health and Care Excellence (NICE) draft guidelines 'Safe Staffing for Nursing in ED Departments'. Both departments were compliant with the following nurse to cubicle ratios: one registered nurse to four cubicles in majors/minors and one registered nurse to two cubicles in resuscitation.
- The NICE guidelines were withdrawn prior to publication. The SHELFORD Group who developed the 'Safer Nursing Care Tool' for inpatients and a revised version for Acute Medical Units and Surgical Assessment Units was currently developing a similar tool for emergency departments. The trust's workforce lead was in contact with another local NHS trust to ensure that the trust could access this tool as soon as it was available.
- Staff told us they did generally manage to get their breaks, even if this was not at the time scheduled.
- Nurse handovers were conducted twice daily to discuss patient flow, conditions, acuity and any other concerns such as breaches to ED targets. Nurses used SBAR (Situation, Background, Assessment, Recommendations) as part of their handover every shift. We observed a good quality handover between a paramedic and a nurse.

## Medical staffing

- We were told that medical staffing was a concern for the trust as a whole, especially for middle grade doctors. This was highlighted within the trust risk register. The trust were carrying out recruitment drives which included recruiting from overseas and creating roles in which a doctor would spend time on different areas across the hospital, thus making a role more appealing. The trust's divisional performance report, September 2016, corroborated this information, reporting that the trust had recently recruited four new middle grade doctors from overseas for ED.
- The trust provided the inspection team with data which indicated that at September 2016, the trust's ED departments as a whole had a vacancy rate for medical staff of 33%. This was further broken down into a 29% vacancy rate for junior medical staff and 38% vacancy rate for senior medical staff.
- During the same period, September 2016, the trust reported a turnover rate of 44% within ED medical staff across the trust.
- Within September 2016, the trust reported a 1% sickness rate for ED medical staff. A bank and locum usage for medical staff across the trust was reported as 22% on average between October 2015 and September 2016.
- With regards to the medical staff skill mix; the trust reported that across the trust's EDs, the proportion of consultants and registrar doctors working was about the same as the England average. The proportion of junior doctors, however, was lower than the England average. The number of middle grade doctors was higher than the England average.
- Medical staff told us that medical cover was staggered throughout the night. We were told that consultants' shifts ran from 8am to 10pm, however consultants often stayed later. There were no specific ED on call



# Urgent and emergency services

consultants overnight, however staff could consult alternative on call consultants if required. A paediatrician consultant was available 24 hours a day. Otherwise, on call consultants were available.

- Data provided by the trust reported that there was less medical cover over the weekend compared to Monday to Friday. Specifically at the weekends, there would be two consultants, four middle grade and nine junior doctors as compared to weekdays where there were three consultants, six middle grade doctors and 11 junior doctors. The reason for this reduction in medical staff members was due to lower patient attendances at the weekend.
- The trust used locum doctors when required. Locum doctors present during the inspection told us they were appropriately inducted and orientated prior to commencing their shift. Furthermore, locums were able to access IT systems to check policies and incident reporting systems. Locum doctors told us they were happy to work in this department. Data provided from the trust reported that the majority of locums used at GHH were internal locums as opposed to agency locums.
- We observed a medical handover. The medical team discussed patients in detail to enable doctors coming on shift to provide appropriate care and treatment. We also saw the lead consultant conduct a short training session during handover; using a patient's live test results. Medical staff told us this was a regular occurrence during handovers.

## Major incident awareness and training

- The trust had a major incident plan specific to Good Hope Hospital that was updated March 2016.
- The trust provided us with a preliminary winter plan for Good Hope Hospital. The plan included relocating a medical ward to make space, having additional paediatric medical presence, processing equipment for hypothermia patients and increasing coverage of a GP led service.
- Staff told us that their emergency decontamination kit was stolen from the department; an alternative kit was immediately borrowed from West Midlands Ambulance Service with training provided on its use until the trust procured a new kit; therefore showing a proactive approach to managing potential major incidents.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated effective as good because:

- We saw a good plan of both internal and external audits to be undertaken over the financial year and beyond.
- Learning from audit results was embedded; the trust recognised allocated staff champions to promote positive change.
- We saw effective cross-team working throughout the department.
- Newly qualified staff were provided with good levels of support to achieve competencies.

However:

- Appraisal rates for nursing staff did not meet trust targets.

## Evidence-based care and treatment

- We saw a plan of audits for 2016/17, which detailed a programme of internal and external audits and quality improvement programmes to be completed. Several audits were specifically for benchmarking the trust against RCEM standards.
- Good Hope Hospital made three submissions to the Trauma Audit and Research Network (TARN) April 2014 to March 2015, and did not submit numbers for the period April 2015 to March 2016. This was due to HEFT not providing the necessary administrative resource to monitor such data for GHH. Therefore, inclusion of TARN analysis had not been completed.
- The trust provided action plans, dated July 2016, following a urinary retention audit which covered all three sites. All actions were set for review in October 2016; however the action plan did not specify whether these actions had been achieved.
- We saw that patients subject to the mental health act had access to competent and trained staff for assessment, and a specific room was allocated for psychiatric patients.

# Urgent and emergency services

- Within the paediatric unit we saw the WET FLAG calculator was present for assessing the need of medicine when resuscitating a child.

## Pain relief

- We saw during observations of patient assessments, and patients and relatives reported, that staff regularly checked pain levels, and staff provided pain relieving medicines as required. We saw staff recorded this in records on a pain score of 0-10 across all 23 records looked at.
- We saw, and patients and relatives confirmed, that staff brought pain relief promptly when patients requested it or it identified as a need.
- Within the paediatric unit, we saw child friendly pain charts so children could easily identify what level of pain they were experiencing.
- Nurses working on triage in ED had patient group directions (PGD) in place to allow them to administer pain relief such as paracetamol and ibuprofen. PGDs provide a framework that allows some registered health professionals to administer a specified medicine to patients without them having to see a doctor. This meant nurses could minimise patients' pain while they waited for assessment and further treatment.
- The trust provided us with a quality improvement plan dated October 2016 which outlined developments made in this area since May 2016. This was following 'Family and Friend Test' results which identified poor pain score checking and poor provision of analgesics. Further actions were identified through this report; and the report was to be shared with staff via internal communications.

## Nutrition and hydration

- We saw staff within all areas of ED offer and provide hot and cold drinks regularly. A volunteer was also working to provide drinks for patients, relatives and staff.
- We saw that baby food, snacks, juice and milk was available within the paediatric area.
- Staff ordered simple meals where required within the department.
- One patient stated that the food on offer was not always suitable for them due to specific allergies.

## Patient outcomes

- From October 2015 to September 2016, the number of unplanned re-attendances to ED within 72 hours was 4029. The average re-attendance rate was between 7-9% during the same period.
- From October 2015 to September 2016, the number of unplanned re-attendances within seven days was 6036, which equated to 6.8% of all patients. This was worse than the England target of 5%, however comparable to the England average for this time period. This means more people were required to re-attend ED for a second visit within seven days than should have done, according to the England national targets although these numbers were similar comparatively to other England EDs.
- In the 2014/15 Royal College of Emergency Medicine (RCEM) audit for mental health for the service did not meet the fundamental standard of documented risk assessment taken. However, Good Hope Hospital met the fundamental standard of a dedicated assessment room for mental health patients. Several actions were identified as a result of this audit, such as identifying key performance indicators (KPIs) for a face to face mental health assessment with a member of the RAID (Rapid Assessment, Interface Discharge) team with 60 minutes. The KPIs were agreed in April 2016, with next steps identified as auditing these KPIs. Further actions included clarifying an appropriate area for mental health assessments to be undertaken. This was achieved in April 2016 by the allocation of a RAID room in ED. A last action point which had not been achieved was that of improving the documentation for the initial risk assessment. The reason given for non-compliance to this action point was due to IT systems not supporting this.
- Good Hope Hospital ED was better than expected for two of the ten measures in the 2013/14 Royal College of Emergency Medicine (RCEM) audit for asthma in children. The trust provided action points from the RCEM audit 2015/2016 in vital signs for children. This included several recommendations such as recognising a deteriorating patient and disseminating learning to staff.
- In the RCEM (2013/2014) audit for paracetamol overdose Good Hope Hospital was worse in comparison to other trusts for two of the four measures and was more in line with the England average for two of the four measures.

# Urgent and emergency services

- Good Hope Hospital was worse in comparison to other trusts for one of the 12 measures of the 2013/14 RECM audit for severe sepsis and septic shock; and was in better for two of the 12 measures.
- In the 2014/15 RECM audit for assessing cognitive impairment in older people, Good Hope Hospital was worse compared to other trusts for two of the six measures, average for one and better for one of the six measures. The trust did not meet the fundamental standard of having an early warning score documented at Good Hope Hospital.
- RCEM audits exploring the initial management of the fitting child (2014/15) at Good Hope Hospital were about the same as other trusts for two of the five measures. Good Hope Hospital was better for one of the five measures. For two of the five measures a sample size of zero was recorded and comparison to other trusts could not be provided. No data was provided for the fundamental standard of checking and documenting blood glucose for the fitting child at Good Hope Hospital.

## Competent staff

- Staff reported they received yearly appraisals during which leadership and development was discussed and identified. Staff described the appraisal process as meaningful and an opportunity to discuss continued professional development.
- ED nursing staff across the trust were not up to date with appraisals. The latest data April to August 2016 showed nursing staff had the second lowest appraisal rate of 72% across all staff groups.
- We spoke with medical staff who told us they received yearly appraisals. Newly hired staff told us they had performance reviews scheduled in the upcoming months. This was corroborated with data from the trust which showed From April 2015 to March 2016, medical and dental staff had an appraisal rate of 100% and 97% respectively, thereby exceeding the trust target of 85%.
- Nursing staff told us they received no formal clinical supervision, but they supported each other informally. The trust reported that clinical supervision was not formally documented. Medical staff told us, and we saw, they received regular formal and informal learning opportunities such as consultant training during handover. Consultants told us of junior doctor development within the trust which incorporated support from named consultants who provide both one

to one and group supervision. Medical staff described additional training they had done whilst at the trust such as Advanced Life Support, and core medical training rotations.

- We were told that support between the nursing staff was good. In particular, several staff highlighted the mentorship programme as positive in terms of day to day support and encouraging further learning and development.

## Multidisciplinary working

- The clinical decision unit (CDU) worked as part of ED to promote admission avoidance through caring for low risk patients who needed to remain under observation between 12-24 hours, but did not necessarily required admitting. This support enabled the ED professionals to work more effectively caring for more urgent patients.
- Staff and paramedics spoke of good working relationships between the hospital and the West Midlands Ambulance Service.
- We saw the RAID mental health team (rapid assessment, interface and discharge) were regularly used within the department to assess those patients with mental health conditions or concerns.
- We observed effective working relations between ED and radiology to accommodate a bariatric patient as soon as possible; rather than waiting until specialist equipment could be sourced.
- We were told that the nursing staff were also supportive of other grades, such as medical staff therefore enabling a positive team based atmosphere.

## Seven-day services

- The ED department at Good Hope Hospital was open seven days a week, 24 hours a day.
- The paediatric ED unit was open between 7am and 3am daily. Between 3am – 7am, children attending ED would be seen in the adults area; a paediatric consultant was available on call at all times.
- Staff were able to refer patients to an out of hours GP service, also based in the hospital, if that was the best pathway of care for them.
- The lead consultant told us that consultant cover was provided on site between 8am and 10pm daily, and although there was no specialist ED consultant cover throughout the night, other consultants with appropriate competencies were available on call at all times.

# Urgent and emergency services

- The trust provided us with their provisional winter pressures plan for 2016 which highlighted services that would be increased. This included extending REACT, the team that includes physiotherapist and occupational therapist support to 8am to 8pm seven days a week and adding additional paediatric medical presence until 9pm daily.

## Access to information

- All staff were able to access the trust's policies and procedures via the intranet to ensure the effective delivery of care. In addition, the senior nursing staff and consultants kept folders of printed information in staff only rooms such as learning from incidents, escalation plans, updates to care and treatment and any general communication. Staff we spoke with were aware of this folder and where to locate it.
- We saw the trust's IT system which displayed data for all patients within ED. This clearly outlined how long each patient had been in the department, and provided times of initial assessment and subsequent consultant review. This was easy to access and used by the flow co-ordinator to manage the stream of patients entering and exiting the department. This information was presented so that all staff could view this, including bank and agency; however screens were away from patient view therefore ensuring data protection laws were adhered to.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw staff seeking verbal consent and giving appropriate information prior to undertaking observations and treatment.
- We were provided with an example where a patient's lack of consent to a particular treatment was respected. Instead staff sought an alternative treatment with the advice that if this was not effective, the original treatment option would be discussed again.
- We were told that patients could self-discharge if they chose to, however two nurses would confirm the patient's decision and complete a relevant form.
- All staff we spoke with were aware of the Mental Capacity Act (MCA) and able to provide examples of where this may be applied. Staff were able to provide examples of when they had assessed a patient's capacity regarding care and treatment. One such example was that of a patient who wished to go outside for a cigarette

- against the medical advice of staff. This patient was assessed as to whether they had the capacity to make this decision; which they had. Therefore the patient left the building to smoke, with a member of staff periodically checking on them for safety.
- We requested data from the trust relating to the percentage of GHH ED staff trained in MCA. The trust did not provide this specific data however told us that 32 staff members had been trained either face to face or via e-learning in the MCA in the year 2015-16. Of this 32, 6 were a doctors, 21 were nurses, three healthcare assistants, one nurse nurse and one administrative staff.
- Staff demonstrated an understanding of working with patients with learning difficulties and disabilities. Staff provided examples demonstrating awareness of how to identify and seek consent from an individual who may have a lesser capacity.

## Are urgent and emergency services caring?

Good



We rated caring as good because:

- We saw excellent examples of staff providing care in a respectful and compassionate manner.
- We observed staff take into account patients personal preferences and needs to provide care in an individualised way.
- Staff consistently kept patients, relatives and carers informed of progress and care. Staff answered questions and were open to listening to patients' and relatives' queries and concerns.
- We saw staff present as supportive to distressed patients and to make an effort to alleviate distress where possible.

However:

- Friends and family test (FFT) results were below the England average for the months of August 2015 to July 2016 with regards to recommending others to use the service.
- Two patients and relatives raised concerns regarding the level of care and support they had received whilst in the department.

# Urgent and emergency services

## Compassionate care

- The trust's Urgent and Emergency Care 'Friends and Family Test' performance (FFT) with regards to how many patients would recommend the service was generally worse than the England average between August 2015 and July 2016. In the latest period, July 2016 trust performance was 81 compared to an England average of 85. We did not have data regarding FFT results for Good Hope hospital specifically.
- We saw many good examples of staff caring for patients in a compassionate and respectful manner. For example, we saw male members of staff step behind curtains whilst female staff undressed female patients.
- We saw that staff did not rush patients; staff explained what care and treatment was to be provided and ensured the patient understood and consented prior to beginning.
- We observed that staff introduced themselves by name to patients and engaged the patient in conversation in a way that left a positive impression upon both patients and relatives. We saw staff hold patients' hand to provide reassurance.
- We saw staff consistently treat patients with dignity, for example when assisting a patient to move higher up on the trolley; the inspectors and male staff were asked to leave for a moment as the patient's gown would have ridden up.
- Staff ensured patients were comfortable and provided extra pillows when needed.
- Staff spoke to patients in a calm, pleasant and considerate way.
- Almost all patients we spoke with spoke very highly of the care they had received, for example describing staff as 'friendly and helpful' and 'wonderful'. Two patients reported (one via a family member) that the care they had received either on this visit to Good Hope Hospital ED or on previous visits was not consistently high. For example, one patient who was a regular attendee due to a chronic condition reported that many staff were excellent and demonstrated a caring approach, however other staff gave the impression that they felt the patient was a nuisance. A further comment received was that some staff tended to use their personal mobile phones rather than care for patients; however again, this individual spoke highly of other members of staff reporting a dedicated approach to patient comfort.

- Staff gave examples of occasions whereby they showed understanding of, and a positive response to, patients' diverse cultural, gender and spiritual needs and met them in a caring and compassionate way, such as enabling patients who did not wish to remove clothing for ECGs (electrocardiograms) for cultural personal reasons, to keep covered or partially dressed whilst still undertaking important medical tests.

## Understanding and involvement of patients and those close to them

- Patients we spoke with during the inspection told us they felt staff had listened to and actively engaged them their care or treatment.
- Relatives and carers told us that they felt staff had kept them informed of progress with the patient, and staff provided regular updates. For example, one relative told us "We always feel we know what is happening". Relatives reported no significant waits to see staff for initial assessments, or ongoing observations.
- We saw one patient become distressed about wishing to go home. We saw staff listened to this patient and provided information regarding their care with the result that the patient's level of distress reduced.
- We noted excellent standards of communication and care at times, for example in the resuscitation area and in paediatrics.

## Emotional support

- We spoke with a patient within the clinical decisions unit (CDU) who became very distressed and emotionally upset regarding family contact. Upon hearing this, staff in the department made effort to phone around several locations outside of the hospital in order to find the relevant individuals; and communicated this to the patient therefore considerably reducing their distress.
- We saw staff permitted patients to have more than one visitor so that different family members might see their loved one and be reassured.
- We saw both nursing and medical staff show emotional support to patients; demonstrating empathy and understanding.
- A mental health team; RAID (Rapid Assessment, Interface, Discharge) was available should any patients be experiencing extreme emotional distress or have a mental health condition.

# Urgent and emergency services

- We observed staff deal sensitively and kindly to those patients attending due to self-harm or attempted suicide. These patients were given dignity and respect at all times and were allowed time alone with family members.

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

Requires improvement



We rated responsive as requires improvement because:

- The department breached the Department of Health waiting time target to either admit, transfer, or discharge patients within four hours of arrival and was worse than the national average between August 2015 and July 2016. Performance in meeting the target declined during this time period.
- Staff within ED reported that due to a lack of capacity within the ED, some patients were cared for outside of cubicles around the nurses stations repeatedly.
- There was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes and in July 2016 this had increased to 51%.
- The department did not meet the trust target of responding to complaints within 30 days. On average, it took 123 days to investigate and close complaints.

However:

- The trust were working towards meeting the needs of the local people over the winter period and had developed a winter pressures plan to address this.
- The recruitment of a flow-co-ordinator aided the controlled running of the department.
- The staff presented as very responsive to the individual needs of patients.
- 

### Service planning and delivery to meet the needs of local people

- We saw that the trust had identified overcrowding, rising acuity and gaps in nursing and medical staffing as risks

to the ED service. As a result, the trust recruited 17 nursing staff and four middle grade doctors and were in the process of recruiting additional medical staff to ensure the needs of the local population were met.

- We saw that the trust had developed a preliminary winter pressures plan for 2016/ 2017 to manage additional patient attendances, and the types of conditions that patients presented with over this time. For example, the trust had procured specialist equipment to aid with hypothermic patients.
- The trust provided data reporting they liaised with local clinical commissioning groups (CCGs) in order to continue to manage the needs of the local population.
- As part of the emergency department, Good Hope Hospital also provided a primary care service using GPs, and an out of hours GP service (Badger Group), to manage patients who attended ED but were more appropriate to be seen by a doctor.

### Meeting people's individual needs

- We saw that within the paediatric unit, the hospital provided toys and games, and employed play specialists who worked until 7.30pm daily. The department also provided facilities for older children such as DVDs and games for older children. The toy cupboards were open for the duration of the play specialists' shifts.
- We saw sensory equipment was available in the paediatric ED; this could be individualised for use with all children. Staff were aware of learning disabilities and other health conditions which might require some adjustments to be made to accommodate patients' individual needs.
- Staff told us how they would work effectively with adults with learning disabilities.
- We saw a breast feeding room available with a clean and comfy chair for mothers who wished to use this.
- We saw that staff in the paediatric unit provided patient and parent information in child friendly ways, including pictorial depictions of the pain scale to encourage children to meaningfully engage with care staff.
- We saw relevant and plentiful information leaflets, tailored to both adults and children throughout ED.
- We observed that staff were able to access equipment for bariatric patients; and that staff worked around bariatric patients to ensure quicker delivery of care if the equipment was not immediately available.

# Urgent and emergency services

- Staff told us how cultural needs were met within the department; for example respecting patients' choice of dress whilst in ED and adapting the way treatment was given to take this into account.
- Staff told us that should any patients request a quiet area in which to pray they would be offered the use of the psychiatric room for this purpose.
- Staff used a telephone translation service, for communicating with patients who did not speak English.
- We saw in the paediatrics area staff provided a special box for keepsakes in the event of a child death; patients could make hand and footprints, take photos and have bracelets made out of prints taken.

## Access and flow

- Good Hope Hospital used a 'Rapid Assessment Area' (RAA) to improve flow through the department and to manage patients effectively. An advanced care practitioner or senior doctor worked alongside two nurses to complete a rapid assessment, comprising of a full physical assessment and a computer generated structured assessment including essential information such as pain scores. Patients were then moved to the appropriate area of ED to await further care and treatment. If required, the minors area could receive patients directly from ambulances to aid flow.
- The department employed a flow co-ordinator to manage the movement of patients through the 'majors' area. The flow co-ordinator attended bed meetings twice daily and nurse handovers to share information and was based within the main reception area of ED. During the announced visit we saw a proactive movement of patients through the department to manage flow effectively.
- The trust performance report for August 2015 to July 2016 identified 3007 breaches of the four hour target for Good Hope Hospital during this time period. This target is set by the Department of Health (DoH) and specifies that emergency departments should admit, transfer or discharge patients within four hours of arrival. Data provided from the trust showed that it was worse than the England average between August 2015 and July 2016 for the four hour ED waiting time target. Furthermore, the trust was seen to decline in meeting this target as this time period progressed. Although this decline was similar in nature to the England average.
- For the above time period, total time in ED ranged between 6.5 hours to over 8 hours at its highest (November 2015). The trust provided data which reported that across the emergency departments; the time admitted patients spent in ED was similar to the England average, with an improvement being noted between October 2015 and April 2016.
- Between August 2015 and July 2016, the trust recorded one '12 hour trolley breach' for Good Hope Hospital. This breach refers to patients who have waited longer than 12 hours in ED following a decision to admit. During this time period; the trust as a whole was reported as being better than the England average
- We noted that there were no patients waiting longer than four hour at the time of the unannounced visit.
- During the unannounced inspection, we saw there were no patients waiting in corridors; staff moved all patients into a cubicle upon arrival. However, we were told that 75% of the time, approximately four to five patients would be located in the corridor awaiting a cubicle at any time. On a 'bad day' this number could rise to 12. Following the inspection the trust informed us that patients without cubicles would have to wait around the nurses station.
- The trust provided data which showed that time until first assessment for the financial year 2016/2017 was 25 minutes on average; however this was as per a report completed in June 2016. This showed an improvement on previous year of 29 minutes.
- Between June 2015 and May 2016, the trust as a whole had a higher number of patients that left the emergency department before receiving treatment than the England average.
- The trusts divisional performance report, September 2016 showed that at Good Hope Hospital, for the months of April to July 2016, time to initial assessments were between 18 and 20 minutes, against a target of 15 minutes. This compared favourably with Birmingham Heartlands Hospital (BHH). Time to treatment for the same time period ranged between 45 minutes and 60 minutes which was comparable to BHH. During the inspection we saw patients were monitored within target timelines.
- Between August 2015 and July 2016, there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In August, 29% of ambulance journeys had turnaround times over 30 minutes; in July this figure was 51%.

# Urgent and emergency services

- During July 2016, an audit on ED attendances was conducted with a specific focus on what, if any, medical options had been taken prior to presenting at ED, such as contacting 111 or self-care. Findings demonstrated that of those questioned, 73% (409) patients had no contact with other health care providers before entering ED. Specifically for Good Hope Hospital, 97 patients completed the survey, of which 11 had taken no action before attending, and 56 had tried self-care. The remaining 30 had either tried to access alternative care, or had accessed alternative care first.
- Due to a lack of bed space within other areas of the hospital, medical outliers were found within ED. This meant the patients that should have been transferred from ED to a longer stay medical ward were not always; therefore ED staff had to manage and care for these medical, rather than emergency patients.

## Learning from complaints and concerns

- Between September 2015 and August 2016 there were 191 complaints regarding the urgent and emergency services provided across the trust. On average, the trust took 123 days to investigate and close complaints. This is outside of the trust's complaints policy which states that complaints should be investigated and closed within 30 days.
- As of August 2016, there were 44 complaints still open. Of these 44, the trust received seven in May, 13 in June, nine in July and 15 in August 2016. Of the total ED complaints received, 48% were in relation to clinical care, 18% related to staff attitude and a further 10% related to communication or information problems.
- The trust gave us a record of complaints for Good Hope Hospital ED made between October 2015 and October 2016. In total, 74 complaints were made within this time frame. Of these, 68 had a primary subject of either staff attitude or privacy and dignity.
- ED unit meeting minutes were provided by the trust for June 2016. These highlighted that Good Hope Hospital had 30 outstanding complaints, seven of which were long term complaints. Senior nursing staff told us that staff attitude was a common complaints theme; and work was being undertaken to address this such as asking staff to complete a 'staff engagement' questionnaire.
- Within nurse meeting minutes provided by the trust for May 2016, we saw that band 7 nurses discussed complaints and made plans to identify common

themes, such as staff attitude and rudeness, and identify learning points for staff. We saw minutes from October 2017 reflected progress made with regards to complaints, and attendees discussed formal complaints management plans going forward.

- We saw information regarding the complaints procedure was displayed on walls within the ED department.
- Most patients and relatives we spoke to told us they would know how to make a complaint, and were aware of PALS (Patient Advice and Liaison Service).

## Are urgent and emergency services well-led?

Good



We rated well-led as good because:

- Local leadership was strong, with a strong senior presence.
- Staff felt supported and encouraged by a positive culture of teamwork.
- Medical and nursing staff received a good level of support from consultant grades.

However:

- Many staff did not attend quarterly update meetings due to ED leads holding this at Birmingham Heartlands Hospital.

## Vision and strategy for this service

- The trust had a strategy and vision for ED 2016, highlighting the values of the department as 'we aspire to excellence, we reflect, we learn, we improve, we innovate'.
- The strategy document outlined what the department had achieved within the last 12 months such as improving the nursing and medical staffing numbers; including increasing retention of existing staff members. The trust had also identified challenges such as on-going discussions around healthcare assistants pay.
- There was a clear overview of the five year plan for the trust urgent and emergency department. This included goals such as improving the culture of care across ED,



# Urgent and emergency services

cross site working for staff, developing the physical infrastructure of ED buildings and interacting more effectively with the local community so ensure patients chose the right level of care.

- Although staff were not all aware of the content of the strategy or values, we saw that staff were working to the values; we saw care being delivered to a high standard, staff who were aware of their role in reporting incidents and learning from these, and staff who were willing to improve the service they delivered.

## **Governance, risk management and quality measurement**

- The trust had recorded the following risks through the risk register for Good Hope Hospital ED in 2016:
- Increased nursing vacancies; January 2016.
- Failure to respond to ED complaints within appropriate timeframe due to increasing complaint volumes and lack of resource; March 2013.
- Inadequate Nursing establishment, poor skill mix impacting on delivery of quality & safe care, performance and service provision; May 2016.
- We saw, and staff told us that the trust were actively addressing risks relating to staffing were by through on-going recruitment programmes.
- Minutes from an ED clinical governance meeting held in May 2016 highlighted that the concern around complaints was being addressed and senior staff were 'almost back on track' with this. Suggestions were made to deal with complaints in alternative ways such as screening complaints to identify those that can be dealt with over the telephone, as opposed to having a face to face meeting.
- Staff told us that overcrowding and increased number of attendances was a risk; this was on the risk register but had been identified in 2009. This risk was reviewed as part of the trust wide risk register.
- The trust provided a performance review for ED dated August 2016. This identified the rising number of attendances and the rising acuity of patients versus the staffing numbers and facilities available. This report highlighted a number of risks and actions including submitting an ED Remedial Action Plan to relevant CCGs, and collaborating with CCGs regarding these concerns.

## **Leadership of service**

- A lead consultant and lead senior nurses managed the urgent and emergency care service at Good Hope Hospital. Sitting above these levels were the head nurse and the lead consultant for the trust as a whole.
- Staff told us that the ED matron was visible and accessible in order to support the running of the department.
- Staff told us that they received both electronic and paper communications from senior staff; such as emails from the lead consultant for the division in which ED sits across the trust. We saw a communications book where staff could find information from handovers, from incident updates and messages and updates from management.
- Staff reported that the head nurse and lead consultant for the trust were visible around the department.
- Staff told us that senior staff provided a debrief immediately after the monthly mortality and morbidity meetings in relation to deaths in the department.
- Medical staff told us they would be able to communicate issues and concerns up to the medical director if they wished; however those spoken to stated they had not found this necessary and were able to talk to relevant consultants.

## **Culture within the service**

- All staff we spoke to of a variety of grades reported a supportive department in which they were happy to work. Staff spoke of an excellent team atmosphere in which the team supported their colleagues.
- Both medical and nursing staff spoke highly of each other; highlighting an open environment where staff felt comfortable to both offer and receive advice and support. Should consultants not be in the department, staff reported they were always available to provide advice and guidance over the telephone.
- Staff described an open culture in which learning could take place and staff members were encouraged to develop their skills both formally and informally.
- Staff of various grades told us that the ED department worked effectively; with both nursing and medical staff presented as respectful and supportive of each-other. All staff we spoke to during both the announced and unannounced inspection reported they enjoyed working within the department, and felt well supported by both immediate managers and colleagues.

## **Public engagement**

# Urgent and emergency services

- We saw that patients were consistently responded to through the Patient Choices website and were asked to contact the patient services officer if the patient described a poor experience.
- The trust had a social media presence to communicate news and updates with the public and to receive responses.
- We saw screens in patient waiting rooms that contained useful information such as public transport details and waiting times.

## Staff engagement



- We saw that the trust used social media such as Twitter to communicate messages to staff, for example regarding national staff surveys, and recruitment opportunities.
- We were told of quarterly ED meetings held at Heartlands Hospital to which all staff from urgent and emergency services were invited. We were told that many staff from Good Hope Hospital did not get the opportunity to attend these meetings; therefore messages from these meetings would be communicated back to staff via internal communications.
- Senior staff told us the trust was working to improve staff morale and had undertaken a 'staff engagement' survey which was due to close December 2016.
- Staff were able to access up to date information about incidents, updates and general communications

through various channels such as 'risky business', an electronic newsletter, ED Pearls which was a paper based information source kept within staff areas, and emails.

## Innovation, improvement and sustainability

- The trust provided examples of innovation within ED, such as the introduction of Emergency Department Practitioners (EDP) into the resuscitation areas. We saw this working well at Good Hope Hospital, with positive feedback from both staff and patients about the EDP.
- A further example of innovation provided by the trust is that of having GPs within the minor injuries area of ED at Good Hope Hospital and Birmingham Heartlands Hospital. This is currently a pilot to explore the efficacy of this plan; with the aim to enable relevant patients to be seen by the GPs, therefore allowing emergency cases to be seen in a more timely fashion by ED staff.
- The trust have developed an Advanced Clinical Practitioner (ACP) programme which address medical staffing gaps; ACPs gain competencies which enable them to work at a medical grade (Through Tier 1 to Tier four). However, the lead consultant of ED for the trust told us of changes in RCEM standards which now prevents Tier 3 ACPs from leading the service as a consultant might during the day; however they can still work at the level of doctor during the night.

# Medical care (including older people's care)

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

## Information about the service

There are nine medical wards at Good Hope Hospital (GHH) with four additional wards providing medical care as the second speciality. We inspected Good Hope medical care services on October 2016.

The medical care service at Heart of England NHS Foundation Trust (HEFT) provides care and treatment for General, Respiratory, Geriatric and Stroke medicine, Infectious Diseases, Cardiology, Gastroenterology, Medical Oncology and Nephrology. There are 801 medical inpatient beds and six day-case beds located across 32 wards.

As of August 2016 in medical services there were 241.4 nursing whole time equivalents and 10 other clinical whole time equivalents at Good Hope Hospital.

Good Hope Hospital had 39,418 medical spells between 1 March 2015 and 29 February 2016.

We visited medical care wards and wards where patients with medical care needs were staying: AMU (acute medical unit), Ambulatory Care, 8,9,10,11, 12 and 24, Hyper Acute Stroke Ward. We spoke with 34 nurses and 15 doctors both of varying grades. We spoke with 26 patients, 10 visitors/relatives and nine allied health care professionals. We also spoke to nine members of the board of governors.

## Summary of findings

We rated this service as good because:

- All staff clearly understood the safeguarding policies and processes.
- Staff reported incidents and received feedback. There was evidence of learning from incidents across the trust taking place.
- Individual patient risks were identified and managed.
- Staff planned and delivered patients care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Most patient outcomes were similar or better than national expectations.
- Staff delivered compassionate and dedicated care.
- There was an open culture and good team working within the service.

However:

- Patients were not always safely discharged in a timely manner.
- Staff were not following The Sepsis 6 (Deteriorating Patient Screen pathway) for the patients with sepsis whose notes we reviewed.

# Medical care (including older people's care)

- The service was not compliant with recommendations for the safer management of controlled drugs and waste regulations

## Are medical care services safe?

Good



We rated safe as good because:

- Staff said they were encouraged to report incidents of harm or risk of harm and staff demonstrated learning from incidents across medical care.
- Individual patient risks were identified and managed. The use of the national early warning system (MEWS) to identify patients at risk of deteriorating was good and there was an appropriate response when concerns were escalated.
- Although staffing levels throughout the medical directorate were consistently below agreed planned numbers the trust were taking active steps to recruit additional staff. Temporary staff to fill the gaps to ensure that people received the care they required.
- All staff clearly understood the safeguarding policies and processes. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

However:

- The service was not compliant with recommendations for the safer management of controlled drugs and waste regulations.
- Compliance with hand hygiene was inconsistent.

### Incidents

- There was an online reporting form for reporting actual and near miss incidents across the medical division.
- Staff understood the incident reporting system and there was a good culture of reporting incidents. They could provide us with examples of when they had reported incidents and understood what constituted an incident.
- Staff we spoke with understood their responsibility to report incidents as means of improving the quality of patient care and minimising risk.
- The majority of staff told us they obtained feedback on incidents reported on both an individual and trust level.
- We saw evidence of feedback from incidents, which were shared trust wide. For example, a staff newsletter 'lesson of the month'. Management based these lessons on reported incidents and errors. They were patient

# Medical care (including older people's care)

focused and written by clinicians for clinicians. For example, in August 2016 lesson of the month focussed on 'deteriorating patients'. Clinicians identified emerging themes from these incidents and refreshed staff on what to do if they identified a deteriorating patient.

- There were no never events during the period August 2015 to July 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between 1 August 2015 and 31 July 2016, staff reported 71 serious incidents. The vast majority (71%) were due to pressure ulcers, which met serious incident criteria. We saw that 11% of serious incidents were due to slips, trips and falls, and a further 11 % were caused by health care associated/infection control incidents.
- Incidents reported between 1 June and 1 September 2016 on medical wards showed an increase in tissue viability and patient falls. These can result in delayed discharges, increased complications and increased costs for providers. Tissue viability is a speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration. Pressure ulcers are an injury that breaks down the skin and underlying tissue.
- When serious incidents took place, the trust held multidisciplinary meetings to analyse information, identify the root cause and contributory factors, and generate action plans. A root cause analysis (RCA) is a structured method used to analyse serious incidents.
- We reviewed a sample of RCAs. All investigations identified the root cause, included recommendations and had a timed action plan. Staff also identified areas of good practice they could share with the trust. For example, we reviewed an RCA in response to a high number of falls. Recommendations made included; ensuring staff supervised fall bays at all times, ensuring all staff completed falls prevention training and encouraging the attendance of the ward pharmacist at safety huddles. Safety thermometer information showed there had been a decrease in the number of falls reported.
- The medicine directorate reported its death rates to the mortality and morbidity performance group on a

monthly basis. This helped the trust to see if staff need to make improvements in the quality of care they were offering. There were no mortality issues at the time of our visit.

- We saw excellent examples of Duty of Candour. Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. For example, following an incident, relatives were encouraged to feedback on how an incident had affected them. Staff also invited patients to meetings where they could discuss how they felt with the nursing and medical team.
- Most of the staff we spoke with were unaware of the term duty of candour, however they were able to give us good examples of being open and honest with patients when things went wrong and apologising to the patient and family members or carers if need be.

## Safety thermometer

- Management displayed results of the NHS safety thermometer on the wards we visited. The safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The results related to the individual wards and showed comparisons with the previous months. However, we observed that reporting of results on some medical wards were two months out of date.
- Management launched the national Sign up to Safety campaign in 2014, which aimed to make the NHS the safest healthcare system in the world. The trust signed up to four Sign up to Safety pledges: reducing harm from deterioration including sepsis, reducing medication related harm; reducing harm from pressure ulcers; and reducing harm in maternity services. Good Hope Hospital (GHH) was contributing to this by implementing local authority improvement projects. For example, reducing harm from diabetic medication by 50% by 2018.

## Cleanliness, infection control and hygiene

# Medical care (including older people's care)

- All staff members we spoke with were aware of the current infection prevention and control practices. There were sufficient hand wash sinks, hand gel and towel and soap dispensers across the medical wards we visited.
- We observed staff following 'arms bare below the elbow' guidance, however we observed inconsistent following of hand washing by staff.
- Aprons and gloves were available in all areas we inspected. The patients we spoke with said they saw staff using protective clothing during and between treatments.
- Staff used side rooms as isolation rooms for patients identified as an increased infection control risk. For example, patients with methicillin-resistant Staphylococcus aureus (MRSA), and to protect patients with low immunity. MRSA is a type of bacteria that is resistant to a number of widely used antibiotics.
- There were no post 48-hour incidents of MRSA at GHH in 2015/16 or 2016/17 year to date.
- All wards carried out monthly audits, which looked at infection control procedures such as hand washing compliance and commode cleanliness. Ward managers gave us examples of action plans put in place to address non-compliance. For example, Ward 8 had completed an audit on 26 June 2016 due to an increase in incidents of clostridium difficile. This is a bacterium that can cause diarrhoea. Overall, there was 93.9% compliance. We saw robust action plans to address areas of non-compliance. For example, a medical ward had put into place actions for staff to ensure side room doors were closed and risk assessments completed if this is not a viable option and staff to offer disposable flannels to patients and advise them not to use their own. The IPC team supported the monthly hand hygiene audit programme carried out by the ward managers. Where audit performance was poor they would support staff and teams. Examples of support offered included extra training and increasing the frequency of audits until practice improved to the agreed benchmark
- We saw completed cleaning schedules.
- We saw documentation on the wards we visited showing that staff had checked equipment regularly, to ensure it was in date and was appropriately packaged and ready for emergency use.
- The equipment we checked was clean, well maintained with good service history.
- The medical wards we visited had enough equipment to meet patients' needs. This included pressure relieving mattresses and bariatric equipment.
- Staff had packed all defibrillators and resuscitation trolleys in a uniform way across the wards we visited at GHH. Staff told us this ensured staff across the trust knew where to find the equipment if a patient needed resuscitation wherever they were located.
- Staff informed us that the in house maintenance team would replace broken or damaged equipment in a timely manner.

## Medicines

- Staff prescribed medicines on the electronic prescribing system (EPS). The EPS had a built in safety reminder which automatically flagged up patients with particular needs or requiring attention, such as those taking antibiotic combination and patients who's time critical antibiotics or analgesia were more than 20 minutes overdue. . There was no mechanism within the electronic prescribing system to ensure that staff administered and rotated patch medicines in line with the manufacturer's guidance.
- A trust wide Quality Improvement programme (QIP) was in place. Part of this was a comprehensive strategy to improve medication safety. This particular project focused on reducing omissions and delays with STAT IV antibiotics which is a time critical medicine. The QIP introduced bleeps in April 2015 which alerted staff when colleagues had prescribed a STAT dose and would continue to bleep until staff had logged the dose as administered on the electronic prescribing system. Compliance was at 80% (November 2016) which was consistent with the trust target.
- An ongoing patient safety initiative was to focus on reducing omitted and delayed medication in Parkinson's disease (PD). If staff miss or delay administration of PD medications patients can deteriorate quickly in terms of their ability to move, speak and swallow. In line with Parkinson's UK 'GET IT

## Environment and equipment

# Medical care (including older people's care)

ON TIME' campaign, the trust had developed a number of resources for staff: such as 'lesson of the month' which reminded staff of the importance of timely administration of PD medication to improve compliance

- All wards had appropriate arrangement for the disposal of medicines. However, staff informed us they would dispose of controlled drugs in the sharps bins rather than dispose of them safely at the pharmacy. This is not in line with Home Office advice and the Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007 (DoH) or Healthcare Waste Regulations (DoH).
- Ward staff reported frequent delays in obtaining patients discharge medications. Staff confirmed that there were occasions where taxis delivered medications to discharged patients houses or patients or relatives would return to collect them later that evening.
- There were suitable arrangements in place to store and administer controlled drugs. Staff recorded regular checks of controlled drugs balances. Two nurses, with a separate signing sheet, audited controlled drugs (CDs) on a daily basis. Staff correctly documented CD's in a register, which was in line with National Institute of Health and Care Excellence guidelines.
- Nurses wore red tabards when administering medication in accordance with trust procedures. This was to tell staff not to disturb them while they administered medicines. This helped to reduce the risk of medication errors.
- All staff received medicine management training at point of induction. This helped to reduce the likelihood of medication errors and therefore patient harm.
- Our pharmacy team visited two wards and the discharge lounge
- The pharmacy was open seven days a week. Clinical pharmacists and technicians worked at ward level during the week. Pharmacy staff also provided a service on the Acute Medical Unit (AMU) at weekends.
- The trust provided an out of hour's emergency medicines cupboard or staff could obtain medicines through the on-call pharmacist service.
- The discharge lounge was open 9-7.30pm Monday to Friday and 10am-6pm at weekends. There was a dedicated member of the pharmacy team assigned to supporting the discharge lounge. This was to ensure staff kept delays due to medicines to a minimum.
- In the discharge lounge, we saw medicines waiting to be collected that required refrigeration stored in a bag left on the side from the previous day. Staff dealt with this immediately once we brought to their attention.
- Staff recorded the room temperatures where medicines were stored in the discharge lounge. Temperatures sometimes exceeded the recommended 250C. It was unclear however if medicines were kept here for any length of time. Staff were not recording treatment room temperatures on ward 8.
- Intravenous fluids on the acute medical unit (AMU) were not secure. Although there was a keypad entry system to the store, staff had disabled it. There were no dates of openings on liquid medicines. This meant staff could not know whether these were safe to use.
- We saw evidence that staff regularly checked and recorded fridge temperatures on the wards to ensure that they were within the correct range for the storage of drugs. However, we found medicines had frozen to the back panel of the fridge on AMU. Staff had also recorded that the fridge temperatures were above the recommended range for a 16-day period. We found staff had not taken any action to address this. The refrigerator thermometer on Ward 8 was not working. Staff had not recorded the temperature for nine days prior to our visit.
- Medicines that required protection from light were not always stored appropriately and were stored on open shelving.
- Prescriptions were stored and tracked safely on the wards our pharmacy team visited.
- Staff reported medicine incidents. Management shared learning with staff. Staff told us management kept them informed of medicines issues through email and their ward meetings.

## Records

- Patient records included a range of risk assessments including manual handling, falls, nutrition and pressure ulcer damage and risks. Staff reviewed risk assessments weekly. The records we looked at were accurate, legible and up to date.
- Staff securely locked patient records in note trolleys.
- During our unannounced visit, on ward 9, we saw that staff did not always complete VIP (visual infusion phlebitis) records for patients. The ward manager told us they had an action plan in place to address this.

# Medical care (including older people's care)

Management would allocate the nurse coordinator less patients on his/her shift to free them up to oversee and check the VIP scores. During our current visit, we saw evidence of staff completing VIP scores correctly.

- We observed evidence of correctly completed DNACPR forms where appropriate with advanced directives for care and medication.
- The trust's aim for 2015/16 was to improve the early recognition and management of patients with sepsis (blood poisoning) in all assessment areas on all sites. We looked at fifteen patient records for patients with sepsis. The Sepsis/Deteriorating Patient Screen Pathway (Sepsis 6) 'documentation had not been completed for any of these patients.

## Safeguarding

- Staff we spoke to were aware of the trusts safeguarding policy and the process involved when raising an alert.
- Staff received training on safeguarding at point of induction and as part of mandatory training. As of August 2016, the modules for safeguarding children's & adults (levels 1 & 2) for medical & dental staff surpassed the 85% completion target in medical care.
- As of August 2016, the modules for safeguarding children's & adults (levels 1, 2 & 3) for nursing & midwifery staff surpassed the 85% completion target in medical care. Safeguarding children level 3 had a 100% completion rate in medical care. All staff we spoke to were aware of the name of the safeguarding lead. Staff spoke extremely high of the safeguarding lead and the level of support provided by her and the team.
- The trust had safeguarding link nurses attached to the wards we visited. Link nurses are part of a system that shares information and provides formal, two-way communication between specialist teams and nurses in the clinical area. Staff told us the link nurses were effective in their roles.

## Mandatory training

- As of August 2016, out of the 19 mandatory training modules for medical and dental staff in medical care nine modules surpassed the 85% target to reach 100% completion. Areas of non-compliance included equality and diversity, waste management and fire safety.

- As of August 2016, out of the 19 mandatory training modules for nursing and midwifery staff in medical care seven modules surpassed the 85% target to reach 100% completion. Areas of non-compliance were waste management and obtaining blood transfusions.

## Assessing and responding to patient risk

- Staff used an early warning scores system to alert them if a patient's condition was deteriorating.
- When a patient's condition required escalation, staff contacted the junior doctor for the ward during the daytime. Staff we spoke with told us doctors responded in a timely manner. Out of hours, they could contact the hospital at night, nurse practitioner, who staff told us responded promptly. Staff could also contact the registrar or consultant if the nurse practitioner did not respond promptly.
- At night, the medical bleep holder could see the hospital dashboard and directed doctors to the place staff needed support. This ensured that any deterioration of a patient would get a rapid response from the medical team 24 hours a day.
- Ward sisters we spoke to provided us with robust examples of actions implemented to address patient risks such as pressure ulcers and falls. These included more link nurses, more training on tissue viability and enhanced observation bays for patients at risk of falls.
- Safety huddles had been implemented by management to improve patient safety. All wards we visited held daily safety huddles. All members of the multidisciplinary team (MDT) attended including medical staff, domestic staff and healthcare assistants. Staff used safety huddles to share any learning from incidents and identify any patient safety issues including, pressure ulcers, falls, patients under deprivation of liberty safeguards (DoLS) and any patients with a hospital acquired infection. Staff spoke positively about the safety huddles and felt they had created a sense of ownership among staff to improve patient safety.
- We saw evidence in the clinical notes that staff members were not following the Sepsis Six pathway. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.

## Nursing staffing



# Medical care (including older people's care)

- The trust had a robust mechanism to assess and assure safe staffing levels and could provide actions and risk mitigation where actual staffing levels fell below established numbers.
- An acuity/dependency review was undertaken twice yearly in line with NHS contractual requirements. The methodologies used were compliant with the NICE guidelines for safe staffing in inpatient wards and AMU/SAU settings (2014). The review incorporated clinical outcomes associated with harm free care and Care Hours Per Patient Day (CHPPD). CHPPD is a measure of the care hours available to each patient compared with the care hours they require based on their acuity/dependency. Where required CHPPD exceeded actual CHPPD there was an indication that the staffing hours on that clinical area were not sufficient for the care required. The results from the review were analysed by the divisional head nurses. The divisional head nurse provided assurance on safe staffing to the Chief Nurse. Management carried out the review in July 2016 and the results indicated that management needed to increase staffing levels on Ward 8 GHH resulting in challenges around the skill mix. The recommendation by the head nurse of medicine was for the division to continue with a recruitment campaign and improvements in skill mix and to review again in 6 months. The review also showed that Ward 11 at GHH required uplift in health care assistant (HCA) staffing during the day. The head nurse of the medicine division put forward a recommendation for the division to submit a business case for an additional HCA per long day.
- Wards displayed the planned and actual staffing figures. On some wards, the actual numbers of staff on duty were lower than the planned number. However, ward sisters told us there was an escalation procedure in place where there were concerns about staffing levels and that staffing levels were always safe due to the use of agency staff or sourcing support from other wards in the hospital.
- Managers told us that bank staff always covered shifts. Management could also source staff from other wards or use agency staff.
- Staff shortages were on the trusts risk register. The service was engaged in a rolling programme of recruitment for nurses, including internationally. Recruitment to elderly care wards was an ongoing issue. The trust held specific elderly care recruitment days to address this. For example, there was an open day on 19

March 2016, where the trust showcased the career opportunities across their elderly care services. This showed the trust was being proactive in recruiting more nursing staff.

- Agency staff members were not given access to the trust's IT systems and were therefore unable to administer medicines using the electronic system. They were also unable to deal with blood products or give intravenous medicines as they did not complete any trust training programmes.

## Medical staffing

- Staff numbers for the August 2016 period in medical care at GHH was 12.
- There were two main medical handovers which occurred every day at 09:00 and 21:00; on weekdays there were additional handovers at 14:00 (to incoming 'twilight' shift SHOs) and at 17:00 (handover of ward jobs/patients to ward cover SHOs and RMO2).
- Ward rounds by consultants were daily on weekdays and at weekends only for newly admitted patients.
- Locums were used to backfill medic vacancies, sickness and annual leave. This ensured patient safety at all times.
- The proportion of consultants working at the Heart of England NHS Foundation Trust was lower than the England average.
- The proportion of junior (foundation year 1-2) staff reported to be working at the trust was higher than the England average.

## Major incident awareness and training

- A major incident plan for the trust was in place dated April 2015.
- Up until October 2016 there has been no formal target for major incident training as the trust did not class it as mandatory. However, at least 70% of staff in each area of medical services had completed emergency planning training. In October 2016, major incident awareness became mandatory with an 85% target.
- Senior management had planned for winter pressures.

# Medical care (including older people's care)

## Are medical care services effective?

Good



We rated effective as good because:

- Staff planned and delivered patients care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Local and national audits of clinical outcomes were undertaken. Staff met patient's pain relief, nutrition and hydration needs.
- Most patient outcomes were similar or better than national expectations. Where outcomes were lower, there was evidence of action to improve. Staff had the skills and knowledge to carry out their roles effectively and in line with best practice. Staff worked jointly to understand and meet the range and complexity of people's needs.
- Staff obtained patient's consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005. Staff supported patients to make decisions and, where appropriate, staff appropriately assessed and recorded their mental capacity.

### Evidence-based care and treatment

- We saw that clinical guidelines and policies were based on The National Institute for Health and Care Excellence (NICE) guidelines. These were available on the intranet for staff to use and follow.
- Management had aligned the trust guidelines to the 'new' national sepsis guidelines. They also introduced the concept of grading sepsis with 'red flags'. However, staff were not following these guidelines.
- The provider reviewed the reports of 86 trust clinical audits in 2015/16 and we saw evidence of actions the trust intended to take to improve the quality of healthcare provided. For example, the acute medicine team at Good Hope Hospital (GHH) highlighted the need to improve the overall uptake of the sepsis-screening tool and sepsis 6 at the point of triage within the acute medical unit and emergency department. To raise awareness, the sepsis pathway and its management has been included in the junior doctor induction-training programme.

### Pain relief

- Patients told us that staff asked if they were in pain on a regular basis.
- We saw evidence that staff used pain scores to assess patients' pain levels. Staff documented these scores correctly.
- Nurses were able to give us examples of how they would assess whether patients with impaired cognitive functioning were in pain. For example, Individuals would be asked to rate their pain as a number with zero indicating no pain and ten being the worst pain imaginable.

### Nutrition and hydration

- There were nutrition and dietetics that specialised in areas such as diabetes, renal and gastroenterology. For example, diabetes specialists provided dietary advice to patients with Type 1, Type 2 and gestational diabetes (diabetes during pregnancy). Their aim was to help patients improve their diabetes control and reduce the risk of long term complications. They also supported consultant diatology clinics, insulin pump therapy clinics ran patient education courses and group sessions and provided education and training to other health care professionals within the trust.
- The trust hosted a Nutrition and Hydration Week in March 2016. , the Trust encouraged patients, visitors and staff to 'eat, drink and move'. The catering team held 'ComeDine with Me' style taster sessions across all three-trust hospitals, during which visitors and staff tried patient meals. This gave patients and staff the opportunity to sample dishes from the new patient menu and to encourage the 'eat and drink well' mantra.
- Staff consistently raised concerns with management around recent changes introduced whereby management had unrestricted protected meal times. The purpose of the original restricted meal time scheme was to allow patients to eat their meals without unnecessary interruption and to allow staff to focus on helping those patients unable to eat independently. Staff told us they felt that unrestricted meal times compromised patient's dignity at times. For example, when male visitors were in female wards and staff members were helping female patients with personal care. Staff also found patients were not always finishing their food because visitors distracted them. Staff had escalated their concerns to the trust executive board. An

# Medical care (including older people's care)

annual review was to take place in October 2016 of open visiting times by the patient experience team. The patient experience team will feed back their findings to the trust executive board.

## Patient outcomes

- The trust took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, A is best. The trust achieved grade C in latest audit from January 2016 to March 2016. Five individual KPI's (key performance indicators) dropped by one grade in the latest audit for 2016. Between October and December 2015 and January and March 2016 GHH achieved A for scanning for both reporting periods, B and C respectively for stroke unit, B for both periods for thrombolysis, B and C respectively for specialist assessments, A for both periods for occupational therapy, A and B respectively for physiotherapy, B for both periods for speech and language therapy, C for both periods for multi-disciplinary working, D for both periods for standards by discharge and A for both periods for discharge processes
- The results in the 2015 heart failure audit were better than the England and Wales average for all of the four of the standards relating to in-hospital care, particularly for cardiology inpatient. GHH achieved 88% compared to the England average of 49%. Eighty-eight percent compliance against the England average of 60% for input by a consultant cardiologist, 94% against an England average of 78% for input by a specialist and 100% against an England average of 92% for the standard received echo.
- The results were better than the England and Wales average for three of the seven standards relating to discharge and was worse than the England average for a further three standards, in particular for referral to cardiology follow-up. GHH achieved 44% against the England average of 54%. For Angiotensin-converting enzyme inhibitors (ACEi), GHH achieved 47% compared to the England national average of 82%. For ACEi/ARB (Angiotensin receptor) on discharge, GHH achieved 74% compared to 85%. Referral to heart failure liaison service was 60% compared to the England national average of 59% and referral to heart failure liaison service (LSVT only) was 68% compared to the England average of 69%. ACEi and ARB's are drugs that help to improve survival of patients with heart failure and staff should prescribe them to patients on discharge as appropriate.
- Discharged care measures were mostly in line or better than the England average at GHH.
- The trust took part in the 2015 National Diabetes Inpatient Audit. The trust scored better than the England average in 14 metrics and worse than the England average in 20 metrics. The indicator regarding "seen by the multi-disciplinary foot team within 24 hours" had the largest difference versus the England average (53%).
- The trust took part in the 2013/14 MINAP audit. The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. The trust scored better than the England average for all of the three measures at each site. However, the percentage of patients admitted to a cardiac unit or ward at GHH was 8.3% lower than the England average of 55.6%.
- GHH showed good performance for NSTEMI patients that were referred for or had an angiography, this was 100 percent compared to the England average of 77 percent. Non-ST Segment Elevation Myocardial Infarction (NSTEMI) is one of the three types of Acute Coronary Syndrome (ACS), and like all ACS, medical staff should consider all NSTEMI a medical emergency.
- The standardised relative risk of readmission for both elective and non-elective admission at trust level was slightly worse than the England average.
- The risk of readmission at the GHH was slightly better than the England average for both elective and non-elective admissions.
- In March 2016, the trust performance against the dementia CQUIN indicator of the percentage of eligible patients aged over 75 asked the dementia question was 88.52%. The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how staff delivers care and to achieve transparency and overall improvement in healthcare. The Trust has only achieved this target in two months as of the time of our visit.
- The trust carried out local patient surveys such as The National Dementia Audit, Chemotherapy Patient Survey and Transplant Patient Survey in the clinical haematology and oncology department. This showed the trust valued patients' opinions and were seeking to improve patient experience at the trust.

## Competent staff

# Medical care (including older people's care)

- Between April 2016 and September 2016, 84.6% of staff within medical care at HEFT had received an appraisal compared to a trust target of 85%.
- There was a preceptorship programme in place to support junior nursing staff.
- There was an induction pack for student nurses working on the ward. The induction pack for new nurses included information on topics such as health and safety, professional values, communication and infection control.
- The daily ward rounds were consultant led and occurred seven days a week. We observed several ward rounds and they were well organised and included staff that were involved in the patients care.
- Pharmacists covered the wards between Monday and Friday. The pharmacy was open over seven days and there was an on call pharmacist for support and information.

## Access to information

- We observed effective multi-disciplinary relationships and cooperation between different professional groups, such as healthcare professionals, nurses and therapists.
- Staff told us that multi-disciplinary team working was good. Therapists felt part of the teams in the specialties they worked in. One member of staff said medical staff and nurses were working better together as there was better communication through board rounds and ward rounds.
- There was also an emerging culture of sharing information since management had divided the three hospitals into divisions; however, senior management needed to embed these further.
- Staff spoke positively about multi-disciplinary working commenting that the electronic handover system allowed staff to access different areas notes on specific patients.
- We saw electronic handovers from morning ward meetings, which contained input from different staff groups. However, the electronic patient board was visible to anyone walking past the nursing station, compromising patient confidentiality.
- Ward staff spoke positively about support received from RAID nurses. The Rapid Assessment Interface and Discharge (RAID) team provides an in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay associated with mental illness as a co-morbidity to physical conditions.
- Policies and guidelines were accessible to staff via the trust intranet. We found they were easy to access and the guidelines we checked were up to date. However, bank staff could not gain access to the guidelines through the trust intranet but told us they were familiar with them as they were also printed out and kept in folders for staff to access.
- Staff reported that the IT system was unreliable. Staff told us this caused frustration and impacted on their already limited time, including the time to spend with patients. The trust was aware of the failing computer system. We had been told the chief executive officer was giving it a high priority.
- Staff provided care summaries for patients to take to their general practitioner on discharge from hospital to ensure continuity of care in the community.
- Staff told us about an electronic patient notes system used for handover purposes to inform different staff involved in a patient's care with the most up to date information. Staff could print this information, however, the printed version only provided the last entry made by a staff group, and therefore some context could be lost as the member of staff reading the notes would not be able to see previous entries.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff was able to demonstrate to us they had a good understanding of capacity and consent. Staff told us that when people could not make decisions about their care and treatment they would make a DoLS application.
- Ward managers were able to give robust examples of recent DoLS applications they had made. For example, a ward sister told us a patient had alcohol-induced psychosis, was very confused and kept trying to leave the ward. The sister applied for a DoLS order. As a result, security disabled the door. Patients could only exit with

# Medical care (including older people's care)

authorisation from the ward clerk. This ensured that the remaining patients could come and go as they pleased, albeit with staff having to unlock the door using the buzzer system.

- On Ward 9, we observed a psychiatric patient who required 2:1 registered mental health nurse ratio. We reviewed the patient's notes. The mental capacity act paperwork was in place, completed correctly and signed. We saw evidence the RAID team had assessed him in a timely manner.
- For the period 2015-2016, 18.5 % of staff on Wards 18, 19 and 20 were trained in MCA and DoLS.
- All staff were trained in Safeguarding Level 1, 97.6 % in Level 2, and all staff in Safeguarding Adults Level 3. Therefore, there was an overall compliance of 98.9%.
- Management displayed Information about the Mental Capacity Act (2005) and DoLS on noticeboards within the ward areas for staff.

## Are medical care services caring?

Good



We rated caring as good because:

- Patients reported that staff treated them with compassion respected their dignity. For example, staff closed curtains when attending to patients' personal care needs.
- Feedback from people who use the service, those who are close to them and stakeholders is positive about the way staff treat people.
- People were involved and encouraged to be partners in their care and in making decisions, with any support they need

### Compassionate care

- Patients reported to us and we saw that staff treated them with compassion respected their dignity. We saw staff asking the patient's permission to provide care and taking steps to ensure the patient's privacy and modesty were protected (closing screens, making sure the patient was covered).
- Patients we spoke to on the wards we visited were satisfied with the quality of service they received. Patients told us that staff were kind and caring but often rushed and under pressure.

- The Friends and Family Test response rate for Medical Care at the Heart of England NHS Foundation Trust was 36%. This was better than the England average of 26% between 1st July 2015 and 31st June 2016. The percentage of medical care inpatients who said they would recommend the trust was 93.7% in the period April to June 2015 and 94.6% in the period April to June 2016.

### Understanding and involvement of patients and those close to them

- We observed positive interactions between doctors, nurses and patients on all of the wards we visited.
- All the visitors we spoke with said they felt involved in their loved ones care.
- Family members said that staff kept them informed about their relatives and patients told us that they had received good information about their care and treatment.
- We saw notice boards for patients and carers displaying information about different support and care available from partner agencies and charities.

### Emotional support

- All medical patients had access to the multi-faith chaplaincy team. They provided services to the whole hospital community and the trust's in-house male and female chaplaincy staff and volunteers regularly visit the wards and departments within the three hospital sites to be alongside everyone in their moment of need to offer spiritual, pastoral and religious care. The team offered a confidential listening and supportive ear and could be contacted by patients, relatives and hospital staff at any time.
- The Breast, Gastroenterology, Colorectal, Urology and Bowel Cancer Screening units had clinical nurse specialists. The Ophthalmology/Vascular unit had clinical nurse specialists providing support to clinics undertaken at GHH. Clinical specialist nurses provided tailored care depending on the patient's level of need. They also provided education and support for patients to manage their symptoms, particularly patients with long term conditions and multiple morbidities.

## Are medical care services responsive?

# Medical care (including older people's care)

Requires improvement



We rated responsive as requires improvement because:

- Patients experienced delayed discharges not only due to lack of available care in the community but also to poor discharge management and arrangements. This included insufficient patient transport and delays dispensing medication.
- Patient access and flow was problematic. Between July 2015 and June 2016, the trust's referral to treatment time (RTT) for admitted pathways for medical services had been worse than the England overall performance.

However

- The latest figures for July 2016 showed the trust achieved their target of referral to treatment time (RTT) for admitted pathways for medical services, 92.1% of this group of patients were treated within 18 weeks.
- There was service planning and delivery to meet the needs of the local population.
- There was openness and transparency in the management of complaints. Complaints and concerns were taken seriously and improvements were made.

## Service planning and delivery to meet the needs of local people

- The needs of different people are taken into account when planning and delivering services (for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation).
- Reasonable adjustments are made and action is taken to remove barriers when people find it hard to use or access services.
- Waiting times, delays and cancellations are minimal and managed appropriately. Services run on time. People are kept informed of any disruption to their care or treatment.

## Access and flow

- Between 1st March 2015 and 2nd February 2016, the average length of stay for medical elective patients at HEFT was 0.4 days, which is better than the England average of 3.9 days. For medical non-elective patients,

the average length of stay was 5.2 days. This was better than the England average of 6.7 days. This suggests patients were receiving timely care and discharge in relation to the England average.

- Staff used electronic patients boards for early identification of patients ready for discharge. The aim of 'Jonah' is to provide safe and timely care as planned by the multidisciplinary team. This should reduce length of stay and increase the number of patients who are discharged as planned each day.
- There was also a rapid enhanced assessment clinical team (REACT). This team consisted of occupational therapists, physiotherapists and occupational therapy technicians who had detailed knowledge of and access to locally available social and care support services. They saw patients on AMU (ward 20), CDU, ECAU (ward 21) and AMU short stay (ward 22). They saw patients who were medically fit for discharge but had additional/new physical, functional or social needs. The aim of the team was to prevent unnecessary admission to hospital, reduce length of stay in hospital, reduce the risk of recurrent falls and readmissions to hospital and to facilitate safe and patient centred discharge.
- The percentage of patients seen in the medical department within 18 weeks of general practitioners referring them was 89.3% in May 2015, and 94% in May 2016. The national average was 92%.
- Between July 2015 and June 2016, the trust's referral to treatment time (RTT) to medical services was worse than the England overall performance. However, the latest figures for July 2016 showed staff treated 92.1% of this group of patients within 18 weeks.
- Specialities above the England average for admitted RTT (percentage within 18 weeks) was cardiology (94.9% against the England national average of 86.5%), neurology (100% compared to the England average of 96%) and thoracic medicine (98.9% compared to the England average of 96.7%).
- Specialities below the England national average for admitted RTT (percentage within 18 weeks) was: dermatology (79.3% compared to the England average of 88.9%), gastroenterology (88.3% compared to the England national average of 94.9%), general medicine (0% compared to the England national average of 96.2%), geriatric medicine (0% compared to an England national average of 98.8%) and rheumatology (96.4% compared to the England national average of 97.1%).

# Medical care (including older people's care)

- Staff told us patient discharges were an issue because of being unable to access appropriate social care. This meant bed availability for patients being admitted was limited.
- Some nurses also told us that delayed discharges also occurred when in-patients missed their booked diagnostic appointments due to a lack of portering staff able to take them. The nurses told us they would take patients themselves wherever able. However, with nursing staff shortages this was not always possible as would leave the ward areas unsafe. In these cases appointments had to be re-booked sometimes days later.
- Between September 2015 and August 2016, 38 % of individuals did not move wards at GHH during their admission, and 62 % moved once or more. Repeated moves can lead to problems such as disorientation and confusion of the whereabouts of ward facilities.
- Ward managers and senior sisters met three times a day to discuss bed capacity and nurse staffing levels. These ensured managers occupied beds and appropriately deployed and shared staffing levels and skills across wards.
- The hospital had lost its Joint Advisory Group (JAG) accreditation. This was due to the endoscopy unit consistently breaching its eight-week referral time. However, the trust was working very closely with JAG to regain this accreditation. The Joint Advisory Group (JAG) on gastrointestinal endoscopy is principally a quality improvement and service accreditation programme for gastrointestinal endoscopy. They support and assess endoscopy units to meet and maintain the JAG standards, offering patients and commissioners a badge of quality. The trust had introduced measures such as a vanguard mobile endoscopy unit to mitigate the breaches. This delivered 10 additional sessions a week. The trust also introduced a number of locum gastroenterologists to support inpatient and outpatient diagnostic services.
- Due to high admission levels, there were a number of medical outliers, (patients admitted by staff to other wards as there was no appropriate medical bed free). This increased the risk of medical staff missing them on ward rounds. On the day of our unannounced inspection, there were ten medical outliers.
- The trust had implemented a buddy system to ensure staff did not miss medical outliers. This is where

assigned medical wards look after patients on their ward until a bed becomes available in the appropriate ward. This ensured patient's medical care was not overlooked.

## Meeting people's individual needs

- Staff completed risk assessments on admission and regularly reviewed them. Care plans reflected patient's individual needs.
- Single sex bays were in place across the medical wards we visited. There were three mixed sex breaches on AMU in June 2016. Staff had reported these breaches as incidents and RCAs were completed. We saw a strong action plan to address these breaches. Action points included for the general manager to agenda mixed sexed breaches at the next joint emergency department/AMU meeting and for the capacity team to review management of G.P flow and how to ensure breaches do not occur.
- Most patients told us staff responded to call bells in a timely manner. However, one long-term patient and one relative told us that staff often left patients waiting. They said they felt this was due to understaffing.
- A telephone service (Language line) was the trust's chosen method when staff needed an interpreter for patients and relatives where English was not their first language. Many of the staff we spoke with told us this method was too time consuming and when possible they would use colleagues or patients visitors to interpret. The trust used volunteers for a variety of roles. For example, in 2016 volunteers implemented supermarket bucket collections to raise money to improve the experience of patients in hospital. Volunteers also spent time with elderly patients to help prevent delirium. Managers told us legal and mandatory checks to ensure compliance with the NHS Employment Check Standards were completed. These included disclosure and barring service applications.
- GHH developed a booklet called 'About Me' in 2015 for patients living with dementia. Staff designed the booklet to provide a snapshot of the patient, including their likes and dislikes; daily care needs; food and drink preferences and how they like staff to communicate with them so staff knew more about them and can respond better to their needs.

# Medical care (including older people's care)

- The 'forget me not' flower magnetic symbol (the national symbol for dementia) was placed above the bed space of a person with dementia to highlight that communication and care they may need to be adjusted in accordance with the patients' needs.
- In 2015, the elderly care wards at GHH were given an award for being dementia carer friendly following a move to open visiting across the trust earlier this year. Staff told us that rate of falls had reduced and that the more open communication had reduced complaints. We saw evidence of this by way of the safety thermometer information.
- Patients relatives and carers of patients with learning disabilities could contact a health facilitation The nurse would complete an assessment to ascertain the patient's needs, requirements, concerns and provided advice and support to them during the patient during their stay.
- GHH had a Health Information Centre based at the front entrance to the hospital where patients and visitors could seek health related advice and information. These were in English , however patients could
- A portable loop induction and minicom system was available on the wards. This was to support individuals with hearing loss disabilities.
- The charge nurse on an elderly ward we visited told us he had learnt how to knit so he could knit 'twiddle mitts' for elderly patients on his ward. 'Twiddle mitts' are knitted mittens or hand warmers with beads, buttons and objects sewn on to them. The mitts are becoming popular gifts for those living with dementia, as having something to 'twiddle' helps to calm agitation and restlessness – both common symptoms of the condition.
- There was a volunteer service at GHH who showed female cancer patients how to cope with hair loss by demonstrating a range of headwear, including scarves and hats.
- The charge nurse on an elderly ward we visited had introduced a 'calm room'. Staff used the room for patients at high risk of behavioural challenges. Staff would monitor patients 24 hours a day and staff would use therapeutic tools such as relaxing music. The charge nurse told us that there had been a decrease in the number of falls and negative patient interactions on the ward since he and his staff had introduced the calm room to their ward. Furthermore, the trust had nominated the ward for the HEFT safety prize.

## Learning from complaints and concerns

- Patient services leaflets were available for patients on patient display boards which informed patients and relatives how to make a complaint.
- Between August 2015 and September 2016, there were 333 complaints about medical care at the Heart of England NHS Foundation Trust. The trust took an average of 99 days to investigate and close complaints; this is not in line with their complaints policy, which states management should close complaints within 30 working days. One hundred and thirty one complaints related to clinical care.
- Ward managers told us they would endeavour to resolve complaints locally in the first instance. Staff were able to explain the complaints procedure, including escalating to Patient Services department. The patient services department handle any concerns, questions, complaints or queries a patient may have.
- Learning from complaints was communicated to staff by the ward manager through team meetings.
- We saw information shared with staff through a 'lesson of the month' circular, which was displayed at ward level.
- We saw numerous thank you cards displayed on ward boards.

## Are medical care services well-led?

Good



We rated well-led as good because:

- Most staff felt able to raise concerns and were confident that these would be listened to. Access to the senior management team was greater through the restructuring of the way the trust manages its services.
- Staff we spoke to who were also aware of the challenges the trust faced.
- Staff were generally positive about the leadership and the levels of engagement, particularly with their line manager.
- There was a positive open culture within teams. We spoke with staff who demonstrated pride and compassion in the care that they provided.
- Staff were encouraged to put forward ideas for improvement. The service took account of patient experience and action to improve care where required.



# Medical care (including older people's care)

However:

- Although the trust had a rolling recruitment programme staff vacancies still remained high. This had a negative effect on staff.
- Staff we spoke to at ward level did not know what the local or trust-wide strategy was.

## Leadership of service

- A divisional structure was put into place approximately six months prior to the inspection. Each division was led by a divisional director with support from a head of operations, head nurse and finance manager.
- Leaders of the medicine wards had the appropriate skills, knowledge and experience to lead effectively.
- The leaders we spoke to demonstrated an understanding of the challenges to good quality care and were able to identify the actions needed to address them. For example, managers were aware of the staff shortages and the impact upon patient care. Actions put in place to address this included block booking agency staff to ensure they were fully staffed at all times in the short term and ongoing national and international recruitment programmes.
- Most of the staff we spoke to told us their managers were visible and approachable.

## Vision and strategy for this service

- Staff awareness of the new set of trust values varied. Management displayed the trust values throughout the hospital for both staff and members of the public to see. Staff at ward level mentioned there were new values and trust vision since the new executive team arrived but were not involved in the development of them.
- No staff spoken to at ward level knew what the local or trust-wide strategy was.
- Staff members we spoke with spoke with pride and compassion about their roles.

## Governance, risk management and quality measurement

- The launch of five new management divisions in April 2016 had provided an opportunity to revise the local framework for ward to board reporting. There were two divisions covering medical care across the trust.

Management were positive that the revised framework would bring medical wards even closer to the board whilst evidencing assurance of clinical quality across the organisation.

- The governance team carried out initiatives on a monthly basis to measure risk and quality on medical wards. These included patient safety thermometer audits conducted on each ward monthly and a monthly audit of areas of potential risk to include falls, pressure ulcer prevention, cannula checks and commode cleanliness.
- Ward results were displayed and wards that fell into the red area and we saw action plan to follow to improve future practice.
- We saw risk register for medicine and associated action plans. The risk register is a management tool that enables the organisation to be aware of its comprehensive high risk profile.

## Culture within the service

- Services and care were centred on the needs and experience of people who used the service.
- There was a culture of openness and honesty on the medical wards were visited.

## Public engagement

- The trust invited patient's relatives and carers to take part in the 'Tell us what you think' campaign. We saw posters and comment cards available in corridors and on some wards. We did not have the results from this campaign as management had not yet collated it.
- The friends and family test response rate for medical care at the trust was 36%. This was better than the England average of 26% between 1 July 2015 and 31 June 2016.

## Staff engagement

- Endoscopy staff told us they had been involved in every stage of the consultation process regarding the new endoscopy units. This included having input into its design and equipment content.
- Management invited staff to take part in the annual staff survey. The 2015 staff survey results had shown an improvement in scores compared to 2014. However the trust remained in the bottom 20% of acute trusts (97 out of 99 acute trusts nationally). The 2016 survey data was not available at the time of our inspection.







# Medical care (including older people's care)

- A separate staff survey highlighted concerns around violence and aggression from patients and visitors. The human resources department were developing an action plan based on root causes with governance.

## **Innovation, improvement and sustainability**

- During 2015/16, patient recruitment was highest in renal medicine and diabetes at GHH.
- An ongoing renal medicine study looking at the identification and management of acute kidney injury was taking place. The trust expected the results to have a national impact.
- Heart of England Foundation Trust was collaborating with local healthcare providers, pharmaceutical and professional services to undertake research. 'Insights for Care' was using diabetes patient data to learn more about how diabetes develops, how diabetes patients use NHS services and how HEFT could improve access to these services and identify ways in which they could deliver better quality care to improve health outcomes for patients.
- A clinical research internship programme consisting of eight nurses and midwives were undertaking research for masters at the University of Birmingham. These students were being developed into future researchers, all of whom had expressed a desire to continue to a PhD.
- The acute kidney outreach to reduce deterioration and death (AKORDD) study recruited over 1700 patients. This aimed to improve patients care and patient outcomes in the management of acute kidney injury patients.
- A doctor in the renal medicine unit was leading as principal investigator on several new studies. The trust reported that the renal medicine unit was the first UK site to use an American device in the treatment of persistent hypertension. This study was ongoing at the time of our visit.
- A respiratory medicine doctor introduced home monitoring for cystic fibrosis patients.

# Surgery

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

## Information about the service

Good Hope Hospital provides a range of emergency and elective surgery for the local population. This includes inpatient and day case surgery and, in addition to general surgery, specialties include, trauma and orthopaedics, urology, and ophthalmology services.

There are four surgical wards, a day case unit and eight operating theatres on the site.

Between April 2015 and March 2016 there were 19,432 surgical spells.

The Good Hope Hospital is one of three acute hospital sites within the Heart of England Foundation Trust. The division of surgery and the clinical support services division manage surgical services at the hospital. The divisions are responsible for surgery, theatres and anaesthetics at all three hospitals and the divisional structure was designed to bring together services delivered on the different sites.

Site specific data was not available for some of the areas covered in the report and therefore when site specific data was not available, divisional data is reported and this is identified in the report.

We visited the four surgical wards (including the surgical assessment unit), the day case unit, operating theatres and recovery. We spoke with 17 staff in addition to meeting with the divisional leadership team and the matrons. We also spoke with 10 patients. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed nine care records and

observed the handover of patients when they were transferred from one area to another and multi-disciplinary handover huddles. We reviewed other documentation from stakeholders and performance information from the trust.

# Surgery

## Summary of findings

We rated this service as requires improvement because:

- Improvements were required in adherence to infection prevention and control practices and medicines management.
- Although staff were aware of the focus on reducing pressure ulcers and falls there was a lack of awareness of other incidents, or any learning which had been identified as a result of incidents. The identification of incidents and risk and the management of risks on the risk register was not always robust.
- The service had below average performance in relation to a range of national measures to assess the effectiveness and responsiveness of care. The effectiveness of care, as measured in national clinical audits, indicated performance below the national average in a number of areas. The risk of an unplanned re-admission following discharge was also higher than the England average for all specialties other than urology. The average length of stay for elective surgery was higher than the England average
- Patients experienced delays at all stages of the patient journey through surgical services. This included delays in scheduling unplanned surgery and delays in returning from recovery to the surgical wards.
- Care provided did not always take account of patients' individual needs, in relation to those living with dementia and those with a learning disability. Access to independent translation services was not promoted. Records of mental capacity assessments and the best interest decision making process was not well completed.

However:

- There was a good awareness and escalation when patients' condition deteriorated and a good awareness of sepsis.
- Initial medical assessments and nursing risk assessments were completed and reviewed

appropriately; there was a multi-disciplinary approach to care and clear plans of care for patients. Care pathways were used for routine procedures to ensure a consistent approach to care. Patients' pain was regularly assessed and effectively managed. Patients were aware of the plans for their care and felt involved in decision making.

- Good clinical leadership was in place at ward level. Staff had access to training and development and completion of mandatory training was generally good. They had attended adult safeguarding training and there was good awareness of safeguarding policies and procedures. Staff worked well together; they were supportive of each other and were committed to improving the quality of patient care.
- Patients gave mostly positive feedback on the care and compassion shown by staff and the timeliness of staff responses when they required assistance. Results from the Friends and Family Test (FFT) were above the national average. We observed patients' privacy and dignity being maintained and a professional and sensitive approach by staff when providing care.

# Surgery

## Are surgery services safe?

Requires improvement



We rated surgical services as requires improvement for safe because:

- Some staff did not consistently adhere to infection prevention and control practices. Medical staff left the operating theatres and attended the wards without changing from, or covering, their theatre clothing. They did not always adhere to the bare below the elbows requirements. Patient records were taken into an isolation room and left in the room. These factors increased the potential for the spread of hospital associated infection. In addition, the hospital did not collect data to determine rates of surgical site infection.
- Improvements were needed in the management of medicines. Monitoring of the temperature of storage areas and stock rotation was not consistent and staff did not always stay with patients to ensure they took their prescribed medicines.
- Patients at high risk of developing pressure ulcers were not always provided with suitable pressure relieving mattresses in a timely manner.
- Staff awareness of lessons learned from incidents was limited and we identified a concern in relation to staff recognition of what constituted an incident.
- Junior medical staff vacancies were high and this resulted in delays to non-emergency care at times.

However:

- Individual patient risks were identified and managed. The use of the national modified early warning system (MEWS) to identify patients at risk of deteriorating was good and we saw examples of the appropriate escalation of concerns. The critical care outreach team and medical staff provided a timely and supportive response. There was good use of the surgical safety checklist for patients undergoing surgical procedures and staff were aware of the never events which had occurred at another hospital site within the trust.
- Patient records provided a record of initial admission assessments and clear plans for the care of patients.
- Nurse staffing levels were monitored and assessed and planned staffing levels were achieved in the majority of shifts.

- Staff were aware of safeguarding policies and procedures. Over 90% of staff had completed adult safeguarding training and staff were conversant with the procedures for reporting safeguarding concerns.

## Incidents

- There were no “Never Events” in surgical services at the hospital between August 2015 and July 2016. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- During the inspection, we found evidence of learning from never events which occurred at another hospital within the trust earlier in the year. There were displays within the operating theatres for staff to see, providing details of the never events and the actions being taken to prevent recurrence. Staff demonstrated an awareness of the issues and the importance of using a surgical safety checklist known as the WHO checklist for all surgical procedures.
- In accordance with the Serious Incident Framework 2015, the surgical division trust wide, reported 14 serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016. Of these, the most common type of incident reported were healthcare associated infections or infection control incidents meeting SI criteria which accounted for 29% of all incidents reported. In the same period the trust told us there were 10 SIs related to pressure ulcers and falls in surgical services at the Good Hope hospital alone, and we found there were three healthcare associated infections meeting the SI criteria in these services. We were unable to obtain clarification on the reason for the discrepancies in the numbers reported through the different systems.
- Root cause analysis was used to investigate and identify the cause and contributory factors from incidents. A matron from another area within surgery investigated serious incidents to ensure an objective approach; however, the matron from the area concerned reviewed other incidents.
- Outcomes of incidents were discussed at divisional monthly quality and safety meetings. The Chief Executive held monthly RCA forums to discuss serious incidents and ensure that actions were put into place by the appropriate staff.

# Surgery

- Incidents were reported using an electronic reporting system and a process had been introduced to ensure they were reviewed within seven days. Staff were conversant with the reporting procedure and were able to access the reporting system.
- During the inspection we identified a patient who should have fasted prior to an endoscopic procedure had eaten breakfast; their procedure had to be postponed for over 24 hours due to inability to re-schedule the patient's procedure for later in the day. This had not been reported as an incident and when we talked with staff, it was clear they had not considered reporting it as such. However, when we discussed it with a senior nurse they agreed to complete an incident report. This gave us concerns as to staffs' understanding of incident reporting and whether all incidents were being identified and reported.
- Staff told us they were informed of learning from incidents through "Learning Lessons" newsletters and ward meetings. There had been a focus on reducing pressure ulcers and falls and when we asked staff about this, they identified actions they were taking to reduce the incidence of pressure ulcers. However, most staff were unable to give any examples of any learning from other types of incidents and were not aware of any serious incidents within the service.
- We saw an example of a "Clinical Safety Alert" which focused on a safety issue related to a specific procedure and the action to ensure it was used safely.
- Junior doctors were provided with a "Risky Business" handout which provided patient safety information, highlighting the importance of patient safety. It gave examples of safety issues that had been raised and provided information about action taken in response.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person." Staff were aware of the duty of candour and were able to give examples of incidents when the duty of candour had been applied. We also saw a copy of a duty of candour letter which had been sent to a patient which complied with the duty.
- A patient said, "I am very impressed with the care on the ward and the way that when things go wrong, they help each other and make sure things are resolved." They said that as a result they felt, "Extremely safe."
- Morbidity and mortality was discussed at directorate quality and safety meetings. Notes of these meetings indicated individual cases were discussed and learning identified. All deaths following surgery for a broken hip were being reviewed to identify contributory factors and themes.

## Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thrombo-embolism (VTE) and catheter associated urinary tract infections.
- The safety thermometer result for the surgical division for July 2016 was 93% for harm free care, as compared to the England average of 94%. Wards 14 and 15 at the hospital scored below the England average, with scores of 93% and 88% respectively. This indicated that a higher than average number of patient harms were reported on these wards.
- Between September 2015 and August 2016, data from the safety thermometer showed the prevalence rate for pressure ulcers decreased from September 2015 to May 2016 after which the prevalence rate increased. The prevalence rate for urinary tract infections increased in August 2015, but decreased towards August 2016.
- Harm free care was part of the nursing care quality metrics which were discussed at monthly quality and safety meetings. Reducing pressure ulcers and falls were identified as priorities for improvement and there was a focus on identifying avoidable incidents through improving the consistency of care and using a pressure ulcer prevention care bundle. Each ward told us of slightly different approaches to ensure patients were assisted to re-position in line with the frequency identified as being necessary in their care plan. Ward managers told us this continued to present challenges. There were no intentional care rounds in place to ensure staff checked all patients on an hourly or two hourly basis, and therefore systems had to be put into place to ensure patients requiring assistance with re-positioning were identified and the interventions carried out.
- Ward managers were knowledgeable about the number of patients who had developed pressure ulcers on their ward over recent months and the wards had displays in place to provide information on the prevention of

# Surgery

pressure ulcers and falls. They used a safety cross to record the numbers each month. The safety cross is a means of recording the incidence of key factors influencing safety daily on a monthly basis, giving information at a glance as to the frequency of these incidents.

- The safety thermometer results were displayed alongside other nursing quality metrics on each ward but were printed in extremely small print making it extremely difficult to read the individual results.

## Cleanliness, infection control and hygiene

- MRSA is a type of bacteria that is resistant to a number of widely used antibiotics.
- One healthcare associated MRSA bacteraemia (blood stream infection) attributable to the trust was reported in surgical services between August 2015 and July 2016.
- Trust data indicated that MRSA screening rates in July 2016 for the surgical division was 85% against a trust target of 90%. The two wards at the hospital not meeting the target screening rates were ward 16 (88%) and ward 17 (89%).
- We observed records which indicated individual patients had been screened for MRSA on admission to the service and staff told us patients who were initially identified as being for admission were routinely screened. However, those admitted from the surgical assessment unit (SAU) were not consistently screened, as if a patient only attended the SAU, screening was not required. The screening for these patients was sometimes missed if they later needed to be admitted for surgery.
- We reviewed trust data on compliance with procedures which have been identified as having a high impact on the risk of infection including intravenous cannula care and urinary catheter care. The data was not broken down to site or ward level, however, compliance for the surgical division was over 95% for the three months to July 2016.
- Two patients developed *Clostridium difficile* (C.Diff) in surgery between August 2015 and July 2016 inclusive.
- The trust completed monthly environmental audits with a target of 85% compliance. Surgical wards achieved 100% compliance for all months between April 2016 and July 2016 except for June 2016 when they scored 89%.
- We found clinical areas (including the wards and operating theatres) and equipment were visibly clean and we observed housekeeping staff cleaning the ward areas. When we asked a housekeeper for the cleaning schedule, we found this only consisted of an outline of the areas to be cleaned each day and not the specific tasks to be undertaken or the frequency of the cleaning of individual parts of the ward such as the toilets. The housekeeper was able to provide information about the frequency of the cleaning tasks but was not aware of any more detailed schedule. This meant that if staff such as temporary staff, were not familiar with the area or had not undertaken a full training programme, there could be variability in the quality of cleaning. A patient told us they had observed an unfamiliar housekeeper at the weekend, wiping bed tables and lockers with the same cloth as they had used to wipe something on the floor.
- We observed a patient with an infection was being cared for in a side room and a sign outside the room clearly identified the precautions staff should take when caring for the patient. We observed most staff used personal protective clothing and equipment appropriately and adhered to the requirements. However, we saw that medical staff had taken the patient's nursing records which were stored outside the room, into the room with them and left them in the patient's room. This increased the risk of the spread of infection.
- Personal protective clothing and equipment were readily available within the clinical areas and hand gel was available at the end of each bed, in the corridors between the bays and attached to each records trolley.
- Trust hand hygiene audits showed 100% compliance for the four surgical wards over the six months to August 2016 in the months in which they were audited. However, all the wards had gaps in the audit data where audits had not been completed for some months.
- Patients told us they saw staff using the hand gel or washing their hands when attending to them and we observed most staff observing hand hygiene procedures. However, we observed an anaesthetist who was not bare below the elbows. We also observed five medical staff, including two consultants, an anaesthetist and two middle grade doctors, who came onto the ward to review patients whilst still wearing their theatre scrubs and without covering them. We asked the ward managers if this happened regularly and they said the doctors often covered the scrubs but it was not unusual

# Surgery

for them to come onto the ward in scrubs and they often raised the issue with them. This was in contravention of the uniform policy and increased the risk of the spread of infection.

- Laminar airflow was in place in some but not all of the theatres used for orthopaedic surgery. There was no separate theatre for elective orthopaedics or ophthalmology. Ophthalmic and elective orthopaedic procedures such as hip and knee replacements are considered to be “clean” procedures in which the impact of a hospital associated infection is high and it is usual to allocate specific theatres for these procedures and not use them for other procedures.
- Surgical site infection (SSI) rates for the hospital were not collected by the trust and therefore it was not possible to identify whether the issues identified above could be directly linked to higher infection rates.
- There was an infection prevention and control display board on some of the wards. These provided information on the ward’s hand hygiene performance and information on infection prevention and control to ensure staff and patients were reminded of the importance of infection prevention and control procedures.

## Environment and equipment

- The surgical wards had secure access and visitors used an intercom to gain entry. This enabled staff to monitor visitors entering and leaving the ward. The environment appeared to be generally well maintained and suitable for the needs of patients. Equipment and supplies were stored appropriately, but we noted some equipment was stored just inside the entrance to some wards in a wider area of the corridor. This gave a cluttered appearance when entering the wards. We also found some acidic cleaner in an unlocked housekeeper’s room on ward 17. These items should be securely stored as they pose a risk to health (COSHH).
- Ward 17 incorporated six surgical assessment trolleys for patients who required observation or assessment for a short period prior to admission or discharge. At the time of our inspection, the trolleys had been replaced by beds to enable the ward to respond to the need for additional surgical beds. However, there were no lockers for the storage of patients’ personal belongings, towels

and wash items. A patient who was admitted to one of these beds six days previously said this was causing them some inconvenience and meant the safe storage of their personal belongings was compromised.

- Staff told us they had access to the equipment required to provide safe care and said that if equipment required repair, it was reported and the maintenance department responded in a timely manner.
- Equipment had been tested for electrical safety, within the required timeframes.
- When we asked about the availability of pressure relieving mattresses we were told most were hired from an external supplier and when a mattress was required, it was delivered within 24 hours. Mattresses ordered during the day were usually delivered the same day and those ordered out of hours were supplied the following day. Most staff were not aware of a target time for obtaining a mattress for patients, although one ward manager said they thought there was a target time of four hours. This meant patients at high risk of developing a pressure ulcer, might not be placed on suitable preventative equipment for up to 12 hours. We saw an example of an elderly patient who was admitted with a fractured femur and was at high risk of developing a pressure ulcer. The need for a pressure relieving mattress was identified at 10.30am and their mattress was delivered at 5pm. Delays in the use of pressure relieving equipment may increase the risk of patients developing a pressure ulcer. Senior managers told us they were negotiating with the supplier to provide a small stock of mattresses centrally on the hospital site to enable them to be obtained more quickly.
- Sterile instruments and theatre procedure packs were sterilised off site and supplied by an external supplier. We did not identify any issues with the service and staff told us they had no problems.
- Resuscitation equipment including a defibrillator and suction apparatus were available in the wards and operating theatres and records indicated the equipment had been checked daily. Emergency drugs were stored with the equipment and were stored in sealed boxes to enable identification of any use or tampering with the contents. In the operating theatres there was a specific anaesthetic trolley for children and also trolleys for emergency tracheostomy and difficult to intubate patients.



# Surgery

- The resuscitation trolleys also had a ‘hypostop’ box. These boxes are brightly coloured for instant recognition and contained all the equipment to treat hypoglycaemia (low blood sugar levels in diabetes). It is good practice to have this equipment available on all wards, where people with diabetes may be cared for.

## Medicines

- The pharmacy department was open seven days a week with clinical pharmacists and technicians working at ward level during the week. An out of hours cupboard containing medicines that might be required in an emergency was available and staff could obtain medicines or advice through the on-call pharmacist service.
- During the week a clinical pharmacist monitored the prescribing of medicines and visited the wards daily. They were readily available for advice about medicines.
- Medicines were stored in line with requirements in locked rooms. Medicine trolleys were secured to the wall when not in use. The temperature of the rooms used to store medicines should be recorded daily to ensure medicines remain in their optimum condition. We found the room temperatures were not always recorded and the temperature of the refrigerators used to store medicines, were either not recorded correctly, or there was a misunderstanding as to how to record maximum and minimum temperatures, as the maximum temperatures recorded indicated the temperatures of the refrigerators were very high. Ward 17 did not have a thermometer to record the room temperature and told us one was on order. The medicines refrigerator on ward 15 was not working and medicines which needed to be stored in the refrigerator were stored on a neighbouring ward, which resulted in difficulties in accessing the medicines in a timely manner.
- Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, monitored and disposed of appropriately. Daily checks of controlled drugs were completed of by two nurses to ensure their usage was monitored.
- We found a controlled medicine had passed its expiry date on ward 17 and this was flagged in the controlled drug record book. We were told pharmacy staff collected expired stock which required return to pharmacy, but there were often long waits of a week or

more for this stock to be collected. We also saw some patients own medicines stored on ward 15 which had passed its expiry date. This increased the risk that medicines which had past their expiry date would be used.

- Bulk intravenous fluids were stored safely but in an area where the temperature was not recorded. This room was surrounded by windows and had the potential to get very warm and staff told us this was a problem in the summer months.
- Prescriptions were stored and tracked safely
- Medicines were mainly prescribed and administration was recorded through an electronic system.
- There was a system in place to ensure that doses of antibiotics or drugs for Parkinson’s disease were not missed or delayed. This involved the nurse in charge holding an electronic bleep which would be activated if any of these medicines had not been given.
- We observed medicines being administered to patients and saw staff wore “Do not disturb” tabards to highlight the importance of them being able to administer medicines without interruptions.
- We observed staff checking the medicine against the medicines administration record and checking the identity of the patient prior to administering the medicines. However, three patients on ward 14 told us staff did not always stay with them until they had taken their medicines. This meant staff signed to say patients had taken their medicines when they could not be sure they had.
- Discharge letters containing details about medicines were verified by a pharmacist and two nurses checked the medicines before giving to patients when they were discharged.
- Staff told us that they had all received medicines training when they started with the Trust.
- Medicines incidents were reported through the electronic incident reporting system and staff told us they were kept informed regarding medicines issues through the email system.

## Records

- Patient records at ward level were not stored securely in line with trust policies.
- Patient records were stored in folders in trolleys on each ward. However, it was not possible to lock some trolleys and others, although having a lock, were not locked. We talked with ward staff about this and on the ward where

# Surgery

the trolleys did not lock, staff told us lockable trolleys were on order. On each ward staff told us trolleys were located near the nurses station, as this was normally manned and it reduced the risk of unauthorised access to the records. Nursing risk assessments and daily care records were stored at the end of patients' beds.

- White boards with patient information were visible from the main ward thoroughfare.
- The main patient record contained entries by the multi-disciplinary team and the profession of the staff making the entry was clear. Care records were completed legibly, dated, timed and signed and the designation of the person making the entry was recorded. Initial admission assessments had been completed and there was a clear plan for the patient. There was a contemporaneous record of the patient's progress and evidence of daily review of the patient by medical staff including a review with senior doctors. In some cases, standardised care pathway documentation was used, for example a total knee replacement pathway and surgical inpatient pathway. These helped to ensure care was provided in a timely and consistent way.
- A nursing risk assessment booklet had been completed for each patient and these included an assessment of each person's nutritional risk, their risk of developing pressure ulcers, and falls, moving and handling assessment and continence assessment. When bed rails were in place, a risk assessment had been completed to ensure they could be used safely.
- SSKIN bundle documentation was used to record the interventions in place to prevent the development of pressure ulcers and these had been completed consistently.
- Observation charts indicated the frequency of vital signs observations required and these were completed consistently. The trust completed monthly audits of the completion of vital signs observations and the surgical wards scored between 97% and 100% between June 2016 and October 2016.

## Safeguarding

- The trust set a target of 85% for completion of mandatory safeguarding training. In the surgical division 98% of nursing staff had completed safeguarding children and adults training within the year to

September 2016. In the same time period, medical staff had a training completion rate of 93% for level 2 safeguarding training. Ward managers in surgery had completed level 3 training.

- Staff were aware of the signs and symptoms of possible abuse and junior staff said they would report any concerns to the nurse in charge of the shift or the ward manager.
- Incident forms completed for a safeguarding concern were flagged to the safeguarding team and staff were aware of how to contact the trust team. A Band 6 nurse told us of a safeguarding referral they had made through the electronic reporting system and the action taken as a result. Staff were aware of how to escalate a concern if necessary.
- On ward 17 we observed there was a display board providing information about safeguarding and deprivation of liberty and contact numbers for the safeguarding team.

## Mandatory training

- The trust set a mandatory target of 85% for completion of mandatory training. In the surgical division, compliance for nursing staff was at least 85% for 15 of the 20 mandatory training modules including resuscitation, moving and handling, infection control and fire safety. Modules with the lowest completion rates of 76% were blood transfusion and waste management. Medical staff had a training completion rate of 100% for nine of the 20 modules. Equality and diversity and waste management had the lowest completion rates at 58% and 42% respectively.

## Assessing and responding to patient risk

- The national modified early warning score (MEWS) was used as a tool for identifying deteriorating patients. The documentation we reviewed across all ward areas showed accurate completion of MEWS scores with each set of nursing observations. The observation chart gave clear guidance on the escalation process in the event of the MEWS score increasing. We saw evidence that staff had acted in accordance with the guidance when three patients' MEWS scores had increased.
- Monthly audits to assess whether escalation of raised MEWS scores had occurred were completed for the surgical division and results showed 100% compliance in July and August 2016 and over 90% compliance in all months since April 2016.

# Surgery

- Staff were clear about the requirements for escalation of MEWS and said when they needed to escalate they received a timely response. A ward manager said, “We always achieve a review of the patient within the required timescale.” There was a critical care outreach team and staff said they provided excellent support and were very responsive.
- A nurse gave us an example of a patient who hadn’t triggered on MEWS but they were concerned about, so they had escalated it to medical staff. They said the doctor was very responsive and attended the ward promptly to review the patient.
- Awareness of sepsis was very good amongst nursing and medical staff and staff told us they had completed sepsis training. Identification of sepsis was included in the junior doctor’s induction process.
- Risk of venous thrombo-embolism (VTE) was documented electronically by medical staff. Trust data indicated that VTE assessments were completed for 98% of patients requiring this in the surgical division. The only surgical ward at the hospital which achieved below 95% in July 2016 was ward 17 which scored 93%.
- Pre-operative checklists were completed prior to surgery to ensure a structured approach was taken and risks identified. We observed the checklist being completed for a patient during our unannounced visit.
- Staff completed the five steps to safer surgery checklist (WHO checklist) electronically for patients undergoing surgical procedures. We observed this in action in a theatre and saw it was completed performed correctly.
- A notice board within theatres highlighted the importance of the use of the checklist and learning from recent never events.
- Audits of compliance with the WHO checklist were completed by the service monthly. Trust data indicated a compliance of 100% in all the surgical theatres at the hospital between April and June 2016 in all theatres except theatre 4 where compliance was 98.9%.

## Nursing staffing

- The service had used a recognised tool to assess their ward staffing requirements in June 2016 and the number of care hours per patient day achieved, were monitored on a continuous basis. A ward manager told us their staffing establishment had been reviewed and an increase had been agreed.
- In August 2016 there were 12 whole time equivalent (WTE) nursing staff vacancies from a total of 88.55 WTE

posts. We talked with ward managers about vacancy levels and they told us they had some vacancies but in most cases staff had been recruited and the service was waiting for them to commence, or they were in the process of advertising to fill the vacancies. They told us they rarely experienced problems in recruiting HCAs but recruiting registered nurses was more difficult. In some cases posts were being held for student nurses who were due to qualify in the coming months.

- Between October 2015 and September 2016 there was an average bank and agency use of 14%. Ward 14 (22%) and ward 17 (22%) had the highest average agency and bank use. Staff told us that when bank and agency staff were used they were usually staff who worked regularly in the service and who therefore knew the wards well.
- Data we reviewed indicated the planned registered nurse staffing levels had been achieved in at least 92% of shifts between May 2016 and August 2016 and health care assistants staffing levels had been achieved in at least 90% of shifts in the same period. In some months, HCA staffing levels of greater than 100% had mitigated a shortfall in registered nurse staffing levels.
- Planned and actual staffing levels were displayed in each ward.
- Most staff we talked with, felt the staffing levels were adequate to meet patient needs when they were fully staffed. However, staff told us they were frequently moved to other wards where there was a short fall of staff and this sometimes caused pressure on their ward.
- The operating theatres had eight whole time equivalent (WTE) Band 5 vacancies. We were told they held monthly recruitment drives and it was possible to fill the shortfalls by using regular bank and agency staff.

## Surgical staffing

- We reviewed medical staffing and spoke with consultants, middle grade and junior doctors. Medical cover was available on-site 24 hours a day. Consultants were available 24 hours, with on-call cover provided at evenings and weekends. Consultants were available on call out of hours
- A registrar was resident during the day between 8am and 8:15pm for surgery and trauma and orthopaedics. A FY2 doctor was rostered 24 hours a day for each specialty.

# Surgery

- In September 2016, the trust reported a vacancy rate of 10% in the surgical division; ENT, General Surgery and Thoracic Surgery reported a vacancy rate of 20%. Trauma and Orthopaedics and Theatres had a vacancy rate of 16% and 17% respectively.
  - Of a total of nine FY2 junior doctor posts in trauma and orthopaedics across the surgical division, four posts were vacant, two of which were for doctors based at the hospital. There were also two specialist trainee posts vacant and one specialty doctor post. We were told staff grade doctors covered gaps in the rota and consultants covered registrar roles when there were gaps. The senior leadership team told us of action being taken to recruit and resolve the issues in the future but accepted the recruitment initiatives had been undertaken too late to cover the current vacancies.
  - We reviewed the medical staff rota for five weeks from 22 October 2016 and saw there were gaps in the rota for FY2 junior doctors for two of the five weeks with only one FY2 doctor rostered instead of two, for six day shifts.
  - We were told that junior doctor shortfalls resulted in delays to patient discharge due to delays in prescribing patients' medicines to take home and increased waiting times in the surgical assessment unit (SAU), as reviews of patients were delayed due to medical staff being in theatres.
  - Junior medical staff vacancies in the surgical division were on the trust's risk register.
  - A junior doctor told us they had been provided with a good induction and staff had been welcoming. They said the consultants were supportive.
- The requirements of the Mental Capacity Act (2005) were not consistently documented and therefore we could not be sure they were being consistently applied.
  - National audits identified that some aspects of surgical care were not effectively managed. For example only 69% of patients with a broken hip had surgery on the day of, or the day after admission. The national emergency laparotomy audit identified some suboptimal management of patients pre-operatively and post operatively.
  - The hospital had higher than expected unplanned re-admission rates for all specialties other than urology and the re-admission rate for elective trauma and orthopaedic surgery was particularly high.

However:

- Patients' pain was effectively assessed and managed. Patients had access to a specialist pain management team as necessary.
- There was good multi-disciplinary working and cooperation between the different professional groups.
- Staff had access to ongoing training and professional development to maintain their knowledge and skills. Annual appraisal levels were high and staff found the appraisal process constructive and developmental.
- Care pathways were in place for a range of surgical procedures to ensure adherence to best practice guidance.

## Evidence-based care and treatment

- Staff were aware of The National Institute for Health and Care Excellence (NICE) guidance relevant to their specialty and had access to the guidance via the trust's intranet.
- Local protocols and guidelines were in place and were based on NICE guidance. The guidelines we reviewed were up to date.
- A comprehensive audit plan for 2016/2017 was in place to assess practice against professional guidance and standards. Evidence was provided of a small number of audits to assess compliance with NICE guidance relevant to the specialty, for example, CG92 Venous thromboembolism: reducing the risk for patients in hospital, PG411 Endoscopic transluminal pancreatic necrosectomy and CG124 Hip fracture management.
- NICE guidance and adherence to guidance were discussed at directorate and divisional governance

## Major incident awareness and training

- An emergency plan and policy was in place and had been reviewed in March 2016.
- Ward managers were aware of their role and told us they had an annual training update.
- We observed a fire evacuation plan was displayed in the ward corridors.

## Are surgery services effective?

Requires improvement 

We rated surgical services as requires improvement for effective because:

# Surgery

meetings. Inability to comply with NICE guidance on gallstones and acute pancreatitis due to access to surgery and capacity had been identified and placed on the risk register.

- An evidence based sepsis care pathway was in place. Staff demonstrated a good awareness of the pathway and when we asked a member of staff to locate it on the trust intranet they were able to do this easily.
- Care pathways were in place for patients undergoing elective knee and hip replacement, which were evidence based. We also saw pathways for surgical short stay, surgical inpatients, and day surgery patients. Pathways were in place for patients admitted with a fractured hip and these were started in the A&E department and followed the patient through to discharge.

## Pain relief

- We found an initial assessment of patient's pain was completed on admission to hospital and pain reviews were completed with each set of vital sign observations.
- Trust monthly audits of records of daily pain assessments and evaluation indicated 100% compliance between July 2016 and October 2016.
- A pain management care plan and evidence based guidelines for the use and management of different types of analgesia had been developed. These included flow charts to guide decision making in relation to the effective use of pain relief medicines.
- We observed the handover of a patient from recovery to the ward. This included information about the pain relief medicine required and the pain relief already given in theatre.
- Patients told us staff asked them about their pain and whether they required any medication to control their pain. Most patients said their pain had been effectively managed. A patient who had a planned operation told us staff had told them they would not have any pain for 24 hours after surgery as they would have a pain block. However, the block "wore off" more quickly and they were given another block. They told us they were offered pain relief during the post-operative period and when they needed it they had additional medicines.
- A pain management team was available; we were told they visited some wards daily and if a patient was referred to the team, they normally visited the same day. Staff told us the team provided training sessions for staff on the ward.

- We talked with a patient who had a full understanding of the medicines being used to manage their pain. They told us their medication was not effective and they had been referred to the chronic pain team a couple of days ago. When we followed this through with the ward manager, they said they would check a referral had been made as they would have expected them to have been seen within 24 hours.

## Nutrition and hydration

- Staff completed nutritional screening and assessment for patients on admission to the hospital and the score was reviewed at least weekly throughout the patient's stay.
- Data provided by the trust indicated nutritional assessments were in place for over 93% of patients in the surgical division between June 2016 and August 2016.
- Patients' food and fluid intake was monitored through the use of food charts and fluid balance charts. We found these were completed consistently and patients were encouraged to maintain a good fluid intake. We noted an instance where staff had identified a patient was not eating well and as a result, nutritional supplements were prescribed and a referral was made to the dietitian.
- There was a consistent approach to the length of time food and fluids were withheld prior to surgery and a pre-operative fasting guideline was in place, based on best practice. Patients told us they were given clear instructions about fasting prior to admission for surgery when they had their operation on the day of admission.
- We observed some patients were fasted prior to surgery following a fractured limb and their surgery was cancelled later in the day, meaning that food and fluids were withheld for an extended period. However, we also reviewed a patient who had been scheduled for theatre and fasted from 3am, but their surgery was cancelled at 9am, and they were immediately given food and a drink.
- We observed the distribution of the lunchtime meal on two wards and found it was completed efficiently and patients were offered a choice of meals. The housekeeper was involved in serving the meals and we saw that on one ward they acted as a mealtime coordinator. Staff checked with patients as to whether they required assistance and when they did, staff provided the assistance they required.

# Surgery

- Protected mealtimes were in place in that ward rounds and staff tasks were halted during mealtimes, but visiting continued.
- We received mixed feedback on the quality of the food and the temperature of hot food when it was served. One patient said, “Some days it (the food) is good, and on others I wouldn’t give tuppence for it.” Patients said food was often warm rather than hot. We also had feedback from younger patients that the portion size was small.
- A member of staff told us they had identified that some reductions in the friends and family test scores were due to dissatisfaction with the food and as a result, the menus were being reviewed.

## Patient outcomes

- Surgical services participated in national audits relevant to their specialty. Performance when compared to other hospitals nationally was variable.
- In the 2015 national Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7.7%, which falls within the expected range and was an improvement from the 2014 mortality rate of 8.9%. The proportion of patients not developing pressure ulcers was 99.5%, which placed the hospital in the top 25% of hospitals nationally. However, the proportion of patients having surgery on the day of, or the day after admission was 68.8%, against a national standard of 85%. This was within the bottom 20% of hospitals nationally and was lower than the 2014 figure of 71.4%. The perioperative medical assessment rate was 82.9% which was an improvement on the 2014 rate of 79.5%, but this still placed the hospital in the bottom 20% of hospitals nationally and did not meet the national standard of 100%.
- In the 2015, the National Emergency Laparotomy audit (NELA), which rated key aspects of care as red (scores of 0-49%), amber (scores of 50-69%) or green (scores of 70-100%), the hospital achieved a rating of green for four measures, amber for two measures and red for five measures. The measures which scored red were, consultant surgeon review within 12 hours of admission, documentation of risk pre-operatively, direct post-operative admission to critical care, and assessment by an older people’s specialist for patients over 70 years.
- The trust participated in the National Bowel Cancer Audit (2015) however, the results were only available at trust level rather than being provided for each hospital.

The trust fell within the expected range for 90 day post-operative mortality rate at 4.8% and for the risk adjusted two year mortality rate at 20.9%. The risk adjusted unplanned re-admission rate was also within the expected range.

- In the 2015 National Vascular Registry (NVR) audit the trust achieved a risk adjusted post-operative in-hospital mortality rate of 0.9% for abdominal aortic aneurysms which was within the expected range and was an improvement on the 2014 rate of 2%. Hospital level data was not available.
- Actions plans had been developed to identify and address issues identified in the national audits with responsibilities and timescales allocated.
- Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to patients from the patient perspective and calculate the health gains after surgical treatment. They cover four surgical procedures: groin hernia, knee replacement, hip replacement, and varicose veins. PROMs data (April 2015 to March 2016) indicated that patients undergoing groin hernia surgery and surgery for varicose veins had a higher than average health gain following surgery, than in England overall and patients undergoing hip replacement and knee replacement had lower adjusted health gain following surgery than for England overall.
- Between March 2015 and February 2016, the hospital had a higher than expected risk of readmission following elective and non-elective admission for all specialties with the exception of urology.
- Elective trauma and orthopaedic surgery had the highest relative risk of re-admission. The senior leadership team identified reduced ortho-geriatrician support, as a factor influencing this. A business case was being prepared for the management of elective admissions.

## Competent staff

- New staff had access to trust induction and clinical induction programmes and a preceptorship programme for newly qualified nurses. A newly qualified nurse told us they were supernumerary initially and they were allocated a preceptor to provide them with support and guidance. They told us they had a development plan for their preceptorship period and they felt able to discuss any issues with their preceptor or any of the other

# Surgery

registered nurses on the ward. They said, "All the staff are supportive and I have never been in a position where there has been no support." A junior doctor also told us they had received a very good induction.

- The trust target was for 85% of staff to have had an annual appraisal. In the surgical division appraisal rates for ENT and thoracic surgery were above the trust target and other specialties within the surgical division were greater than 82% in August 2016. The divisional theatre appraisal rate was 92%.
- Staff found the appraisal process constructive and supportive. There was discussion and feedback on their performance, competencies and training along with opportunities for future development.
- Staff told us they had access to a range of in house training to ensure they maintained and developed their skills. For example a health care assistant said they had completed an end of life study day, and an ECG skills study day within the last six months. They said, "They try their hardest to enable you to reach your goals." Another member of staff told us they had completed a nationally recognised qualification to enable them to progress towards an assistant practitioner role.
- Trust data indicated there was good engagement in the medical staff revalidation process. A new process for nursing re-validation commenced in April 2016 and the trust was providing support for staff undergoing re-validation.

## Multidisciplinary working

- Patient records we reviewed contained good evidence of multi-disciplinary involvement in patients' care and treatment. For example, we observed that a patient admitted under general surgery, was reviewed by the diabetes team and a diabetes consultant had been involved in the patients' care. The patient had been admitted to the intensive therapy unit (ITU) and the critical care outreach team visited the patient following their transfer to the surgical ward.
- We observed good multi-disciplinary relationships during the inspection and the involvement of physiotherapists, occupational therapists and pharmacists in discussions about patients' care and treatment. In the operating theatres all grades of staff interacted well with each other and supported each other. They were professional and patient focussed.
- There was some orthogeriatrician input for patients admitted with a fractured neck of femur funded by the

medical division. However, the senior leadership team identified the need for increased orthogeriatrician support. An advanced care practitioner had been appointed to provide input into the care of older people in orthopaedics and their role was seen as extremely beneficial to patients and staff.

- Multi-disciplinary reviews of patients with complex discharge needs were carried out and an electronic system to coordinate admissions, discharges and transfers was in place. Referrals to other services such as social services were made through this system.

## Seven-day services

- Diagnostic radiography was available on site outside normal working hours and seven days a week. Patients requiring interventional radiography were transferred to neighbouring hospitals.
- Pharmacists were available between 9am and 5pm Monday to Friday, between 9am and 1pm on Saturday and between 10am and 1pm on Sunday. Between 1pm and 4pm at the weekend, there was a discharge & emergency supply service.
- Physiotherapy and occupational therapy were available seven days a week.
- Consultants carried out ward rounds at the weekend and there was a consultant on call rota out of hours. We also saw weekend plans for patients were in place to ensure clarity about the plans for the patient's care over the weekend.
- Emergency theatre lists took place at the weekend.

## Access to information

- Policies, guidelines and protocols were accessible for staff on the trust's intranet.
- We received feedback from medical staff about the difficulties of accessing electronic patient data due to there being three different IT systems for different parts of patient care.
- Discharge letters created through the electronic prescribing system, were posted to GPs and a copy was given to patients to take home.
- Information was displayed on the wards in relation to actual and planned staffing levels, pressure ulcer and falls prevention and the visitor's charter.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

# Surgery

- We found records of patients' consent for surgery in their care records and records indicated a discussion had been held with patients about the surgery and its risks and benefits. When patients were undergoing planned surgery there was a record of the information given to them at the pre-assessment stage.
- Patients told us their surgical procedure had been explained to them fully and they had the information they needed prior to being asked for their consent. They had felt able to ask questions and their questions had been answered by the medical staff.
- An audit of consent forms for 30 thoracic surgery patients was undertaken in 2015 and the results presented at the Clinical Standards Committee. It identified some areas of good practice and areas to be improved, including ensuring the site of the procedure was documented in emergency procedures. Audits of consent in general surgery and other surgical specialties had not been undertaken.
- When patients were unable to make some decisions for themselves, we found the requirements of the Mental Capacity Act (2005) were inconsistently applied. For example, a patient was admitted with sepsis and their documentation indicated they had dementia or delirium and were confused, but there was no reference to their capacity to make a decision regarding a surgical procedure and they had signed the consent form. The patient had a urinary catheter inserted and there was no information in the records, of consent or a mental capacity assessment in relation to this procedure. In another patient with vascular dementia, the consent form for people unable to make decisions was completed. The doctor had signed the section stating the procedure was in the patient's best interest, but the best interest section of the form was not completed. There was no information in the care records to explain whether other options were considered and why the procedure was in the patient's best interest.
- However, a band 5 nurse gave us a good account of involvement in meetings where patients' capacity was discussed and the multi-disciplinary team were involved in the decision about the patient's best interest.
- A ward manager told us the doctors did any mental capacity assessments when they were required and this is appropriate when they are undertaking the procedure, however, we would have expected nurses to undertake mental capacity assessments for procedures

which they undertake, which require verbal consent. Another ward manager said nurses had undertaken training in mental capacity, but would not feel confident to complete the assessments themselves.

- Another member of staff said, "Nurses do pick up the issues but the doctors tend to make a RAID referral rather than do a mental capacity assessment." RAID is a specialist multidisciplinary mental health **service**, working within all acute hospitals in Birmingham.
- Training for staff in surgical services in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) was being undertaken. In September 2016 all nursing staff at band 7 and above had completed training. Only 14% of consultants and the same percentage of band 5 nurses had completed training.
- Staff told us they could obtain advice from the safeguarding team on mental capacity issues and DoLS.

## Are surgery services caring?

Good



We rated surgical services as good for caring because:

- We found staff to be caring and compassionate in their approach and the feedback from most patients was positive. Patients' privacy and dignity were maintained and staff showed empathy for patients. They were respectful and professional in their approach.
- The surgical wards scored well in the Friends and Family Test (FFT).
- Patients felt involved in decisions about their care and were aware of the plans for their care and treatment. Patient information was provided in the form of verbal information and patient information leaflets. Prior to elective knee and hip replacement surgery, patients were provided with a range of information to help them understand the procedure and the part they needed to play prior to surgery and following discharge.

However:

- We identified some issues related to noise at night which disturbed patients. Some patients said doctors talked over them and did not involve them in discussions.

## Compassionate care



# Surgery

- The Friends and Family test (FFT) was used to obtain patients' views on whether they would recommend the service to family and friends. The FFT results between August 2015 and July 2016 showed the average response rate overall for surgical services at the hospital was 43% as compared to a national average of 29%. The response rate for ward 15 was well above the national average, but the response rates for the other three surgical wards was below the national average, ranging from 20% to 27%. The percentage of patients recommending the hospital was high and all wards achieved a score of over 90% for at least 10 of the 12 months with no ward scoring under 82% in any month between August 2015 and July 2016.
- We noted ward 14 had been awarded a "Pride of Nursing" award by a local newspaper following nominations by patients and Ward 16 had been awarded a "Compassion in Care" award in 2015.
- We observed care being provided and we saw good interactions between staff and patients. Staff were professional and friendly and patients clearly had good relationships with them.
- Patients we talked with generally gave us positive feedback about the care and compassion of staff. One patient said, "You couldn't get better staff, they must be hand-picked." However, some patients told us the attitude and approach of staff was variable. One patient said, "It depends; some bend over backwards for you and others don't give you the time of day. It depends on the shift." We had similar comments from patients on other wards. For example, a patient told us, "Some have all the patience in the world and others have none. At night it depends on which team are on; some are light-hearted and others shut themselves in the office and only come and check on us occasionally."
- We also had some comments from patients on another ward about noise at night from staff who were very loud when together and generally disturbed the ward when they were not attending to patients. Patients told us this had happened the previous night and when we reported it to the ward manager, they told us they would talk with the staff concerned, to ensure the issue did not recur.
- We saw privacy and dignity were maintained for patients. For example, we saw a patient being assisted to the toilet and the member of staff talked with them

quietly and reassuringly. When the member of staff had to pop back with items for the person they knocked on the door and said, "It's only me. Can I come in?" before entering.

- Staff described the actions they took to maintain patients' privacy and dignity during personal care and we saw curtains were normally drawn around the bed space when care was provided.

## **Understanding and involvement of patients and those close to them**

- Most the patients we talked with told us they knew the plan for their care and their treatment was fully explained to them. One patient said they were offered the choice of two treatments for their condition and they said the advantages and disadvantages of each were explained to them. They said they were allowed to make the decision themselves about the treatment they felt was best for them. Another patient said, "Senior staff are excellent in informing me of plans and how I am progressing."
- A patient who was admitted for planned surgery told us they had attended a clinic before admission where the procedure had been explained to them and they were told what to expect during their admission and recovery. They were also provided with written information about the procedure. They knew the plan for their care and their estimated discharge date.
- We saw the information given at pre-operative assessment and the information leaflets provided, were documented in a patient's care records.
- However, some patients said medical staff introduced themselves when they did a ward round but then did not involve them in the discussion. A patient said, "They introduce themselves, then they talk amongst themselves and ignore you." Another patient said, "They don't talk to you, they talk to each other." When asked if they felt able to ask questions, they said, "They have two minutes and then they are on to the next person, so you don't get the time." However, the patient who said they did not have the opportunity to ask questions during ward rounds said they were "100% involved in decisions" about their care and were able to make their own choices. These comments may therefore have reflected dissatisfaction with the communication during ward rounds and the amount of information given by senior medical staff rather than decisions being made without their involvement.

# Surgery

- Patient information leaflets on a range of surgical procedures were available on the ward along with information about voluntary organisations providing support for people with long term conditions such as brain injury and Parkinson's disease.

## Emotional support

- Clinical nurse specialists in breast care, colorectal surgery, gastroenterology, urology and bowel cancer screening were available. They provided additional support to patients undergoing surgery.
- Patients told us they were not aware of the provision of any specific services to provide emotional support. However, a patient told us, "Staff provide a lot of emotional support. They give 100%."
- A multi-faith chaplaincy team regularly visited the wards and departments and provided spiritual, pastoral and religious care. The team offered a confidential listening and support service.
- Rooms were available on the wards, which could be used to talk with patients or relatively privately. A member of staff said doctors provided sensitive information to patients very well and gave them time privately, to gather their thoughts.

## Are surgery services responsive?

Requires improvement 

We rated surgical services as requires improvement for responsive because:

- We found capacity issues in surgery affected the timely access to treatment and created delays in the patient pathways through the service. Delays occurred in scheduling unplanned trauma and orthopaedic surgery, due to a lack of theatre capacity. Patients were transferred to theatre for elective surgery without a post-operative bed being available and this caused delays in transferring patients from recovery to the wards following surgery. The surgical assessment unit was being used as an inpatient facility during the inspection and this was a frequent occurrence.
- The average length of stay for patients undergoing elective surgical procedures was higher than the England average.

- Patients were transported to theatre from ward 2 through a basement corridor that provided an unsuitable environment for patients prior to and following their procedure.
- Professional translation services were not promoted within the service and family members were often used to translate for patients. We found limited provision for patients with complex needs and a lack of staff awareness of the adjustments that might be required to support people with additional support needs such as those with a learning disability or those living with dementia.

However:

- The service collaborated with commissioners and other local stakeholders to plan services to meet the needs of the local people.
- Information was available to patients about how to make a complaint or raise a concern and there were a low number of complaints reported for the service.

## Service planning and delivery to meet the needs of local people

- Discussions had been held about the configuration of surgical services across each of the trust sites and there was a view that some services should be provided at the hospital whilst others should be centralised at other hospitals within the trust. The local community in Sutton Coldfield had engaged in the discussions and their views were sought. Due to the potential merger with a neighbouring trust and collaboration with commissioners involved in the Birmingham and Solihull Sustainability Plan (STP), the timescale for review of this was uncertain.
- The service did not report any breaches of the requirement to provide single sex accommodation for patients over the previous year. We noted there were adequate numbers of bathroom/shower and toilet facilities which were for single sex use and signage was clear.
- We found patients requiring transfer from ward 2 to the operating theatres were transported through a basement corridor. The corridor had low ceilings, exposed pipework and cabling. The environment was hot and claustrophobic and was not suitable for patients who may already be anxious prior to surgery.

## Access and flow

# Surgery

- We found delays and issues in relation to patient flow at all stages of the patient pathway through surgery.
- Bed occupancy in surgical services was very high. Between September 2016 and September 2016 the average bed occupancy for ward 14, ward 15 and ward 16 was 92%, 93% and 94% respectively. Ward 17 had an average bed occupancy of 68% however, this ward incorporated six surgical assessment trolleys, which would have lowered the reported occupancy figures when patients did not stay overnight.
- During the inspection we observed that the six assessment trolleys in the surgical assessment unit had been replaced by beds, due to a lack of available surgical beds in the hospital. This impacted on the ability of the ward to provide surgical assessment.
- The trust's referral to treatment time (RTT) for admitted pathways for surgical services was in line with the England average from July 2015 to July 2016. Data showed 90% this group of patients were treated within the 18 week target time in July 2015 rising to 92% in March 2016.
- Data showed 72% of this group of patients were treated within the 18 week target time.
- Theatre utilisation rates were 87% in June 2016, 88% in July 2016 and 87% in August 2016. Additional theatre sessions were being considered to improve theatre capacity but there were uncertainties regarding funding.
- Patients admitted for elective (planned) surgery were taken to theatre when there was not always a bed available on a surgical ward identified for them for their post-operative recovery. As a result, some patients had to remain in the recovery area for an extended period until a bed became available. For example one patient told us, and their records confirmed, they met the criteria for discharge from recovery to the ward at 12.45pm but they were not able to return to the ward until 5pm due to a lack of beds. Staff in theatres and on the wards, said delays to patients returning to the ward from recovery was a frequent occurrence. Ward staff said they spent considerable time liaising with the bed management team to try to identify beds for patients in theatre.
- Data supplied by the trust indicated the time taken for patients to be transferred to the surgical ward from recovery when they met the criteria for discharge, was on average of 17.8 minutes between September 2015 and September 2016. This conflicted with the information we obtained from patients and staff during the inspection and may be due to the large number of surgical procedures in which patients are returned to the ward quickly, masking a smaller number of extended waits.
- Some emergency orthopaedic patients experienced waits for surgery due to a lack of theatre capacity for non-elective orthopaedics and therefore stayed in hospital for a longer period than may otherwise have been necessary. During the inspection we saw a patient whose operation was cancelled on the day it was due to take place, due to a lack of theatre capacity. We also talked with a patient who waited for four days for surgery for a fractured limb. They said they had been told this would enable them to access the expertise of a particular surgeon who was an expert in this type of fracture. Their discharge was also delayed as they were waiting for a package of care to be arranged in a nursing home for support their recovery.
- The National Hip Fracture audit (2015) showed that only 68% of patients with a broken hip had surgery within 48 hours of admission.
- The trust's performance in relation to cancelled operations, as a percentage of elective admissions, was higher than the England average during quarter one and two of 2015/6 and quarter one of 2016/17. These figures did not include non-elective surgery such as in the examples given above. The number of cancelled operations and patient not treated within 28 days overall for the period between July 2015 and July 2016 were between zero to three per month.
- The average length of stay for elective admissions within surgical services at the hospital was higher than the England average for trauma and orthopaedics and general surgery. The average length of stay for non-elective admissions was in line with England averages and for urology was lower than the England average. The senior leadership team identified the need for increased ortho-geriatric support as a key factor in reducing length of stay in trauma and orthopaedics.
- A electronic system was used to coordinate admissions, transfers and discharges. This system linked with social services, physiotherapy and occupational therapy to enable delayed discharges to be monitored and expedite discharge.

## Meeting people's individual needs

# Surgery

- Patients reported variable response times by staff to requests for assistance. One patient said, “If I ring the buzzer they are very responsive.” Another patient said, “I don’t need to ring my bell during the day as there are always staff in and out and I just ask them.” Others told us they had to wait for assistance. One person said, “Sometimes you have to wait a little because they are busy; it’s often around 10 minutes.”
- One patient told us they had some difficulty understanding the accents of staff and felt it was made worse by the background noise within the ward as they had a hearing impairment.
- Translation services were available for people whose first language was not English, however the use and promotion of the availability of these was low. Most staff were aware of the existence of a telephone translation service but they said it was rarely used. One person said, “You can get interpreters if needed but they are horrendously expensive so we try to avoid if possible.” Staff told us they used a variety of sources of translation. They frequently referred to the use of staff and relatives and one person referred to the use of picture communication cards which were available on the ward. The use of an independent interpreter is preferable to using family. Patient information leaflets were not readily available in other languages.
- When asking staff about the adjustments and arrangements that could be made for people with additional support needs such as those with a learning disability, staff told us patients normally had a carer who was encouraged to stay with the person and they also said patients frequently came in with a hospital passport to provide information about their support needs. Some staff said that if patients did not have a carer with them, they would consider whether one to one support was needed. They did not identify any other adjustments or arrangements which could be put into place for patients.
- The involvement of carers for patients living with dementia or with a learning disability was promoted and we found “Recognising the Carer” patient information leaflets on some wards, describing the commitment of the trust to involving carers and what they could expect from the trust.
- Staff told us there was a Learning Disability Liaison team based at a neighbouring hospital who could be telephoned for advice. However, they told us it was difficult to get hold of the team.
- Staff at ward level had a basic understanding of dementia and delirium and forget-me-not flower labels were used to identify those patients living with dementia on the patient information boards on each ward. Ward 15 had a display board providing information about dementia, information leaflets and “This is me” booklets which could be used to identify to provide personal information about people and their preferences. Ward 14 had similar “About me” documentation available for completion.
- Training was being provided to increase staff knowledge and awareness of dementia and delirium in conjunction with training on the Mental Capacity Act (2005). However, as recorded earlier in this report, training was not fully rolled out for nurses below a band 7.

## Learning from complaints and concerns

- 115 complaints were received in relation to surgical services between October 2015 and October 2016. The main category of complaints was, “All aspects of care and treatment,” followed by information and communication.
- The trust complaints policy stated complaints should be investigated and closed within 30 days, however, the average time taken to investigate and close complaints was 134 days.
- In the year to September 2016 there were 11 complaints related to ward 14, seven complaints for ward 15 and five complaints for ward 16 and ward 17.
- A patient who had been admitted for planned surgery told us they were provided with information about the Patient Advice and Liaison Service (PALS) and the complaints process prior to admission. During the inspection we observed information boards on the wards with copies of an information booklet subtitled “A guide to giving feedback or reporting a concern.” This booklet also provided information about the NHS Complaints Advocacy Service.
- Staff told us that if a patient raised a concern with them, they would try and resolve the issue and if a patient wanted to make a written complaint they would direct them to the forms which were available within the booklets available on the information board.
- Feedback to staff about complaints was given at handover and at ward meetings. A ward manager told us the main theme from complaints was communication issues.

# Surgery

## Are surgery services well-led?

Requires improvement 

We rated surgical services as requires improvement for well led because:

- Although improved managerial and governance structures had been put into place they were not fully embedded. There was no clear strategy for surgical services at the hospital and clinical staff were uncertain of the future. There was limited evidence of the engagement of patients and the public in improving and developing services.
- Although the risk register was reviewed at directorate clinical governance meetings, there was no clear plan for resolution of risks or identified timescales. There was a lack of understanding and awareness of the risk register at ward level.
- 

However:

- Ward managers provided good clinical leadership and staff felt well supported.
- Staff had a strong loyalty to the hospital and a desire to improve services for patients.
- Quality improvement mechanisms had been put into place to increase accountability for specific issues such as reducing avoidable pressure ulcers and a nursing quality matrix was in place to monitor the quality of nursing care.
- Individual directorates or services had developed some aspects of their service and we found some examples of innovation and early adoption of new treatments.

### Leadership of service

- Staff told us there had been improvements in leadership and management since the last inspection. We received positive comments about the new divisional structure and staff told us the path for escalation of issues was clearer and more timely. There were also benefits from the delegation of decision making. For example, the time taken to recruit staff for some posts had been reduced as they no longer had to gain authorisation at a senior level. A senior leader told us, "It feels a lot better now and we can make the argument for surgical

patients." A more junior member of staff said, "It is more organised now and the division feels as a whole team." Staff also commented on positive divisional meetings and the fact they were multi-disciplinary.

- Ward managers demonstrated good clinical leadership and staff felt well supported by them. One member of staff said, "The ward manager and sister are very open and you can discuss anything with them and raise any concerns." Staff told us they were visible on the wards and during the inspection we saw this was the case.
- A member of staff said, "This is a safe environment to work in because we support each other and there is always someone to call on if we need them."
- Some wards had monthly ward meetings whilst others held meeting less frequently but all produced a monthly ward newsletter for staff, to ensure they were informed of key issues.
- The ward managers had a good understanding of the ward's position in relation to staff appraisals and training and the ward's performance in relation to pressure ulcers, and falls.
- Ward managers felt supported by their matrons and they were positive about the availability of a senior nurse to respond to issues, even though the matrons had responsibilities for other hospital sites and therefore were not always at the hospital.
- Ward managers recognised the advantages of taking a collective approach to influence change and said they felt able to raise issues collectively. However, they said that even when this happened, "Things don't always change." A ward manager gave an example of issues related to the arrangements for out of hours viewings in the mortuary.
- Staff told us matrons visited the wards regularly and they occasionally saw the divisional lead nurse, however, they rarely saw the Executive team. One person said, "We don't see the directors much, it would be nice to see them occasionally." Another person described seeing the director of nursing, "Very, very occasionally."
- There was very little awareness amongst senior clinical nurses in terms of the priorities for the trust and surgical services in the future. Matrons and ward managers were not involved in discussions about future plans for the surgical division and were not unaware of any discussions to shape the future of surgical services.

### Vision and strategy for this service

# Surgery

- Staff could not articulate the trust vision and values, although we observed the values were displayed in the ward areas. They were not aware of any future plans for surgical services and when asked about the trust's priorities they did not have any clarity about this.
- There was no clear long term strategy for surgical services but it was recognised that some re-configuration of specialties and types of service offered across each of the hospital sites was required. Priorities for the next year had been identified for the surgical division, including a review of demand and capacity and a workforce review.
- The senior leadership team told us that since the creation of the surgical division, six months previously, cross site working and development was being encouraged. This needed further development in some specialties and relationships with other divisions were also being developed.
- However, local leaders said governance arrangements had changed and significantly improved in recent months.
- A process had been put into place to reduce the number of avoidable pressure ulcers occurring in the trust. An investigation and root cause analysis (RCA) were conducted and the RCAs were reviewed at an RCA forum led by the Executive team. A performance notice was issued to wards with the request for an action plan to address the issues when a grade 3 or 4 avoidable pressure ulcer was reported for a ward. We saw a copy of a performance notice that had been issued and the subsequent action plan developed by the ward manager.
- A nursing quality matrix had been developed which consisted of key performance indicators which were audited and reported monthly for each surgical ward. Audits were completed by ward staff and were peer reviewed every three months. A process similar to that described for reducing pressure ulcers was in place to address performance below the expected level. Wards were expected to achieve 95% to be compliant and when a ward scored below this level, the matron was involved and a quality improvement performance framework was followed.

## **Governance, risk management and quality measurement**

- A divisional structure was put into place approximately six months prior to the inspection with one division being devoted to surgical services. Theatres, including anaesthetics, were managed within the clinical support services division. Each division was led by a divisional director with support from a head of operations, head nurse and finance manager.
- The surgical division was subdivided into three groups of specialties. All the groups reported to the divisional quality and safety committee. We reviewed the minutes of a quality and safety committee meetings and saw there was representation from the full range of directorates and managerial groups. Each directorate provided an update of the governance issues for their directorate at the meeting and these were discussed. Directorate clinical governance and audit meetings were held on one site and staff from other sites were expected to attend the meetings to enable information to be shared between sites.
- Four half day governance meetings were held each year when theatre lists were not held, to enable staff to be released to attend. Consideration was being given to increasing the number of these to nine per year.
- There was a lack of clarity about the quality priorities for the trust and the division. Senior clinical staff at Band 7 and above each gave us different answers when asked to identify the quality priorities.
- The operating theatres also completed monthly audits including infection prevention and control audits, spot audits of swab counts and surgical scrub technique, in addition to WHO checklist audits.
- The risk register for surgery provided by the trust and dated September 2016, included only one risk specific to the hospital; this was increased mortality following surgery for a broken hip. The senior leadership team told us a review of all deaths following this procedure was being undertaken to identify any possible factors.
- The risk register we were provided with, contained no information about actions taken to reduce or mitigate the risk, or timescales for review and for further controls to be put into place.
- An issue we identified in relation to delays for patients moving from recovery back to the ward had been placed on the risk register in 2007 as a trust wide issue and remained on the register. There were only two risks above 12 on the risk register. One was a lack of junior doctor support on the trauma and orthopaedic wards. This had been on the risk register since 2013 and had not been resolved. The leadership team told us the steps they were taking to recruit and address the issue

# Surgery

had been commenced too late to resolve the current issues. The second risk above 12 on the risk register was an inability to comply with NICE guidance in relation to gallstones and acute pancreatitis. We were told the issues were related to access to theatres and theatre capacity which impacted on waiting times.

- The theatre manager was aware that theatre staffing was on the risk register but ward managers were not proactive in identifying risks for their ward and were unaware of any risks on the register.
- The concern we identified in relation to the basement corridor environment was raised at the previous inspection and no action had been taken in the intervening period to make improvements.

## Culture within the service

- The trust values were displayed on notice boards on the surgical wards and we also saw the “6Cs” also displayed. The 6Cs was a national initiative to embed a culture of compassionate care in nursing practice and represented care, compassion, competence, communication, courage and commitment.
- Some staff talked about a change in culture since the last inspection. They said it had changed from a “blame” culture to an “open” culture. One person said, “The atmosphere is completely different.”
- Most staff were very positive about the possible merger with the neighbouring trust and although the future was uncertain, they felt the new leadership team had the potential to bring about positive change.
- Staff at ward level felt well supported and told us they felt they had opportunities to develop and maximise their potential.

## Public engagement

- The senior leadership team told us they had engaged with the local community when considering the provision of surgical services at the hospital and neighbouring sites within the trust. However, this was the only example we were given of the engagement of the public in the development of services.
- The friends and family test questionnaire used by the service included the opportunity for patients to comment on what the service did well and where they could improve. It also asked about peoples’ experience of care at different times of day. Staff indicated they used the information from these questionnaires to

identify themes and areas for improvement. The surveys were given to patients on discharge and patients we talked with on the wards said they had not been asked for any feedback on the service or the care provided.

## Staff engagement

- Staff showed a commitment and loyalty to the hospital and many of those we talked with had worked at the hospital for a number of years. All the staff showed enthusiasm and a willingness to work together to provide the best possible care for patients.
- We were told the establishment of divisions had changed communication channels. A member of staff said, “We don’t have as much contact with the other divisions, but we have divisional meetings once a month and so we have increased contact with the other sites.”
- Staff said there was better communication from the board to the ward.
- Junior doctor forums had been introduced to engage with the junior doctors and enable them to raise issues and concerns.

## Innovation, improvement and sustainability






- A multi-disciplinary pathway had been introduced for patients requiring major lower limb amputation. This included diagnostic arterial imaging for most patients as appropriate, a multi-disciplinary discussion of the most appropriate options for each patient and multi-disciplinary involvement post operatively. Written information and counselling was offered to patients and their family.
- Some specialties, for example colorectal surgery, produced an annual report; a service improvement and development plan had also been produced.
- The service provided us with a list of improvement projects which they had committed to for the current financial year. These included a band 5 development programme and developing a nurse led pre-assessment service.
- The service had just become one of three centres in England for treating peritoneal metastases and pseudomyxoma peritonei. (cancerous tumours in the membranes covering the abdominal organs and abdominal cavity). A patient information video had been produced and patients were invited back for an annual social event to meet other patients who had undergone the same procedure to provide support for them.

# Surgery

- There was limited orthogeriatrician input into orthopaedics at the hospital and the service had recognised the need for further resources. An orthogeriatric advanced care practitioner role had been introduced as a result and a second trainee post had been funded to ensure the medical care of orthopaedic patients was optimised. This was thought to be one of the first such roles in the country.



# Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

A range of outpatient and diagnostic services were provided at Good Hope hospital. There were 361,349 outpatient appointments at Good Hope hospital between the periods April 2015 to March 2016. The trust offered a combination of consultant and nurse led clinics for a range of specialities. The range of clinics included ENT (ear nose and throat), cardiology, dermatology, gastroenterology, urology, diabetes, pain management, rheumatology and therapy services. The trust also offered a range of comprehensive diagnostic and interventional services to patients, including a phlebotomy service (taking blood), diagnostic imaging, x-ray, CT scanning and ultrasound.

We visited several outpatient areas including ophthalmology, orthopaedic and rehabilitation centre, therapies, oncology and the plaster room. We also visited radiology and diagnostic imaging services.

During the inspection, we spoke with 47 staff including volunteers, nurses, clerical staff, consultants, radiographers and other allied health professionals. We spoke with 10 patients and reviewed 23 sets of patient records.

## Summary of findings

We rated this service as good because:-

- Staff in diagnostic imaging adhered to diagnostic imaging policies and procedures. These were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME)R.
- Incidents were investigated; we reviewed incident reports and root cause analysis documents from outpatients and diagnostic imaging and found these contained details of concerns, findings from investigations, recommendations and arrangements for shared learning.
- Staff followed The National Institute for Health and Care Excellence (NICE) clinical guidelines in outpatients and diagnostic imaging departments.
- Staff in the outpatient and diagnostic imaging departments treated patients with kindness, dignity and respect. Staff behaved in a professional and caring manner.
- Patients were involved in decisions around their care.
- Language line was available if required and interpreters could be booked if needed.
- Outpatient areas were well signposted.

# Outpatients and diagnostic imaging

- There was a local strategy plan in place for outpatients and diagnostics; this included a range of objectives such as to develop a paperless system and the development and implementation of a workforce strategy that reflected the service needs.

- Staff felt supported by their direct line manager and that they could raise concerns with them. They also felt they were listened to and heard. Managers told us of an open door policy.

- We saw some excellent examples of innovation

However:-

- There were no service records on the lasers in ophthalmology and staff were unable to locate these at the time of the inspection. The local rules for YAG and KTP (types of lasers) were displayed, however these were not dated. Local rules should be signed and dated by the laser protection advisor.
- Feedback to staff on individual incidents was limited.
- There was a lack of hand hygiene audits for the main outpatient areas.
- Several staff found the trust computer systems to be time consuming and felt that individual systems did not communicate.

## Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:-

- We saw staff washing their hands and using the gel provided.
- Incidents were investigated; we reviewed incident reports and root cause analysis documents from outpatients and diagnostic imaging and found these to contain details of concerns, findings from investigations, recommendations and arrangements for shared learning.
- Outpatients and diagnostic imaging departments were tidy, clean, and uncluttered. Equipment had I am clean stickers applied, this showed equipment had been cleaned. In diagnostic imaging, we saw evidence of the cleaning of ultrasound probes before and after use.
- Equipment was maintained and tested in line with trust policy. We saw that labels were applied which identified when equipment had last been checked. Service reports were available to view in diagnostic imaging. There were plans in place to replace or purchase additional pieces of equipment in diagnostic imaging.
- Hospital staff kept medications locked and secure in cupboards. Prescriptions were stored securely.
- Records reviewed were legible, accurate and up to date.
- Staff were aware of their roles and responsibilities in relation to safeguarding and knew how to raise matters of concern.
- Nursing, medical and dental staff received mandatory training. The training consisted of 17 modules including infection control, information governance and manual handling.
- Staff in diagnostic imaging adhered to diagnostic imaging policies and procedures. These were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME)R.
- Procedures were in place to ensure that the probability and magnitude of accidental or unintended doses to patients from radiological practices were reduced as far as reasonably practicable.

However:

# Outpatients and diagnostic imaging

- Service records for lasers were unavailable to inspection staff at the time of the inspection; staff were unable to locate these. Local rules for YAG and KTP (types of lasers) were displayed, however they were not dated. Local rules should be signed and dated by the laser protection advisor.
- Feedback to staff on individual incidents was limited.
- There was a lack of hand hygiene and infection control audits for the main outpatient department.
- Staff knew how to report incidents. We spoke to a healthcare assistant who told us that they did not complete incident reports but they would inform the nurse in charge and the nurse would then complete this.
- Staff told us they did not receive individual feedback when they raised an incident but that managers sometimes shared learning around incidents verbally and via email. Staff could access learning in relation to serious incidents (SI'S) on the hospital intranet site, this included the background to the incident, assessment and recommendations.
- Radiation incidents were reported to the Care Quality Commission (CQC) and discussed in radiation protection meetings. Exposures much greater than intended, occurring otherwise than as a result of equipment failure must be reported. These were discussed at site risk management meetings; we reviewed the minutes of these.
- Feedback from incidents was disseminated trust wide. We saw information on lessons of the month and how many serious incidents had occurred. The trust launched the lesson of the month initiative in September 2012; the purpose was to increase organisational learning and to communicate lessons learnt.
- Incident reporting and management policies were in place, these contained details on incident reporting, flow charts, information in relation to reporting of injuries, diseases, and dangerous occurrences regulations 2013 (RIDDOR) incidents.
- We reviewed four sets of outpatient meeting minutes from September 2015 to July 2016, one incident was discussed in July 2016. This was in relation to the wrong date of birth being on a patient's notes. We also reviewed three radiology team brief minutes from June 2016 to July 2016. We saw incident themes were discussed in meeting minutes dated July 2016. We reviewed minutes from the access and outpatients directorates meeting dated August 2016 and saw specific incidents were discussed.
- We saw a serious incident report dated November 2015 that contained evidence that duty of candour regulations were applied. The duty of candour is a legal duty on hospitals, community and NHS trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
- Incidents were investigated; we reviewed incident reports and root cause analysis documents from

## Incidents

- There were no never events reported between August 2015 and July 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the outpatient's directorate at Good Hope hospital reported no serious incidents (SI) which met the reporting criteria set by NHS England between August 2015 and July 2016.
- There were 222 incidents in Good Hope outpatients department between September 2015 and September 2016. Of these, 187 resulted in no harm, 27 as low harm, six as moderate harm, one was severe harm and one was catastrophic. At the time of our inspection the serious incident was under investigation.
- The trust advised us that the catastrophic incident which resulted in a patient death was investigated by both the manufacturer and the coroner at inquest. Both the manufacturer and the inquest concluded that the deceased had died from a cardiac event when a cardiac resynchronisation therapy device did not deliver a shock as a result of battery depletion. The trust advised us that no neglect rider or prevention of future death reports were issued. In certain circumstances and when there is evidence to support it the coroner can record a verdict with a neglect rider attached. This can happen when there is clear evidence that neglect caused or contributed to a person's death.
- There were 153 incidents in Good Hope diagnostic imaging department, 127 resulted in no harm, 24 were low harm and two were classed as moderate.

# Outpatients and diagnostic imaging

outpatients and diagnostic imaging and found these to contain details of concerns, findings from investigations, recommendations and arrangements for shared learning.

- Staff had a clear understanding of the principles of duty of candour. They were aware of their responsibilities to be open and honest and to inform patients under duty of candour regulations. For example, one staff member in diagnostic imaging told us that if they had x-rayed a patient's wrong ankle they would be open and honest about the mistake and explain to the patient why they would need to complete another x-ray. Another member of staff had not had any personal experience of this but was able to discuss when the principles had applied to a colleague. There was no specific training on duty of candour provided by the trust.

## Cleanliness, infection control and hygiene

- Outpatients and diagnostic imaging departments were tidy, clean, and uncluttered. Equipment had 'I am clean' stickers applied, this showed equipment had been cleaned.
- In diagnostic imaging, equipment was clean including ultrasound probes which were cleaned before and after each use.
- We saw cleaning schedules in place for estates, nursing and housekeeping staff. We also saw cleaning rotas for equipment in diagnostic imaging.
- Personal protective equipment (PPE) such as gloves and aprons were used appropriately and available for use throughout the departments. Once used aprons and gloves were disposed of safely and correctly. We observed staff using PPE when treating patients.
- Staff washed their hands regularly and used hand gel. Hand gel was readily available in all areas and staff adhered to the 'arms' bare below the elbow policy.
- Patients we spoke with told us that staff had washed their hands when they received treatment. Staff told us how infection control leads visited their working area and observed and encouraged correct hand washing. We saw posters on display requesting patients use hand gel.
- The trust told us that the main outpatient department and clinics do not carry out hand hygiene audits due to the audit tool used not being appropriate for the

environment. They also told us that there had been occasional use of the five moments audit but that this did not reflect practice due to the unsuitability of the tool.

- We saw evidence the five moments audit tool had been completed in October 2016 however, no overall compliance figure was recorded. The tool incorporates the World Health Organisation (WHO) five moments (the key moments when healthcare workers should perform hand hygiene). The tool emerged from WHO guidelines on hand hygiene in health care.
- The exception was oncology outpatients, there was 100% compliance rates in an infection control audit dated September 2016. The audit covered the environment, handwashing, cannulation, and metrics. Staff told us they were aware of the importance of infection control as the patients they cared for had low immune systems. Hand hygiene audits in oncology were regularly completed where we saw a compliance rate of 100% in September and October 2016.
- We requested infection control audits for the outpatients department at Good Hope hospital. The information received showed the last audit completed was August 2014 when a compliance rate of 88% was achieved. No further data was available.
- Staff told us that patients with an infection were x-rayed at the end of the day and the room and equipment was cleaned in line with the trusts infection control policies. If this was not possible the patient would be x-rayed and staff would follow infection control procedures such as wearing gloves and aprons. The room would then be deep cleaned and put out of action for an hour. At the time of our inspection there were no patients with an infection for us to be able to corroborate this.
- Sharps bins were available in treatment areas, labels recorded the date they were placed and in use. This was in line with health and safety regulations 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.
- Housekeeping staff supported in cleaning of the environment and any equipment. We saw that staff helped with general cleaning duties in-between patients. Staff helped with cleaning tasks when patient numbers decreased.

## Environment and equipment

# Outpatients and diagnostic imaging

- Most equipment was maintained and tested in line with trust policy. We saw that labels were applied which identified when equipment had last been checked. Service reports were available to view in diagnostic imaging. There were plans in place to replace or purchase additional pieces of equipment in diagnostic imaging.
- Service records were absent for lasers in ophthalmology on the day of the inspection and there were no up to date signatures for YAG and KTP (types of lasers). This equipment did not belong to diagnostic imaging but was checked by the medical physics team off site.
- Resuscitation trolleys were in all areas we visited; these were checked and signed on a daily basis.
- Ultrasound units in diagnostic imaging were less than five years old and complied with NICE guidelines.
- We saw a radiation policy was in place in diagnostic imaging and was ratified in June 2016. The aim of the policy was to ensure as far as reasonably practicable the safety of children, young people, families, staff and others who may be exposed to hazards arising from the use of ionising radiations (gamma rays) and non-ionising radiations lasers, magnetic fields, ultrasound and optical radiation sources.
- A local strategy plan was in place for outpatients and diagnostics; this included a bid for an additional scanner for use on the Good Hope site to reduce the need and expense to outsource examinations.
- We reviewed three health, safety and security audits for the outpatient department at Good Hope hospital. Action plans had been implemented to address any concerns.

## Medicines

- The main pharmacy department was open to outpatients from Monday to Friday from 9am to 5pm and on Saturdays from 9am to 1pm.
- The oncology department had its own satellite pharmacy. The satellite pharmacy was open between the hours of 9am and 5pm Monday to Friday. The on-site pharmacist screened prescriptions, dispensed medications, worked alongside medical staff and the laboratory. Chemotherapy for patients at Good Hope was made up at the Heartlands hospital.
- We checked the storage and management of medicines and found effective systems were in place.

- The trust provided medicines management training for registered nurses across the outpatient and diagnostic imaging departments. Hospital staff kept medications locked and secure in cupboards.
- Doctors wrote prescriptions for pain relief if required, the hospital pharmacy dispensed these. Prescription pads were stored securely.
- Patient group directions (PGD's) were in place in the ophthalmology department. PGD's provide a legal framework that allows registered health professionals to supply and or administer a specified medicine to a predefined group of patients without them having to see a doctor.
- Records showed that staff completed daily temperature checks on fridges used to store medications and that temperatures were within the acceptable range. All medicines checked were in date.
- Staff were aware that they could access medication policies on the intranet.
- Radiopharmaceuticals (drugs that contain radioactive materials) were delivered to the nuclear medicine department on a daily basis. Delivery records were recorded on an electronic system. We also saw that old radiopharmaceuticals were stored safely until a registered company removed them; staff recorded the removal date. All radiopharmaceuticals stored were in date.

## Records

- We reviewed 23 patient records across outpatient and diagnostic imaging departments.
- Medical records were available for clinics, patient records included medical histories, allergies, previous correspondence and results of any investigations.
- Records were stored securely in outpatient reception areas. In the orthopaedic and rehabilitation centre we witnessed a volunteer carrying notes to and from the clinics.
- Records were found to be legible, accurate and up to date, they were both electronic and paper based.
- Audits of availability of notes for outpatient clinics showed that out of the 39, 7045 medical records requested from September 2015 to August 2016, 34 records were not found.

## Safeguarding

# Outpatients and diagnostic imaging

- Staff were aware of their roles and responsibilities and knew how to raise concerns. One staff member provided an example of when they had contacted the local authority in relation to safeguarding concerns.
- Safeguarding policies for both adults and children were in place and had been reviewed following the introduction of the Care Act 2015. The policies contained information on types of abuse, deprivation of liberty safeguards (DOLS), mental capacity and consent.
- The chief nurse had leadership responsibility for safeguarding at an executive level and ensured oversight of the governance arrangements around safeguarding. The safeguarding team was positioned corporately.
- The safeguarding team consisted of nurses with specialist skills in both adult and child safeguarding, they provided training, advice, support and supervision to front line staff.
- Staff complied with The World Health Organisation (WHO) checklist in diagnostic imaging. The checklist was audited on a monthly basis. Data was reviewed per room where interventions were carried out and validated monthly. This information was then shared at the radiology directorate meetings and published on the dashboard.
- Training statistics exceeded the trust target of 85%. 100 percent of nursing, medical and dental staff in outpatients and diagnostic imaging (trust wide) having completed their mandatory safeguarding adults and children level one and two training.

## Mandatory training

- Staff received mandatory and statutory training through a combination of e-learning and face-to-face training sessions.
- Nursing, medical and dental staff received mandatory training. The training consisted of 17 modules, including infection control, information governance and manual handling.
- Training required by medical and dental staff varied to that of nursing staff. 16 of the 17 modules for nursing staff (trust wide) had a completion rate higher than the trust target of 85%. Resuscitation training had the lowest completion rates of 63%. The trust set a mandatory target of 85% for completion of mandatory training.
- 10 of the 17 modules for medical and dental staff (trust wide) had a training completion rate above the trust

target of 85%. Training completion rates for seven modules were below the trust target. The lowest completion rates were for trust management (35%) and blood transfusion (30%).

## Assessing and responding to patient risk

- Staff were aware of actions to take if a patient's condition deteriorated and were able to tell the inspection team the emergency contact telephone numbers they would use.
- Staff adhered to diagnostic imaging policies and procedures. These were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME)R. The regulations are intended to protect patients from unintended, excessive or incorrect medical exposures, ensure the benefits outweigh the risks in every case and make sure patients receive no more than the required exposure of radiation for what they need. Staff used a password protected electronic system to access policies and procedures. This meant that staff could access the right information at the right time to respond to any risks.
- Diagnostic imaging staff ensured they had the correct patient prior to carrying out any procedures. Staff had a clear understanding of the trust protocols and policies.
- Diagnostic imaging had radiation protection supervisors in place; the supervisor's responsibility was to assist the line manager in ensuring that the local rules were read, understood, and followed by relevant staff. Supervisors attended regular radiation protection committee meetings; we reviewed the minutes from the previous two years (2015 to 2016).
- The WHO safety checklist for radiological interventions was followed in the diagnostic imaging department. The WHO checklist is a tool designed to improve procedures, ensuring key safety checks are completed during care.
- Posters were displayed in diagnostic imaging to warn of radiation risks and hazards and to inform where radiation exposure took place.
- Exposure charts and local rules were in place in all rooms in diagnostic imaging; these were up to date and version controlled. Local rules are the way diagnostics imaging work to national guidance and vary depending on the setting.
- Ultrasound reports were available in diagnostic imaging; these showed that cleaning of ultrasound probes took

# Outpatients and diagnostic imaging

place before and after examination, if latex or latex free probes were required, initials of the chaperone in attendance, details of any probe cleaning fluid and the serial numbers of any bottles used.

- An Environment Agency Licence was in place in diagnostic imaging. Nuclear medicine uses radiopharmaceuticals. Radiopharmaceuticals are drugs that contain radioactive materials called radioisotopes. They may be put into a vein, taken by mouth, or placed in a body cavity. Depending on the drug and how it is given, these materials travel to various parts of the body to treat cancer or relieve its symptoms. The department requires an environment agency licence specifying the type and amount of radioisotopes being used.
- There was a procedure in place to establish if the patient was pregnant or breastfeeding. The procedure included guidelines for breast feeding mothers undergoing a nuclear medicine investigation, consent forms for the patient to confirm they were not pregnant, a flowchart and special considerations. An example of a special consideration was if the patient had communication difficulties or if their pregnancy status could not be determined due to a life threatening condition.
- We saw a patient in outpatients suffer a medical episode. Staff dealt with the situation in a calm, efficient manner; they ensured the patient's dignity and privacy was respected at all times.
- Staff knew what to do and who to contact if a patient was to suffer a cardiac arrest.

## Nursing staffing

- Nationally accredited acuity tools were not used in outpatient areas, however the workforce lead and outpatient department matron have developed a local tool. This included three levels of acuity for outpatient department clinics, each one requiring a different establishment and skill mix. This meant that clinic staffing could be checked against the acuity of the clinic and new clinics could be commissioned with the appropriate staffing resource.
- There were no measures of planned versus actual staffing as the clinic resource was spread according to the acuity level of the clinics and where there was a discrepancy this was raised with the senior nurse of the department.
- The Heart of England NHS Foundation trust reported a vacancy rate of 26% in outpatients, radiology was the

only unit included within the core service of outpatients due to the data provided by the trust (as of September 2016). Vacancy rates for nursing staff were higher than the trust average for nursing staff at 8%.

- The trust reported a sickness rate of 10% in outpatients (April 2015 to March 2016). Radiology is the only unit included within the core service of outpatients due to the data provided by the trust. The sickness rates for nursing staff were higher than the trust average for nursing staff at 5%.
- The Heart of England NHS trust reported a staff turnover rate of 77% in outpatients (As of September 2016). Radiology is the only unit included within the core service of outpatients due to the data provided by the trust. The turnover rates for nursing staff were higher than the trust average for nursing staff at 8%.
- The trust gathered information from staff surveys and recognised work was required to improve the perception and feelings of staff. Trust divisions were developing action plans to address the main issues presented by staff and were working in partnership with human resources (HR) representatives to highlight positive changes. The manager of the outpatient department told us that they had sufficient staffing for all planned clinics.
- Between October 2015 and September 2016 Good Hope hospital reported a bank and agency usage rate of 7% in outpatients. For the five months from May 2016 to September 2016, usage varied between 5% to 8%. From October 2015 to April 2016 no agency and bank usage rates were reported.

## Medical staffing

- As of September 2016, the Heart of England NHS foundation trust reported a vacancy rate of 4% in outpatients; senior medical staff reported the highest vacancy rate of 18%.
- Between April 2015 and March 2016, the Heart of England NHS foundation Trust reported a sickness rate of 1% in outpatients; junior medical staff had reported a sickness rate of 0% and senior medical staff reported a rate of 2%.
- As of September 2016, the trust reported a staff turnover rate of 14% in outpatients, only data for senior medical staff was available.

# Outpatients and diagnostic imaging

- Between October 2015 and September 2016, the trust reported a bank and locum usage rate of 11% in outpatients; this rate was higher than the trust wide bank and locum usage rate of 8%.

## Major incident awareness and training

- Training events were organised around emergency scenarios, for example major incident awareness and Ebola personal protective equipment (PPE).
- Staff awareness around major incidents was varied, for example, one member of staff we spoke with could tell us where they would find information in relation to the plan, and another was unaware of any plan.
- There was an “overview of emergency planning arrangements” document in place. The document detailed information around what was a major incident, budget, training, staffing and equipment. It also contained a link to the trusts major incident plan.
- The physiotherapy notice board displayed a major incident plan within the orthopaedic and rehabilitation centre; this included maps of major incident routes and security numbers.
- Procedures were in place in diagnostic imaging to ensure that the probability and magnitude of accidental or unintended doses to patients from radiological practices were reduced as far as reasonably practicable. The procedure included an equipment fault form, a flow diagram in relation to the reporting process for radiation incidents; including when to report an incident to the CQC as well as a radiation incident action and evidence record checklist.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The department was inspected but not rated for effective.

- There was evidence of good team working in clinics, within the diagnostic imaging departments and across the specialities.
- We saw staff had a good awareness of The National Institute for Health and Care Excellence (NICE) guidelines and this was demonstrated in their practice.

- Staff felt that their appraisal contributed to a positive learning experience and were able to give examples of how they had improved their practice as a result.
- Emergency diagnostics were available seven days a week either within the trust or at one of its sister hospitals.
- We reviewed patient records in relation to consent; patients signed and dated the documents.
- Staff could access appropriate pain relief for patients if required.

However:

- Several staff found the trust IT system to be time consuming and that individual systems did not communicate. This was particularly the case in the outpatients department.
- Staff in the orthopaedic and rehabilitation centre told us that at busy times there was not always enough seating for patients.

## Evidence-based care and treatment

- Staff followed NICE clinical guidelines in outpatients and diagnostic imaging departments. We observed care being delivered that adhered to best practice including infection control techniques and witnessed a radiographer acting in accordance with the NICE guidance Chronic Obstructive Pulmonary Disease in the over 16: diagnosis and management. Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) documents were in place and adhered to in diagnostic imaging. Procedure was followed by staff to ensure the correct patient was being exposed to radiation. Radiographers approached patients and asked them questions to ensure they were the correct patient and it was the correct examination prior to x-ray. Staff knew how to access relevant policies and procedures on the intranet.
- The trust did not discriminate on the grounds of age, race, religion, gender, disability or sexual orientation. Decisions made were based on the patients’ health needs. For example staff in oncology told us that patients would be prioritised if they needed urgent chemotherapy and that each patient is important.
- Diagnostic imaging staff used the pause and check protocol. The protocol is a checklist for all radiographers to complete prior to taking an x-ray. This ensured the referral; patient and examination was correct prior to exposing the patient to radiation.



# Outpatients and diagnostic imaging

## Equipment

- Staff in the outpatients department could access records electronically but told us that entering data onto multiple computer systems was time consuming and that the systems did not communicate. This meant staff took longer to input patient information and that they had less time to spend with patients.

## Facilities

- Staff in the orthopaedic and rehabilitation centre told us that at busy times there was not always enough seating for patients. This meant staff had needed to ask patients or visitors to give up their seats on occasions. At the time of the inspection, there were sufficient seats available.

## Nutrition and Hydration

- Patients in the oncology department could have sandwiches and volunteers completed tea and coffee rounds.
- There were plans in the oncology department for a drinks machine that was donated from fundraising.
- There were restaurants available to patients at the hospital, these offered a selection of hot and cold food and beverages.

## Pain relief

- The trust did not have a specific pain management policy; however there was a tool available to address patient pain. There was a pain management team on site.
- Staff could access appropriate pain relief for patients within outpatients and diagnostic settings. Doctors in clinics wrote prescriptions for pain relieving medications when required.

## Patient outcomes

- Follow up to new rates from April 2015 to March 2016 were similar to the England average at Good Hope hospital.
- The trust advised us that the diagnostic imaging department had not signed up to the Imaging Service Accreditation Scheme (ISAS) however; they had made a start on building evidence and were working towards the accreditations. The ISAS scheme is a patient focused assessment and accreditation programme that is

designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff working in safe environments.

- The trust provided us with details of an audit that was completed on the impact of the increase in number of breast fast track clinics during the month of February on radiology. The audit was aimed at improving the service for patients. Data on fast track clinics was collected including start times, end times, number of patients seen and numbers of procedures performed by clinics. The outcome indicated that the fast track clinics were not being used to their full capacity which was impacting on staff time and equipment use. Therefore the number of clinics were reduced from five to four at Good Hope hospital.
- Availability of notes audits took place for outpatient department clinics, out of the 39'7045 notes requested between September 2015 and August 2016, 34 records were not retrieved.

## Competent staff

- Managers supported staff in their development through the appraisal process. Staff told us they were up to date with their appraisals and were aware when they were next due.
- Data provided showed that between April and September 2016 across the trust 83% of staff within the outpatient department had received an appraisal. This was slightly lower than the trust target of 85%. Between April 2015 and March 2016, 100% of medical staff received an appraisal, while only 67% had an appraisal from April to September 2016.
- Staff felt that their appraisal contributed to a positive learning experience. For example one staff member we spoke with was not aware of how their body language was being interpreted when they were communicating with other staff and patients; as a result they were able to change this and the staff member told us that they had appreciated being informed.
- The trust provided new staff with an induction booklet. Agency staff received a shorter version of this.
- Staff in diagnostic imaging had individual training files. Folders contained information of which x-ray units staff were trained to use, academic training courses they had attended and evidence of continuing professional development.

# Outpatients and diagnostic imaging

- We observed a student radiographer practicing a radiographic technique under the direction of a band 5 radiographer.

## Multidisciplinary working

- Nursing staff in the orthopaedic and rehabilitation centre spoke of good multi disciplinary working with doctors, staff in the plaster room, physiotherapists and administration staff.
- We observed reception staff, nurses, healthcare assistants, consultants and volunteers all working together to ensure the smooth running of the clinics.

## Seven-day services

- Emergency diagnostics were available seven days a week either within the trust or at one of its sister hospitals.
- Consultants and doctors provided medical cover in radiology from Monday to Friday between the hours of 9am and 5pm.
- Out of hours medical cover was provided at all other times by a doctor and a consultant. One staff member was based at the Heartlands hospital and reported on cases for all three hospital sites and could view images remotely. They were available to attend site if requested or if contacted directly by a clinician.
- At weekends, there were two consultants on duty during the day. There was a rota for interventional radiology which provided a 24/7 service based at the Heartlands hospital; however at the time of our inspection this was compromised due to vacant consultant post. The rota was therefore being supported by another local trust. There was a procedure in place for clinicians to contact this trust and to transfer patients if required.
- Opening hours of outpatient departments varied and included weekend provision when required.
- There were no formal arrangements for the pharmacy to dispense medications at weekends to outpatients.

## Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients.
- Policies and protocols were accessible to staff on the trust intranet, meaning staff could access them as and when required.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A consent for examination of treatment policy was in place, this set out the specifics around obtaining consent from patients.
- Hospital newsletters were available (October 2016). The October print referenced obtaining consent and was available to all staff and patients. The article discussed the consent policy and its application to all staff.
- One staff member was able to give an example of when they had participated in a best interest meeting in relation to a patient who did not have capacity to make decisions around their care and treatment and discussed how they involved the patients' carer.
- We reviewed patient records in relation to consent; patients had signed and dated the documents.
- Guidance was available to staff on making decisions regarding Deprivation of liberty (DOLS). This included names and contact details of DOLS Leads and the relevant supervisory bodies.

## Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- Staff in the outpatient and diagnostic imaging departments treated patients with kindness, dignity and respect. Staff behaved in a professional and caring manner.
- Patients were involved in decisions around their care.
- The main outpatient departments reception area provided patients with privacy when booking into their appointments.
- Staff used language that was jargon free and easy to understand. Staff gave patients the opportunity and the time to ask questions.
- The oncology department had close links to the Douglas McMillan service and signposted patients to additional support services such as the local cancer support centre.
- A chaperone policy was in place, all staff were expected to chaperone during intimate procedures.

## Compassionate care

- Outpatient and diagnostic imaging staff interacted positively with patients, putting them at ease.

# Outpatients and diagnostic imaging

- Patients were fully involved in their care and told us they felt respected, knew what would happen next and that they could find no fault. They also told us they were treated with dignity and respect, that staff were willing to change appointments and that confidentiality was respected at all times. Staff were described by patients as “helpful and polite”.
- We observed staff support patients in a professional and caring manner.
- Processes were in place to respect patient’s dignity and staff responded to their individual needs. We observed a consultant ask a patient if information they had recorded onto a dictaphone was correct. The consultant then played the information back to them to review.
- Friends and Family Test (FFT) data was not available from the trust for the main outpatients area; however information was available from other outpatients departments. The FFT is a survey which asks patients whether they would recommend the NHS service they received to friends and family. Out of 1,629 respondents in ophthalmology from March 2016 to September 2016, 1,111 said they were extremely likely to recommend the service to family and friends, 1,366 out of 2,298 echoed this in the trauma and orthopaedic department as did 810 out of 1,211 respondents in physiotherapy.
- Local radiology audits showed that from March 2016 to October 2016 100% of the patients surveyed (the number of patients who participated was not available) would recommend the service to friends and family.
- Staff respected confidentiality; they closed doors and drew curtains when patients received care and treatment.
- Feedback left on CQC comment cards included “I am very pleased with the care and treatment I received here” and “good service, attentive and friendly staff”.
- One staff member was able to give an example of how they had maintained a patient’s dignity when they became unwell and how they had put up a screen to achieve this.
- A chaperone policy was in place, all staff were expected to chaperone during intimate procedures.

## Understanding and involvement of patients and those close to them

- Staff introduced themselves to patients and explained what they were going to do.
- Patients could take a friend or family member into their consultation if they wished.

- We observed a consultant spending time explaining to a patient their condition and regularly checking their understanding.
- Staff used language that was jargon free and easy to understand. Staff gave patients the opportunity and the time to ask questions.
- Staff had access to a telephone translation service for patients whose first language was not English. Interpreters could be booked if needed.

## Emotional support

- The oncology department had close links to the Douglas McMillan service and would signpost patients to additional support services such as the local cancer support centre.
- Staff were dedicated and empathically described how they supported vulnerable patients.
- Staff spoke to patients about their care and treatment in a reassuring manner.
- Staff gave us an example of how they had spent several hours providing emotional support to a patient until they ensured that appropriate support was in place. They also told us of an occasion when two staff had worked several hours over their shift to ensure a patient could have their treatment.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as because:-

- The physiotherapy department facilitated late, early and Saturday clinics. and had obtained a licence to consult the public in about relation to opinion around opening times.
- Outpatient areas were well signposted.
- We saw a large selection of leaflets were available to patients in the outpatient department. Leaflets were available in different languages.
- Staff were able to tell us how a patient would make a complaint.
- Reception areas provided a confidential space for patients to book in. The main outpatient department housed the Patient Advice and Liaison Service (PALS) in addition to a health information centre.

# Outpatients and diagnostic imaging

However:

- Not all outpatient departments recorded verbal complaints; missing out on a valuable opportunity to learn.
- Patients and staff told us that finding a parking space to attend appointments could be challenging at times.
- The Heart of England NHS foundation trust took an average of 73.5 days to investigate and close complaints. This is not in line with their complaints policy which states complaints should be investigated and closed within 30 days.

## Service planning and delivery to meet the needs of local people

- Outpatient and diagnostic imaging departments had sufficient seating and toilet facilities at the time of our inspection.
- Departments were easy to find and well signposted.
- There was public transport available from outside the hospital on Rectory road and a train station was situated in nearby Sutton Coldfield. Hospital maps were available to download on the trust internet site.
- The physiotherapy department facilitated late, early and Saturday clinics. and had obtained a licence to consult the public in about relation to opinion around opening times.
- Patients and staff told us that finding a parking space to attend appointments can be challenging at times. A range of tickets at a discounted cost were available for multiple hospital visits ranging from three to a 28 days, details of these can be found on the trust internet site. There was also a 20 day exit carnet valid for 90 days. Exit carnets were only available to certain patient groups who had a serious long term condition and needed to attend the hospital on a regular basis. Patients receiving certain income –related benefits could park free of charge if they provided proof at the parking office.

## Access and flow

- The trust collected information about the number of outpatient referrals. The figures show that there were 361,349 outpatient appointments at Good Hope hospital from April 2015 to March 2016.
- The specialities with the highest attendance rates at Good Hope hospital from July 2014 to June 2015 were orthopaedics (12%), therapies (11%), cardiology (9%) and ophthalmology (9%).

- Referral to treatment times (RTT) within outpatients for non- admitted patients were consistently below the England average of 92% from August 2015 to July 2016. The latest figures for July 2016 showed 89% of patients were treated within 18 weeks compared to the England average of 91%.
- Did not attend rates at Good Hope hospital were 8.5% from April 2015 to March 2016 when 30,1999 patients did not attend their appointments. The trust wrote to patients four weeks prior to their appointment and telephoned patients two weeks before. At the time of our inspection; there was a call reminder service in place; additionally the trust were piloting a 'did not attend' review to understand why patients failed to attend their appointments.
- The percentage of people waiting less than 31 days from diagnosis to definitive treatment from April to June 2016 (trust wide/all cancers) was 99%.This was better than the England average of 96%.
- From April to June 2016 the percentage of people seen by a specialist within two weeks of an urgent GP referral (trust wide/all cancers) was 93.3%.This was slightly worse than the England average of 93.7%.
- Cancer waiting time data (trust wide) from April 2016 to June 2016 showed that the percentage of people waiting less that 62 days from urgent GP referral to first definitive treatment was 87%.This was better than the England average which stood at 81%.
- Diagnostic waiting time data showed that the percentage of patients waiting more than six weeks to see a clinician in the period August 2015 to January 2016 was higher than the England average. Between February 2016 and July 2016 percentages were better than the England average.
- There was a 'cancellation on the day' policy in operation in diagnostic imaging. Any cancelations on the day were escalated to a senior member of the clinical team and it was only done as a last option.
- From the 39,7045 medical records requested from September 2015 to August 2016, 34 records were not found. The trust reported that they mitigate the risk to patients seen without records by producing a temporary set of records which include an outcome form, patient labels, latest clinical letters or a new letter continuation sheet for written notes and commissioning for quality and innovation form (CQUIN).

# Outpatients and diagnostic imaging

- The percentage of clinics cancelled at the Heart of England NHS foundation trust within a six week period as of September 2016 was 7%; 19% of cancellations were over a six week period.
- The main reasons for cancellations of clinics as reported by the trust were annual leave, sick leave and covering alternative commitments such as theatre and urgent clinics.
- The trust did not collect data on the percentage of patients waiting over 30 minutes to see a clinician. At the time of our visit people said that their appointments were running on time.
- The trust had a clinic recycling process in place since January 2016. This meant that when clinics were cancelled with notice by the hospital another clinic would take place. This was having a positive impact on the outpatient service as weekend initiative clinics were brought into the weekday. From January 2016 to October 2016 557 extra clinics had been undertaken as a result.
- Data provided by the trust showed that from March 2016 to August 2016 the average wait for a MRI was four weeks. There was an average of three weeks wait for an ultrasound scan. Patients waited on average two weeks for CT, Fluoroscopy and Nuclear Medicine. There was an average of one week wait for plain film scans. On average patients waited for less than one week for a mammography.

## Meeting people's individual needs

- The outpatient department was modern, spacious and comfortable and had separate waiting areas for clinics.
- Reception areas provided a confidential space for patients to book in. The main outpatient department housed the Patient Advice and Liaison Service (PALS) in addition to a health information centre.
- Leaflets were available for patients. Staff in oncology provided patients with a pack containing leaflets on chemotherapy such as side effects, contact numbers to the unit, who to contact outside of working hours and information about car parking.
- Staff had access to a telephone translation service for patients whose first language was not English. Interpreters could be booked if needed.
- We saw a large selection of information leaflets available to patients in the outpatient department. Leaflets were available in different languages.

## Learning from complaints and concerns

- There had been 14 complaints received in relation to the outpatients and diagnostics from 2015 to 2016 (including two in paediatrics).
- We saw an example of a complaint received in relation to a consultant. The complaint was investigated and dealt with appropriately. The patient was provided with a written response which included any actions that had been taken. It also provided details of how the patient could contact the parliamentary Health Services Ombudsman if they wished their complaint to be reviewed.
- The Heart of England NHS foundation trust took an average of 73.5 days to investigate and close complaints. This is not in line with their complaints policy which states complaints should be investigated and closed within 30 days. Complaints about clinical care accounted for 42% of all complaints received followed by appointments, delay or cancellation (21%) and communication and information problems (21%).
- Staff were able to tell us how a patient would make a complaint and that they may be advised to contact the PALS service located in the main outpatient department.
- Staff who worked in the orthopaedic and rehabilitation centre told us that there was no system to record verbal complaints but that written complaints would be forwarded to the departmental manager. Staff in the physiotherapy department kept a log of formal and informal complaints.
- A complaints policy was available for staff to access on the intranet.
- The main outpatients department had "tell us what you think about our service" leaflets. The leaflets provided useful advice such as when you should report a concern, who to contact with any feedback and suggestions.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

# Outpatients and diagnostic imaging

- The trust had a vision, which was to build healthier lives. Staff knew the values caring, honest, supportive and accountable and worked within them. Trust values were displayed on posters throughout the departments.
- Regular meetings took place in outpatients and diagnostic imaging at senior leadership, operational and directorate management level.
- Staff felt supported by their direct line manager and felt that they could raise concerns with them.
- Managers recognised the importance of encouraging supportive relationships amongst staff and discussed how they had referred staff to additional sources of support when required.
- Staff told us that their ideas were listened to and implemented. One staff member told us how their manager had been supportive of an initiative they wanted to launch.
- Staff achievements were displayed in the physiotherapy department.
- A celebrating staff board was visible to all in the waiting area and displayed information on staff achievements and recognition awards.

## Leadership of service

- Staff achievements were displayed in the physiotherapy department. A celebrating staff board was visible to all in the waiting area and displayed information on staff achievements and recognition awards. We saw two staff recognition awards; one was for the development of a training scheme to increase the skills and support of workers. This enabled them to offer assessment appointments and help to reduce waiting times; another award recognised an individual staff members for improving the care offered to patients who suffered from shoulder conditions.
- Staff felt supported by their direct line management and that felt they could raise concerns with them, they also said they were listened to and heard. Managers told us of an open door policy.
- Staff told us that the chief executive officer had provided team briefings to staff. We saw a comprehensive set of notes in relation to a chief executives team briefing including information on performance, finance, infection control, serious harm and referral to treatment times.

- Managers recognised the importance of encouraging supportive relationships amongst staff and discussed how they had referred staff to additional sources of support when required.
- Staff told us that their ideas were listened to and implemented. One staff member told us how they were in the process of devising a booklet around patient risk. They told us their manager had been supportive of this. Staff in the oncology department recently raised over six thousand pounds for patients through completing a triathlon; the plan was for the funds to be used to improve patient care on the unit.

## Vision and strategy for this service

- The trust had a vision, which was to build healthier lives. Staff knew the values caring, honest, supportive and accountable and worked within them. Trust values were displayed on posters throughout the departments.
- In the radiology department we saw a presentation that had been delivered to staff in April 2016 around the clinical support services divisional structures. The presentation contained information around service objectives, behaviours, values and what these meant in practice.
- The imaging department had a its own mission statement which was pioneering the future of medical imaging; its vision was to provide an inclusive and progressive diagnostic imaging service delivering excellence for all, now and for generations to come, staff were aware of this and the role that they played and felt pleased to have such consistent standards.
- There was a local strategy plan in place for outpatients and diagnostics which included a range of objectives such as to develop a paperless system and the development and implementation of a workforce strategy that reflects service needs.
- A ward to board assurance report looked at patient experience, metrics, harm free care, medications and infection control.

## Governance, risk management and quality measurement

- The main outpatients department had a charge nurse who was supported by a band six sister. The outpatient services were also supported by a matron, group manager and an operations manager.

# Outpatients and diagnostic imaging

- The site leads for radiology met weekly to discuss the performance dashboard and any issues; they also held monthly error meetings to try to improve the standard of radiology techniques.
- Performance was reported at divisional level through a monthly performance review, the review documented key performance indicators and quality dashboards across the departments.
- Regular meetings took place in outpatients and diagnostic imaging at senior leadership, operational and directorate management level. Staff in diagnostic imaging told us we were unable to review minutes taken at directorate executive team level due to the confidential nature of the discussions. However, lists of topics discussed at the meetings were viewed.
- Risk registers were in place which identified current risks. Managers were able to articulate the current risks and what was being done to mitigate them; for example in the physiotherapy department it was identified there were issues with the computer and information inputted by staff would on occasions not save to the system. As a result of these concerns it was placed on the risk register and two weekly meetings were arranged with information technology services.
- We saw a risk management form had been completed in diagnostic imaging (last updated October 2016) due to risks posed by an ageing scanner. Risks identified included the scanner being at high risk of faults and breakdowns which could not be fixed and spare parts not being available with a recognition this may delay treatment. The assessment included the person responsible, had regular updates which included a business case, reviewing room plans and completion of a cost exercise.

## Culture within the service

- We found passionate staff who were dedicated to a patient centred approach. Staff were proud of the service and what they had achieved.
- Staff were encouraged to be open and honest with each other and their service leads.

## Public engagement

- Staff in the physiotherapy department told us how they had obtained a licence to enable them to seek the opinions of the general public around opening times.

- The trust sought feedback from patients through local audits, Friends and Family tests (FFT), The Patient Advice and Liaison Service (PALS) and the complaints process.
- Patients participated in a survey in relation to their pharmacy outpatient experience. Over 160 patients took part in the survey. Of those, 84% of patients felt the hospital was performing well, 6% felt they were performing satisfactorily and 10% felt they were not performing as well as they should.
- We saw that a FFT suggestion box was located in the main outpatient area; we also saw posters inviting patients to give their opinion on what they thought about the service.

## Staff engagement

- Trust Staff (approximately 2,500) were invited to participate in a Staff Friends and Family test (June 2016). The test asked two questions; would you recommend the trust for care/treatment of friends and family and if they would recommend the trust as a place to work for friends and family. From a response rate of 31% the results showed that 73% of staff would recommend the trust for care and treatment. The results from the test were published in the trust newspaper dated August 2016.
- Physiotherapists offered Pilates sessions to staff under the “work out at work” initiative; they also offered appointments to office staff to provide advice around back care.

## Innovation, improvement and sustainability

- We saw some excellent examples of innovation. In diagnostic imaging an induction pack had been introduced for the radiographer to reflect on their practice. Following completion of the induction a discussion took place between the radiographer and the on-site lead. This would provide the radiographer with the opportunity to reflect on their role and ensure they had the knowledge to practice safely.
- “You said, we did” information was displayed in the physiotherapy waiting area. Staff had recognised the need to communicate such information and a notice board was compiled as a result.

# Outstanding practice and areas for improvement

## Outstanding practice

Good Hope Hospital ED:

- The trust employed a nurse educator for the ED specifically to ensure nursing staff are competent practitioners. Newly qualified staff had a local induction and a period of preceptorship. Newly qualified staff that we spoke to told us that they received very good support.

GHH Outpatients and diagnostic imaging:

- We saw some excellent examples of innovation. In diagnostic imaging an induction pack had been introduced for the radiographer to reflect on their practice. Following completion of the induction, a discussion took place between the radiographer and the on-site lead. This would provide the radiographer with the opportunity to reflect on their role and ensure they had the knowledge to practice safely.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

##### ED:

- The ED at Good Hope Hospital must ensure they follow policies and procedures about managing medications; including storage, checking medications are in date, and safe disposal of medications.
- The ED must ensure that cleanliness standards are maintained throughout the department in order to ensure compliance with infection prevention and control requirements.

##### Surgery:

- The trust must consistently maintain medicines within their correct storage conditions to ensure medicines are suitable for use.
- The trust must ensure that theatre staff where appropriate clothing outside of theatres to reduce the risk of spread of infection.

### Action the hospital SHOULD take to improve

#### Action the hospital SHOULD take to improve

##### GHH ED:

- The ED should continue to monitor the management of complaints for Good Hope Hospital, ensuring these are investigated and managed within trust timescales.

- The ED should ensure that all appropriate patients receive a risk assessment relevant to their individual needs upon entering the department; for example falls risk assessments.
- The ED should ensure that the room used to assess patients experiencing mental health symptoms is safe and fit for purpose, and free from clutter.

##### GHH Surgery:

- The trust should ensure compliance with the Mental Capacity Act (2005) is documented.
- The trust should take action to improve adherence to infection prevention and control procedures
- The trust should ensure patients have timely access to pressure relieving equipment suitable for their needs.
- The trust should review unplanned re-admission rates to identify themes and take action to reduce.
- The trust should take steps to reduce delays in the patient journey and ensure people are able to access care and treatment in a timely way.
- The trust should take steps to improve the environment for patients who were transported to theatre through the basement corridor.
- The trust should ensure patients have access to translation services when required.



# Outstanding practice and areas for improvement

- The trust should ensure governance structures are embedded and a structured approach is taken to the identification and management of organisational risk.

## **GHH Outpatients and diagnostic imaging:**

- The trust should ensure local rules for lasers are signed and in date.

- The trust should ensure service records for lasers in ophthalmology are up to date and accessible for relevant staff.

The trust should ensure a robust system is in place to monitor infection control in main outpatient areas including hand hygiene compliance.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulations were not being met:</b></p> <p>Medicines were out of date, stored in the medicine cupboards and fridges throughout ED.</p> <p>Inconsistent checking of controlled drugs and refrigerator temperatures in ED.</p> <p>Monitoring of the temperature of storage areas in the surgical department and stock rotation was not consistent and staff did not always stay with patients to ensure they took their prescribed medicines. Regulation 12 (2) (g)</p> <p>Medical and Nursing staff at Good Hope Hospital in theatres and the emergency department did not follow good IPC practices.</p> <p>Staff in theatres at Good Hope Hospital were wearing their surgical theatre clothing outside of the theatre environment.</p> <p>Medical staff in theatres did not always adhere to the bare below the elbows requirements.</p> <p>The hospital did not collect data to determine rates of surgical site infection.</p>

This section is primarily information for the provider

## Requirement notices

The emergency department at Good Hope Hospital had blood on the floor from a previous patient which was not cleaned before the cubicle was used for the next patient. Regulation 12 (2) (h)