Heart of England NHS Foundation Trust

Birmingham Heartlands Hospital

Quality Report

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

Ratings

Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Good
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, 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.

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 which was taking place at the same time. We thought it would be excessive to have two inspection teams putting undue pressure on the staff on the units. We also did not inspect Children and Young People and End of Life services.

We rated Birmingham Heartlands Hospital by core services only, and have not aggregated the location overall, as we have did not undertake comparison services in full. We have described the previous inspection findings compared to this in the provider report. .

- Within the Emergency Department (ED), capacity was the issue, having not met the national targets for some time. We saw that because of the number of patients coming into the department they needed to wait in corridors on trolleys.
- Ambulance handovers were delayed, which increased the turnaround time of the vehicles. Also people then waited longer to receive treatment.
- The flow did not appear to be working effectively all the time, we saw majors patients who required triage within 15 minutes which was not taking place.
- Pain relief was not always given to patients in a timely fashion. We received feedback from patients regarding this.
- Within medicine, staffing was an issue, which meant the hospital had to use bank and agency staff regularly.We also saw that the hyper acute stroke unit did not meet the British Association of Stroke Physicians guidelines for staff to patient ratios. Within critical care access to allied healthcare professionals did not always meet national guidance.
- Delayed discharges were an issue both in medicine and surgery, with regard to the arrangements managed by hospital staff and the impact of insufficient porters and patient transport issues (please note the patient transport outside of the hospital was operated by another provider).
- Medical outliers were having a negative effect on patients. The wait was longer for specialist input from professional staff.
- The hospital had four never events between August 2015 to July 2016.Three of these related to the surgery directorate.
- Medicines management needed to improve in terms of the storage and checking arrangements both in surgery and the outpatients department.
- Some patients assessed as requiring a pressure-relieving mattress waited too long which put them at risk of skin damage.
- Within critical care we saw that the environment prevented the staff from delivering care to an optimum level.We noted that the rooms designated for infectious patients did not have modern facilities such as negative air pressure to reduce the risk of cross infection.

Summary of findings

- Outpatients did not always ensure the security of patient records, risking other people seeing them.
- Clinics often did not run to time causing delays for patients who had arrived on time. Staff were concerned that the late tickets were at risk of being rushed.

However;

- Access to staff training, MDT working and the arrangements in place to support stroke patients in ED was good.
- Staff were observed throughout the hospital as caring and patient focussed. We saw compassionate care amongst the critical care staff.
- Leadership and culture within critical care promoted high quality care.
- Incident reporting was particularly well embedded within outpatients and diagnostic imaging.
- Five steps to safer surgery checklists were used to maintain patient safety.
- In outpatients we saw that patients and families were partners in their care, given sufficient information to make informed choices.
- Clinics were available outside of core hours to help patients.

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.
- The nurse educator told us in detail about the training plans for the ED nurses.

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- We saw an example of outstanding practice in the imaging department. There was an excellent induction document introduced by senior imaging managers. This gave radiographers opportunities to reflect on their practice and innovative ways of thinking about how they work.After staff had completed the induction, a discussion took place between the radiographer and the on-site lead. This also ensured staff had the necessary knowledge to practice safely.

Importantly, the trust must:

- The trust must ensure that the premises are suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time.
- The trust must consistently ensure medicines are stored appropriately and are suitable for use.
- The trust must review and improve security and access arrangements at the unit.
- The trust must review its clinical waste storage at the unit.

In addition the trust should:

- The trust should consider that patients have a pain assessment and are provided with pain relief which is timely.
- The trust should mitigate and action risks on the risk register by regularly reviewing the risks in a timely manner.
- The trust should consider a review of the appraisal system to ensure that they are all meaningful and that those areas with low completion rates, staff review and target.
- 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.

Summary of findings

- The trust should ensure there is a robust system in place to monitor infection control and hand hygiene compliance in the main outpatient clinics.

Please note all the 'Musts' and 'Shoulds' can be found at the end of the report

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated this service overall as requires improvement; • When we carried out the inspection we found there were a number of safety issues. In particular the level of overcrowding and use of the corridors to house patients on trolleys. • There were risks around timely assessment and handover and the standard of care that staff were able to give because of this. • There were mixed levels of mandatory training and infection control measures. • Pain relief was poor for patients we received mixed feedback from patients and families. • There were significant issues with delays and flow of patients through the department. • There was poor morale amongst staff and little patient engagement. However; • Staff training and education, stroke management, multidisciplinary working and working with other stakeholders was of a good standard. • Research was evident and results were used to inform improvement in care.
Medical care (including older people's care)	Requires improvement 	We rated the service overall as requires improvement because: • Nursing and medical vacancies were high and planned staffing levels were not always being met. • Infection control measures were not consistently applied and we saw poor levels of hand hygiene. • Patients experienced delayed discharges not only due to lack of care in the community, but to poor discharge management and arrangements. This included insufficient patient transport (operated by another provider) and porter provision.

Summary of findings

- There were a number of medical outliers: patients who were admitted to other wards as there was no appropriate medical bed free. Medical reviews of these patients were on some occasions being missed.

However:

- The trust had a rolling recruitment drive both nationally and internationally and were recruiting with success.

Surgery **Requires improvement**

We rated this service as requires improvement because:

- BHH reported three never events from 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. Two of these incidents related to procedures which were carried out on the wrong site of the patient's body, indicating that learning from one incident did not take place in a timely manner.
- Medicines were not stored safely and in line with requirements. We found some patient's controlled medicines were past their expiry date, medicines which should have been protected from the light were not, and the temperature of the refrigerators used to store medicines exceeded recommended limits at times.
- Patients with a fractured hip waited for up to 12 hours for their pressure relieving mattresses..
- Patients experienced delays in their journey from admission to discharge. This included delays in returning from the operating theatres to the wards due to a lack of available beds on the surgical wards.
- Delays in discharging patients occurred due to waits for medicines to take home (TTOs)
- Services were not always responsive to the needs of individual patients and those who were vulnerable. Staff did not always use the trust's translation service and instead used

Summary of findings

patients' families and friends to interpret for them when discussing patient care. There was limited provision for patients living with dementia or a learning disability.
- Governance structures were in place but were not fully embedded. Risks were not always identified and managed appropriately.
- Staff described a blame culture when being held to account for incidents during root cause analysis (RCA) executive forum meetings.

However, we also saw:

- There was a good incident reporting culture. Managers shared learning from incidents with staff through newsletters, ward meetings, handovers, between teams and staff notice boards.

Critical care

Good

We rated this service as good because:

- Staff were caring and compassionate.
- There were sufficient and competent medical and nursing staff available to provide care and treatment for patients seven days a week. However the availability of other health professionals such as physiotherapists did not meet intensive care core standards.
- The leadership, governance and culture of critical care services promoted the delivery of safe, high quality person-centred care.

However we also saw that:

- The critical care units (ITU and HDU) did not meet the needs of a modern service. There were no toilet or bathroom facilities within either ITU and HDU.
- Heartlands Hospital is a regional infection diseases centre. There were three side rooms within the intensive care unit (none within the high dependency unit), which could be used for critically ill infective patients. However, none had modern facilities (negative pressure to contain any bacteria within the room) to reduce the risk of, cross infection to other patients.

Summary of findings

Outpatients and diagnostic imaging

Good 

We rated this service as good because:

- Staff were encouraged to report incidents of all kinds and all staff we spoke with were aware of how to do so.
- Staff demonstrated good knowledge and understanding of safeguarding and were able to give recent examples of how they had followed protocols.
- The departments were clean and logs showed that they were regularly cleaned and checked.
- Medicines were stored appropriately and checks of controlled drugs completed daily.
- Patient records were clear, legible, up to date and available for clinics.
- We saw evidence of strong multidisciplinary working across departments, divisions and grades of staff.
- Policies and protocols were based upon national guidance and reviewed and updated appropriately.
- The World Health Organisation (WHO) checklist was used and practice seemed to be embedded.
- We saw effective pain relief used for patients receiving treatment.
- Staff told us they had effective access to information that enabled them to provide care and treatment to patients.
- We saw that staff provided compassionate care for patients and respected the privacy and dignity of those attending the departments.
- Patients and their family members or carers were fully involved in planning and choosing their care and treatment.
- Patients gave positive feedback about the staff as being supportive and caring.
- The breast clinic offered a 'one stop' service which patients could access quickly and receive results and treatment if possible on the same day.
- Clinics ran during the evenings and weekends which gave patients choice of appointments and was working to reduce waiting times.
- Staff displayed the trust values and understood what these were.

Summary of findings

- We saw and staff described that in most areas of the departments there was strong leadership in place and senior managers felt well supported by the executive team also.

However:

- Patient records were left out on open trolleys which meant they were accessible and visible for other patients to see so did not ensure confidentiality was being maintained.
- A piece of equipment in the ophthalmology department was three months overdue for servicing. This machine was still in use and therefore could be unsafe for patients.
- Staff told us that clinics were often overbooked, appointments were often not long enough for patients and so clinics would over run and be held later that arranged. This impacted upon patients waiting times and staff had concerns that appointments may seem rushed.
- The controlled drugs documentation in the ophthalmology department indicated that use of these was not always witnessed and/or signed out appropriately.

Birmingham Heartlands Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Birmingham Heartlands Hospital

- There are 709 beds at this hospital at the time of our inspection.
- This trust is a Foundation Trust, this means they have the freedom to decide locally how to meet their obligations. They are accountable to local people, who can become members and governors. Also they are authorised and monitored by an independent regulators for NHS Improvement.
- At the time of the inspection the trust was starting the process to seek approval to merge with University hospitals Birmingham Foundation Trust.
- The Hospital is based in the East of the city of Birmingham, which is an area of deprivation
- 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 Birmingham Heartlands Hospital

The health of people in Birmingham 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 Birmingham Cross City.

This trust has four main locations:

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

Activity and patient throughput

For the 2015/16 year the trust had:

Detailed findings

- 223,189 A&E attendances.
- 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
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

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

Urgent and emergency services

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

Information about the service

Between 1 April 2015 and 31 March 2016 there were 262,601 attendances in the emergency department (ED) at Heart of England NHS Foundation Trust. This placed the trust in the top quarter compared to all trusts in England. The numbers of ED attendances resulting in admission was higher than the England average for 2014/15 and 2015/16. Between September 2015 and August 2016 there were 223,189 attendances in ED(61% were at Heartlands Hospital.) From April 2014 to August 2016 the majority of patients (76%) attending ED at Heartlands hospital were above age 17,while 24% of patients were in the 0-16 age group.

The emergency department at Heartlands Hospital had a minor injuries unit, resuscitation area and an adult major area with two sections which included high dependency cubicles. There was also a clinical decisions unit and a paediatric department.

We conducted an announced inspection of the ED department at Heartlands Hospital during the day-time on Wednesday 19 October 2016, and an unannounced inspection during the evening of Saturday 29 October 2016.

We spoke with 32 staff, seven patients and families and reviewed 16 patient records We also observed 11 episodes of direct patient care and observed the minor injuries reception for one hour.

Summary of findings

We rated this service overall as requires improvement;

- When we carried out the inspection we found there were a number of safety issues. In particular the level of overcrowding and use of the corridors to house patients on trolleys.
- There were risks around timely assessment and handover and the standard of care that staff were able to give because of this.
- There were mixed levels of mandatory training and infection control measures.
- Pain relief was poor for patients we received mixed feedback from patients and families.
- There were significant issues with delays and flow of patients through the department.
- There was poor morale amongst staff and little patient engagement.

However;

- Staff training and education, stroke management, multidisciplinary working and working with other stakeholders was of a good standard.

Research was evident and results were used to inform improvement in care.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

We rated safe as inadequate because:

- There were a number of safety issues. In particular, the level of overcrowding and use of the corridors to house patients on trolleys.
- There were risks around timely assessment and handover and the standard of care that staff were able to give because of this.
- Mandatory training requirements had not met the trust's own targets.
- Infection control measures required improvement.
- Pain relief management was poor.
- The Friends and Family survey results were worse than the England average.
- There were significant issues with delays and flow of patients through the department.
- There was poor morale amongst staff and little patient engagement.
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Incidents

- Internal and external data showed the emergency department had mixed safety performance over time. Between August 2015 and July 2016, the trust did not report any incidents which were classified as never events for urgent and emergency care. 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.
- 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 incident related to treatment delay where staff overlooked an elderly patient waiting on a trolley in the corridor. Another SI related to infection control and another related to major incident planning in response to a flood in ED.
- There were an additional 35 incidents reported between June 2016 and July 2016; 24 of these resulted in no harm, nine were classed as low harm, one resulted in moderate harm and one resulted in severe harm. Of these 35 incidents, seven (three no harm and four low harm) related to delays in treatment, tests, or diagnosis.
- Five incidents related to falls; three of these were linked to staff not being able to observe patients fully due to overcrowding. Two of these resulted in no harm; however, one resulted in moderate harm.
- Five incidents related to medication errors with four resulting in no harm and one in low harm. Two further incidents related to inappropriate attendance at the ED resulting in low harm in one case as this caused a delay in treatment, and no harm in the other case. There was one incident relating to access of information and one to equipment failure; both resulting in no harm. The trust reported 14 incidents as 'other' which were a mixture of delays in treatment, failure of equipment, inappropriate attendance and violence and aggression.
- Staff knew how to report incidents and told us they could access the trust's electronic reporting system' they used.
- Staff told us that the trust put a 'lesson of the month' on the website. The trust also sent out quarterly leaflets called 'risky business' and ED managers produced a written communication for staff on their specific issues.
- Staff told us the matron received an email about any incidents and would then share this with staff at handover or individually if needed. Staff showed a mixed response in wanting to read and learn from incidents.
- Staff felt poor responses to patients' requests for pain relief by staff and risks associated with overcrowding were the biggest incidents. However incident report data we reviewed did not support this, Staff said they did not report these types of incidents because everyone knew these issues existed.
- We requested information from the trust relating to mortality and morbidity meetings over a 12-month period. The trust shared two sets of papers covering four cases.
- The ED education lead nurse told us about duty of candour training which the trust planned annually. Duty of candour (DoC) is a regulatory duty that is related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person. Band 7

staff led the root cause analysis (RCA) process for serious incidents and checked whether DoC investigation was required. We reviewed four RCAs from 2016 which did not refer to duty of candour.

- Band 6 staff told us they were involved in saying sorry when things went wrong but did not understand the term' duty of candour'. We saw a letter where the trust had correctly applied duty of candour. This case involved a patient who had died whilst waiting in the corridor to be assessed. The initial handover had taken place and the patient was waiting to be transferred to a cubicle.

Cleanliness, infection control and hygiene

- Staff told us that they did not take part in any audits. However, the matron confirmed the trust carried out infection control audits in the department. We reviewed infection control audit data over the 12-month period from October 2015 to September 2016. This showed the trust met its own target of 85% compliance for hand hygiene for ten of the twelve months for the emergency department.
- We consistently saw good hand hygiene practice in the adult majors department. All areas in ED had hand washing materials apart from one sink in the sluice area. However, in the paediatric department we saw poor hand hygiene and cleaning procedures and staff were not wearing personal protective equipment. This involved patients with high temperatures and suspected infections. The inspectors escalated the poor infection control procedures to senior staff.
- The trust audited the procedure of insertion of cannula into the vein and on-going care of the cannula and we saw audits from October 2015 to September 2016. The trust set its target at 100% for insertion and ongoing care; it met the target for insertion for four months in the 12 month period however, the trust did not meet the target for on-going care.
- The trust also audited ongoing catheter care and we reviewed audits over from October 2015 to September 2016. The ED met its target of 100% compliance for four months over the 12-month period.

Environment and equipment

- The ED layout was not contained in one area but spread out over a wide footprint. The nurses' station faced the majors' corridor opposite the assessment and high dependency cubicles. Other cubicles were positioned away from the nurses' station and were isolated. Staff working on the majors department of the ED told us they could not easily observe patients because of the layout and felt this put patients at risk. One corridor was used for patients that had been brought in by ambulance and were awaiting triage. We observed patients had been left alone on a corridor where staff could not easily view patients. We observed overcrowding with several patients waiting on trolleys in two corridors. Staff told us they were extremely concerned as overcrowding occurred regularly as the department was too small.
- Staff felt it was easy to overlook patients waiting on trolleys in the corridor, as they were busy looking after patients in the already full cubicles. We saw one elderly patient laid on a trolley and we observed them three hours later still in the same position Staff had positioned them at the far end of the corridor. This patient was unable to communicate their needs and was unaccompanied. Staff told us the patient were waiting for a bed and could not say what food, drink, or personal care they had received that morning since triage. A corridor nurse was allocated to look after the patients on the corridor. Staff told us this was difficult to do because of the number of patients and the layout and size of the corridors. This was part of the action taken in line with the ED escalation plan to ensure safer patient placement, however the environment was still not ideal.
- The fire exits were blocked on the day of our inspection as they were so overcrowded. On numerous occasions we saw trolleys could not get past stationery ones. People had to move to allow others to gain access through the doors as families and carers were sitting or standing in front of exits. Staff could not easily go about their work due to overcrowding.
- Senior staff knew about a plan to develop a new ED, which was planned for about five years' time. The trust had plans to develop the ED at a new location in the hospital which took account of the layout and safe patient placement.
- The trust did not have an interim solution to the overcrowding problem. The trust supplied us with the 'ED safety plan', which related to the development of a new ED. It was clear form this plan that the trust recognised the risks relating to overcrowding and lack of clear observation of patients in corridors and triage delays.

- Signposting to the different departments within ED was confusing. It was not clear where patients should go to access the different entrances for children, minor injuries, and major illness or injuries.
- The trust had a dedicated room for seeing people with acute mental health problems which had two doors with one leading to the minor injuries waiting room and the other onto an unmanned corridor with open treatment rooms. It was not possible to lock the doors to the mental health room. The treatment rooms nearby were also unlocked and contained equipment that someone could potentially have used for self-harm. Staff told us that a mental health nurse usually accompanied patients. However, we observed a unaccompanied suicidal patient. A member of staff noted this and ensured the patient was positioned so they could be observed.
- We saw environmental inspection reports for 2015. These included areas to be inspected and actions taken or to be taken for remedial work. We saw the mental health assessment room was not included on the reports.
- Resuscitation equipment and consumables were all in date with checks completed except for defibrillation pads in the resuscitation area as they were being cleaned. This was not a risk to patients as the trolley in the majors department was nearby and fully equipped.
- General equipment such as oxygen, suction and machinery were maintained and consumables were in date. However there was an open sharps bin on the floor in one assessment cubicle. The trust supplied inspectors with an equipment risk and maintenance log for 2016. This showed that staff knew what equipment they had and that the equipment was checked regularly.

Medicines

- Controlled drugs were stored appropriately. Staff told us they checked the drugs fridge each week to ensure medication was in date and there was enough of each drug. However, they did not have a record of this.
- We saw staff recorded fridge temperatures correctly.

Records

- We reviewed eight sets of patient records. There was evidence of observations recorded in six of these records, although in one case these were infrequent. .
- Staff had recorded pain assessment in six out of the eight records. Staff recorded intentional rounding (regularly checking if patients required any nursing care) in three cases.
- The trust told us they did not audit the quality of record keeping. The Nursing and Midwifery Council (NMC) has standards for record keeping and the ED did not have a system of checking if records met this standard.

Safeguarding

- Staff knew how to make a safeguarding referral. We saw contact information on display in the nurses' station in the majors area. This showed clearly who and how to contact safeguarding leads. The trust had an up-to-date policy for adult and child safeguarding.
- The trust set a mandatory target of 85% for completion of mandatory safeguarding training. For safeguarding children and adults level 1 & 2 training, 100% of nursing staff had completed the training, exceeding the trust target of 85%. Safeguarding children level 3 training had a completion rate of 84%, which was just below the trust target. Completion rates shown included both ED nursing staff and emergency care management nursing staff.
- Medical staff had a training completion rate of 100% for safeguarding children and adults' level 1 which exceeded the trust target of 85%. Safeguarding children level 3 training had a completion rate of 77% for ED medical staff, which did not meet the trust target of 85%.

Mandatory training

- The trust set a mandatory target of 85% for completion of mandatory training.
- For nurse training, eight of the 17 mandatory training modules had a completion rate of 100%, and five modules, met or exceeded the trust target of 85%. However, the training completion rates for four modules did not meet the trust target. Blood transfusion administering and waste management training had the lowest completion rates of 68% and 78% respectively.
- For medical staff training, eight of the 17 mandatory training modules had a completion rate of 100% and one module exceeded the trust target of 85%. However, ten modules had training completion rates below the trust target. Blood transfusion administering and waste management had the lowest completion rates of 44% and 36% respectively.

- Staff told us some modules were part of a one day training session taught away from the workplace and other modules were completed online. Staff told us they sometimes fell behind with the online modules as they were very busy on a daily basis and found little time to sit at a computer whilst on duty. This was the same for nursing and medical staff.

Assessing and responding to patient risk

- In June 2015 the time to initial assessment for patient's arriving at the ED by an emergency ambulance was 13 minutes compared to an England average of five minutes. In May 2016 it was 12 minutes compared to an England average of seven minutes. Time to initial assessment for the trust had been consistently higher than the England average throughout this period. The twelve month average for the trust was 14 minutes compared to an England average of six minutes.
- 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 2015, 49% of ambulance journeys had turnaround times over 30 minutes, in July 2016 the figure was 53%. This meant that it took longer than it should have for ambulances to drop people off at the ED and become available for the next patient.
- A black breach occurs when a patient waits for over an hour from arrival at the emergency department by ambulance until they were handed over to the emergency department staff. Between August 2015 and July 2016, Heartlands Hospital reported 349 black breaches. There was a downward trend in the monthly number of black breaches reported over this period. 113 black breaches were reported in September 2015 with the lowest number of nine black breaches in July 2016. For the remainder of the twelve month period, 23 black breaches were reported on average each month.
- The ED at Heartlands Hospital operated a triage system for majors where a senior nurse was in charge of the flow coordination assessment point. The aim was to see all patients in majors within a 15 minute window, to ensure a safe system of rapid assessment and treatment (RAT).
- All patients were logged onto the electronic system which could be monitored from the assessment station. All patients for resuscitation were taken there for immediate assessment. There was a minor injuries reception where a receptionist took initial details from patients and people waited in turn for treatment.
- We observed patients waiting for longer than 15 minutes for triage in the majors department. The patient electronic flow system recorded the waiting times for triage. This ranged from five minutes to one hour 42 minutes, with an average of 38 minutes on the day of our inspection. We saw staff triaged three patients with stroke symptoms within 18 minutes.
- Data from the trust showed on average it took 154 minutes for a doctor to see a patient at Heartlands ED. This was longer than it took at Good Hope Hospital ED (106 minutes) and Solihull Hospital (69 minutes) minor injuries unit.
- Staff told us patients waiting in the corridors were risk assessed. However, we found some of these patients were still awaiting triage and therefore no risk assessment or observations were recorded in their notes.
  - Staff told us a patient had died whilst waiting on the corridor during the last 12 months. The patient was brought in by ambulance; staff performed an initial assessment which found the patient to be stable. The family of the patient advised staff of the patient's deterioration and they were moved to the resuscitation area. The trust provided information to inspectors that showed 15 ambulance patients were waiting in the corridor. Staff at all levels told us they were very concerned about being unable to observe patients in the corridors effectively. The trust provided inspectors with the root cause analyses (RCA) for the year before our inspection. These did not include the RCA for the death of a patient waiting in the corridor. The trust shared this RCA with us following the inspection. This showed there was overcrowding on the day of this death ranging from 50% to 150% above what was expected. The trust told us this had negatively impacted on patient care that day. In response to this, the trust had put an action on their action plan to change the way patients were triaged when they arrived at the ED.
  - At the time of our inspection, the resuscitation area was fully occupied with five patients. We saw one of these patients did not have any observations carried out for three and a half hours.

- ED used the modified early warning scores for adults (MEWS) and the paediatric early warning scores for children (PEWS). We saw use of the documentation with the track and trigger guidance printed on the back of the forms. This information was to help staff take action when the scores reached a certain level. We saw data from the trust on the recording of MEWS and PEWS from October 2015 to September 2016, which showed ED achieved between 96% and 100% of safe observation recording throughout this time period.
- When the emergency department became full, the escalation process was to inform the matron who then informed the senior nursing team. The clinical decision unit was used to house patients waiting for tests or for a bed in the hospital. This unit was staffed by ward staff to ease the workload of the ED staff. In addition, there were three cubicles in the minor injuries area for assessing patients waiting in the corridor. This was to allow staff to triage or medically assess patients more quickly. These cubicles were unmanned, so patients were taken from the corridor, seen and then returned back to the corridor to wait. We saw the trust's ED escalation plan which detailed actions for normal, pressure, critical, and unsafe levels of activity.
  - Not all senior nursing staff had knowledge of how to arrange hyper acute transfer of self-presenting major trauma patients. Suspected major trauma patients needed to be assessed using the regional trauma network's triage tool. Heartlands Hospital ED was a trauma unit and not a major trauma centre, so any patients at stage one or two of that tool should immediately trigger a hyper acute transfer to a major trauma centre. The senior nurse was not aware of the triggers or process for a major trauma transfer.
- The trust scored about the same as other trusts for the five questions in the ED Survey questions relevant to safety for 2014. This information related to Heartlands Hospital and Good Hope Hospital. Patients were asked five questions such as: "had they been told about danger signals when they got home."

Nursing staffing

- The ED at Heart of England NHS Foundation Trust for August 2016 had 25.9 less whole time equivalent (WTE) nursing staff in post than they had budgeted for. For September 2016, the Heart of England NHS Foundation Trust reported a vacancy rate of 23% in urgent and emergency care and a vacancy rate of 21% in emergency care management for nursing staff. In September 2016, the trust reported a turnover rate of 9% in urgent and emergency care for nursing care. Between April 2015 and March 2016, the trust reported a sickness rate of 3% in urgent and emergency care and a sickness rate of 9% in emergency care management for nursing staff.
- Between October 2015 and September 2016, Heartlands Hospital reported a bank and agency usage rate of 26% in urgent and emergency care and 20% in paediatric urgent and emergency care. Urgent and emergency care had the highest agency and bank usage in March 2016 (29%) and the lowest usage in January 2016 (21%). Paediatric urgent and emergency care had the highest agency and bank use in February 2016 and June 2016 (20%) and the lowest usage in January 2016 (16%).
- The trust told inspectors that identifying an acuity tool for use in ED had been problematic. In 2015 the departments piloted the Royal College of Nursing Baseline Emergency Staffing Tool (RCN BEST). This had been difficult to implement and no solid recommendations could be drawn from the data.
- Following this, both departments were measured against the National Institute of Clinical Excellence (NICE) draft guidelines 'Safe Staffing for Nursing in ED Departments'. Both departments were compliant with the nurse to cubicle ratio guidelines of 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 developing a similar tool for emergency departments. The Shelford Group represented ten of the leading NHS multi-specialty academic healthcare centres in England. The trust's workforce lead was in contact with another local NHS trust involved in its development to ensure the trust could access this tool as soon as it was available.
- Nursing staffing plans had been put into place against a 24 hour activity and flow plan in September 2015. Staff told us shifts started at 7am, 2pm, 7pm and 2am and described the ratio of qualified and health care assistant staff on each shift.

- Senior staff told us ten nurses had recently been recruited to the emergency department. Locum cover was provided by nurses who were regular locums to the department. The department aimed to reduce locum use following the nurse recruitment.
- We saw trust data for nurse staffing in the ED for September 2016 showed the trust covered 81% out of 100% of shifts for qualified nurses and 85% out of 100% of shifts for health care assistants.

Medical staffing

- In September 2016, the Heart of England NHS Foundation Trust reported a vacancy rate of 33% in urgent and emergency care for medical staff. The vacancy rate for junior doctors were 29% while the vacancy rate for senior and career medical staff were 38%. For September 2016, the trust reported a turnover rate of 44 % in urgent and emergency care; junior doctors had a 0% turnover rate while senior and career medical staff had a turnover rate of 44%.
- The trust reported a sickness rate of 1% in urgent and emergency care; junior doctors had a sickness rate of 1% while senior and career doctors had a 0% sickness rate in September 2016 . Between October 2015 and September 2016, the trust reported a bank and locum usage rate of 22 % in urgent and emergency care; medical agency and locum use varied over the 12-month period from 19% to 25%. The highest usage of 25% was in February 2016 and June 2016 and the lowest usage of 19% was in October 2015. The proportion of consultants and middle career doctors working at the trust was about the same as the England average. The proportion of junior doctors was lower than the England average, and the proportion of middle career doctors was higher than the England average.
- Consultants covered the department each day from 8am to 10.30pm. However, consultants told us they usually worked up to midnight. At night, there were three middle grade doctors on shift. Sometimes an advanced nurse practitioner (ANP) replaced a doctor at night however this person could not lead the service.
- Senior medical staff told us that there was a significant gap in middle grade doctors at about 50%. Data showed this was at only 25%; however this did not reflect the reality that some of these doctors were trainees and were not up to middle grade level yet. For September 2016, the planned number of shifts that needed to be filled with middle grade doctors was 262 and only 198 were covered. The trust usually covered the outstanding shifts with junior doctors. 378 shifts were covered instead of 270 shifts and to a lesser degree with consultant hours, at 118 shifts instead of the planned 104 hours.

Major incident awareness and training

- We saw the trust policy on chemical incident management, 2016, which clearly showed the emergency department responsibilities and plan for managing chemical incidents. This included smallpox, white powder incidents (suspected anthrax incidents), viral fevers produced by an escape of blood from a ruptured blood vessel and plague.
- Staff told us security staff provided staff with good support when required and they could be easily contacted. They described situations where they had to call them to attend for physical and verbal aggression.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated urgent & emergency services as requires improvement for effective because:

- There were poor patient outcomes in relation to Royal College of Emergency Medicine (RCEM) audits for sepsis, asthma, paracetamol overdose, mental health in the ED and cognitive impairment assessment.
- Management of pain relief was poor.
- There was a lack of support for vulnerable people to eat and drink.

However we saw:

- Multidisciplinary working was good.
- Staff had access to training and educational support.
- There was involvement in research to improve patient outcomes.

Evidence-based care and treatment

- We saw the trust's audit results for 2016/17 showed for the year to date it took on average 37 minutes from

arrival to triage. This was much longer than the trusts' 15 minute target. Triage times were highlighted hourly on the ED escalation tool so that staff could take a pro-active approach to managing this.
- The trust told us observations were shared via the nursing metrics data, published in the communication folder and discussed at the directorate meeting. We saw the communications folder in the staff room in ED.
- Fractured neck of femur pain relief was an annual spot check audit completed against the Royal College of Emergency Medicine (RCEM) guidance; the trust last completed this audit in February 2016 and it was due for presentation.
- The trust recognised they needed to improve sepsis care and launched a new teaching programme in 2015 and showed us the teaching pack they used. Sepsis audits were presented as part of the directorate meeting and senior staff shared this with other staff via email and communication updates with reasons why targets had not been met.
- Falls in the over 65's and alcohol audits were Commissioning for Quality and Innovation audits (CQUINs) in 2015 and were reported centrally via the trust performance team.
- The trust told us they had a clinical pathways group working on repeated audits for chest pain. This indicated less than 20% of patients received an electrocardiogram (ECG) within 10 minutes of arrival since 2011. An ECG is a simple test that can be used to check the heart's rhythm and electrical activity. Sensors attached to the skin are used to detect the electrical signals produced by your heart each time it beats. This was due to be re-audited when the quality improvement measures were in place.

Pain relief

- Staff and patients in the adult majors department told us pain relief checks and the administration of pain relief was poor. We checked patient records of patients attending the department in pain against the time pain relief was first given.
- We asked four patients who were in pain when they arrived about pain relief. Two of these patients said they had not been asked about pain at all on triage. For the other two patients, pain relief was given after 40 minutes in one case and two hours for the other patient.
- The department had a poster on display stating pain relief would be given within 20 minutes. Staff said they felt the continual overcrowding of the department was the cause of this. In paediatrics, we saw staff used child friendly pain scores.
- The trust told us they knew pain relief was an issue in ED and showed us a copy of their quality improvement plan produced in March 2016. The results showed that ED was very poor in timely administration of pain relief. The gold standard guidelines stated 50% of patients should receive pain relief within 20 minutes and the ED achieved 2.5%; within 30 minutes was set at 75% and ED achieved 5% and within 60 minutes was set at 98% and ED achieved 10%.
- The trust told us that poor assessment of pain was partly due to language barriers and recognised the need for pictorial pain relief charts. We did not see these charts available in the adults department.
- In the CQC ED Survey 2014, the trust scored 5.12 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.
- The trust scored 6.88 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was also about the same as other trusts.

Nutrition and hydration

- Staff told us that they made snacks and drinks available and support staff brought a trolley around three times daily. We saw this during the inspection.
- We saw some vulnerable patients were positioned on trolleys in the corridors who required support with eating and drinking. We did not see any support given to these patients. However, we raised this at the time of the inspection and staff responded immediately.

Patient outcomes

- Nursing staff at band 7 and below had a lack of awareness of any clinical audits or research other than the recent commode audit the department was involved in.
- Senior doctors told us about research they were either involved in or knew about. We saw a comprehensive list of projects including measurement of blood markers in anaphylaxis, QUEST study which was a retrospective review of severe sepsis and the HECTOR project which involved management of elderly trauma.

- In the 2013/14 RCEM audit for asthma in children, the trust was about the same as other trusts for eight of the ten measures for Heartlands Hospital and was better than expected for two of the ten measures.
- In the 2013/14 Royal College of Emergency Medicine(RCEM) audit for paracetamol overdose, Heartlands Hospital was worse than expected for three of the four measures and was about the same for one of the four measures.
- In the 2013/14 RCEM audit for severe sepsis and septic shock, Heartlands Hospital was worse than expected for two of the 12 measures and was better than expected for the other two of the 12 measures.
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, Heartlands Hospital was worse than expected for one of the six measures and was about the same as other trusts for five of the six measures. The trust did not meet the fundamental standard of having an early warning score documented at Heartlands Hospital.
- In the 2014/15 RCEM audit for the initial management of the fitting child, Heartlands Hospital was about the same as other trusts for five of the five measures. Heartlands Hospital met the fundamental standard of checking and documenting blood glucose for the fitting child.
- In the 2014/15 RCEM audit for mental health in the ED, Heartlands Hospital was worse than expected for two of the eight measures and was better for three of the eight measures. Of the two fundamental standards included in the audit, Heartlands Hospital did not meet the fundamental standard of documented risk assessments taken. Heartlands Hospital met the fundamental standard of having a dedicated assessment room for mental health patients at Heartlands Hospital.
- .Data from the trust showed 50 per cent of total re-attendances at ED within 72 hours trust wide were at Heartlands Hospital compared to 33% at Good Hope Hospital and 17% at Solihull. The average re-attendance rates were between 7% and 9%. However, the zero to five years age group and the 21 to 25 age group had the highest attendance rates at 11% followed closely by the 26-30 age group at 10%. The average re-attendance rate remained similar at seven days, with an 8% average. The England average re-attendance rate at seven days is 8%.

Competent staff

- Between April 2016 and September 2016, 75% of urgent and emergency care staff had received an appraisal. This did not meet the trust target of 85%. From April 2015 to March 2016 allied health professionals and medical and dental staff had an appraisal rate of 100% and 97% respectively, which exceeded the trust target of 85%. Nursing and midwifery staff had an appraisal rate of 54% and other staff a rate of 70%, which fell below the trust target of 85%.
- Staff we spoke with said they were up-to-date with their appraisal. The majority of staff told us their appraisals were meaningful in relation to development and could be used to discuss problems. Senior nursing staff told us they were aware of difficulties in achieving appraisal targets and had a system where one person would be responsible for a particular group of nurse appraisals.
- New staff said they were supported well on joining the department and during induction. They said they got to meet the matron at induction and felt the training supported them into their new post. The trust supplied us with a copy of the band 5 induction pack that they gave to each new emergency department nurse.
- Junior doctors said they had regular training and educational support. Doctors described the link to a local university with their research fellow based at the emergency department. They also told us about links with another local university.
- The emergency department had a nursing lead for education who told us about the yearly update training. They advised that all nurses did safeguarding training to level 3 and major incident training was run monthly between January and December. In addition, a new customer care session had been added as a result from patient feedback, this was to start in 2017.
- Female genital mutilation (FGM) training had been recently added to the training programme which a specialist midwife had delivered. They told us and we saw the mandatory training programme for emergency department qualified nurses and health care assistants. This training was a mixture of trust mandatory training and role specific training.
- The trust had links with a local university to support nurses wishing to complete the degree level Fundamentals on Emergency Nursing Practice (FENP) course.
- All qualified nurses have a competency based learning framework to support revalidation based on the FENP

course for those already educated to degree level. The department had a doctor who was revalidated for trauma, which supported the department to be trauma compliant.
- Both medical and nursing staff said they felt supported by senior staff and could go to them to discuss patients and ask for advice.
- The paediatric department was led by a paediatric physician and had three dual qualified medics. The paediatric nursing staff were trained as sick children's nurses.
- All band 5 nurses and health care assistants did a three month rotation in the clinical decision unit, minor injuries, majors and resuscitation and paediatrics.

Multidisciplinary working

- The department had a professional standards procedure designed to aid multidisciplinary working to aid effective flow through ED. The standards laid down rules for seeing patients with a GP letter, patients requiring resuscitation, non-resuscitation, shared care (where more than one specialty needed to be involved), and patients for admission to hospital.
- Staff told us it was difficult to adhere to the standards for medical patients as this was where they had the greatest number of patients and the medical teams were overstretched**.**
- The ED department took part in multidisciplinary working on care pathways. The group met monthly to discuss various pathways to improve patient experience and outcomes. Examples of pathways included: stroke, fractured neck of femur, spinal injuries and paediatrics.
- Staff told us about the arrangements with the rapid assessment and interface and discharge team (RAID) for people who attend ED with acute mental health problems. The RAID team were a specialist team of mental health professionals who assessed and planned care for patients.
- We spoke with staff from the stroke team who were specialist staff that supported ED. Staff in ED called them to review patients who were suspected of having a stroke. Their aim was to see patients within 15 minutes. Staff told us the pathway worked well and all appropriate patients were seen. They said ED staff valued the role but felt there were not enough stroke specialists to enable them to be as effective as they would like.

Seven-day services

- The emergency department operated a 24-hour service for minor and major injury and illness.
- Patients who attended the emergency department for major illness and required tests could access them on the same day and staff allocated them to the seated area of the clinical decision unit (CDU). Patients were taken from CDU for tests and would wait for medical staff to review them.
- The CDU was manned by a qualified nurse and health care assistant. In addition, any patients for admission who were waiting for a bed were nursed in the CDU. Observations, tests and reviews were carried out whilst patients were waiting.

Access to information

- Staff had access to the electronic patient record and we observed several computer points within the clinical area of the department. We saw staff regularly accessing records and they were able to access x-ray scans, blood tests and other results.
- Staff had access to the patient flow screen, which included patient identification, time of arrival, details of illness or injury, progress of care and alerts such as allergies or safeguarding issues.
- Each patient had a set of written records which all staff groups could access. We saw these contained observations and examinations.
- Staff told us they always received ambulance handover for patients arriving in an ambulance. Staff were given information about observations, symptoms and severity of the patient's condition.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw verbal consent being obtained from patients for general tests, examinations and observations.
- There was a mixed response from families when we asked them about consent for children and adults lacking capacity. Three quarters of respondents said staff asked for verbal consent and a quarter told us staff had not told them what was happening regarding tests and treatments in advance so did not have the opportunity to consent.
- Consent for procedures was documented in the patients' notes.

Urgent and emergency services

- Senior leaders confirmed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training were included as part of annual staff training.

Are urgent and emergency services caring?

Requires improvement

We rated urgent & emergency services for caring as requires improvement because:

- The Friends and Family Test performance was generally worse than expected in comparison to the England average between August 2015 and July 2016.
- The trust scored worse than other trusts in the CQC ED survey, for the questions 'If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so ?' and 'Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?'
- We observed mixed levels of compassionate care. We witnessed four patients who received poor care.

However we saw:

- Good emotional support in the paediatric department. One parent in particular was very upset and staff showed understanding and compassion.
- There was a child friendly environment.

Compassionate care

- The Heart of England NHS Foundation Trust Urgent and Emergency Care Friends and Family Test performance was generally worse than expected in comparison to the England average between August 2015 and July 2016. In July 2016, the trust performance was 81% compared to an England average of 85%.
- We saw a number of good interactions between patients and staff on the reception of the minor injuries area. In particular, one patient did not wish to disclose sensitive information and staff handled this compassionately.
- Inspectors observed staff giving care in the majors, resuscitation and paediatric department. Overall, this was compassionate and staff gave explanations of what was happening. There were four exceptions to this where we observed that an elderly vulnerable patient was trying to call out to staff for help and on several occasions staff walked past the patient with no acknowledgement. The patient was unaccompanied with nobody to support them to ensure their needs were met. Another case involved poor signposting and the third involved lack of compassion towards the family of a dying patient. The fourth involved the parent of a child in the paediatric department who described the hospital as "heartless".
- We spoke with six patients and families who responded with mixed feelings Half said staff were caring and they had given them clear information so they knew what was happening.
- There were two CQC feedback cards from patients and families. One was very positive and said staff were "comforting and had a good bedside manner" and one said the "care was poor".

Understanding and involvement of patients and those close to them

- We observed good communication between staff and patients where explanations about tests, diagnosis and treatment were discussed.
- The paediatric department had a variety of child friendly information available as well as play specialists to help the children understand what was happening to them.
- The results of the CQC ED survey 2014 showed the trust scored about the same as other trusts in 22 of the 24 questions relevant to caring. The trust scored worse than other trusts for the questions 'If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so ?' and 'Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?'

Emotional support

- We spoke with parents in the paediatric department and we saw one parent became very emotional. Staff responded quickly in a caring manner and supported the parent.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Urgent and emergency services

Requires improvement

We rated urgent & emergency services for responsive as requires improvement because:

- ED had not met the four hour waiting time for a number of years.
- Poor flow throughout the department caused up to 16 hour delays in patient care.
- The percentage of patients that left ED before being seen for treatment was higher than the England average.
- Complaints were not managed in a timely manner.

However we saw:

- Good collaboration with other stakeholders to plan services.
- An effective and responsive stroke pathway.

Service planning and delivery to meet the needs of local people

- Senior staff told us that they were part of the System Resilience Group which was a regional group looking at emergency care resilience. The group was represented by all of the hospitals in the area, clinical commissioning groups, GPs, the council, and NHS England. The aim of the group was to look at the region as a whole and discuss ways of working together to benefit all the people who used the different services.
- The trust had developed a remedial action plan (RAP) for discussion at this group alongside all other trusts in the region. This contained work such as: improvement of the four hour wait target and better flow through ED and staffing levels.

Meeting people's individual needs

- We saw a sign up in the minor injuries area asking people to say what their ethnicity was to enable effective communication. Staff told us they could access a language translation service in the majors department. We were told the staff population was ethnically diverse and would frequently translate for people whose first language was not English. This is not in line with best practice.
- Staff told us they could care for obese patients appropriately. Staff said they had good communication with the ambulance service, which would make them aware in advance of any patient with bariatric needs. They also had a range of suitable equipment such as chairs and trolleys.
- We saw a sign displayed in the department about FGM and training for the recognition of this was now on the department's mandatory training programme.
- Staff in the paediatric department had an awareness of learning disabilities. They told us that they would involve the play specialist and support the child whilst waiting by allocating them a cubicle rather than waiting in the general waiting area. Staff were aware of the referral pathway to the health visitor if support was required in primary care.
- The paediatric department décor was child friendly with toys and activities for the children. There was a separate waiting area for older children.

Access and flow

- We saw trust data that showed it had not met the ED standard of 95% for seeing people within four hours, over an extended period. We were told despite the fact that considerable investment and planning had gone into remedial actions, performance remained below the required regulatory and contractual levels.
- Within the 2015/16 financial year, the trust experienced a considerable rise in demand above both the contracted levels and the previous year attendances. There had also been a rise in the presenting acuity, particularly at the Heartlands site.
- The trust told us there had been considerable staffing challenges in ED for all grades of medical staff, but was particularly acute at 'middle grade' level. ED had also seen significant vacancies within its nursing workforce. A combination of both of these issues had impacted on the ability of ED to efficiently respond to demand and capacity issues.
- Continual high levels of delayed transfers of care were impacting on patient flow and the availability of beds and in turn performance against the emergency access standard. The trust escalated this problem to all other health and social partners to deliver on the necessary agreed improvements.
- The ED attendances for the year to date were 4.2% over what was expected. Compared to August last year emergency admissions had also risen by 6%.
- The report from NHS England on ED waiting times for 2015 to 2016 showed that the Heart of England NHS

Urgent and emergency services

Foundation Trust was worse than expected in comparison to the England average for the four hour ED waiting time target between August 2015 and July 2016. This report also showed that between August 2015 and July 2016, the percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust each month was better than the England average. Between December 2015 and July 2016 this fluctuated over the winter period bur remained static overall.

- During the first inspection day there were four people waiting longer than four hours for admission with the longest at 16 hours 27 minutes. Staff told us it was usual to have between five and 20 people waiting. During out-of-hours on the second inspection day, there were no long waits for admission. Trust data showed there were two patients waiting longer than 12 hours on a trolley from October 2015 and September 2016.
- Between June 2015 and May 2016, the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was higher than the England average. Between June 2015 and May 2016 performance against this metric showed a trend of decline. Percentages where higher than the England average for the entire period with the exception of March 2016 when percentages where slightly better than the England average.
- The same report showed between June 2015 and May 2016 the monthly total time in ED for admitted patients at the trust was consistently similar to the England average. Performance against this metric showed a trend of improvement between October 2015 and April 2016.
- The majors department operated a rapid assessment and treatment system (RAT). A computer generated assessment was completed by an advanced clinical practitioner, or doctor and qualified nurses. This involved a top to toe assessment to ensure the patient was then referred to the most appropriate area. This system was set up to reduce waiting for an initial assessment.
- The stroke team told us they were available for eight hours out of a 12-hour day to provide raid assessment of stroke patients. They told us all patients accessing ED by ambulance were offloaded and seen within 15 minutes. We observed this during the inspection.

Learning from complaints and concerns

- Between September 2015 and August 2016 there were 191 complaints about urgent and emergency care services at the trust. The trust took an average of 123 days to investigate and close complaints. This was not in line with the complaints policy, which stated the trust should have investigated and closed complaints within 30 days.
- As of August 2016 there were 44 complaints still open, of these seven were received in May 2016, 13 in June 2016, nine in July 2016 and 15 in August 2016. Of all complaints received, 48% were in relation to clinical care, 18% related to staff attitude and a further 10% related to communication or information problems. In the category of clinical care were a number of complaints about pain relief, waiting on trolleys and delays in treatment. These complaints supported concerns found by the inspection team regarding these three issues at the time of the inspection.
- The senior nurse confirmed complaint handling was a problem, but advised us they felt it was improving. They told us they had dealt with 78 complaints that were behind schedule since July 2016.
- Complaints specific to the emergency department were emailed to the matron who then emailed the team or individual with feedback. Themes were fed back through the six weekly ED newsletter however, the trust told us no newsletters had been produced for six months.
- We saw patient complaint leaflets in the reception of the minor injuries department**.** We did not see any in the majors or resuscitation areas.
- Staff told us if patients wished to make a complaint they would give them a patient advice and liaison service (PALS) leaflet which had the details of how to make a complaint.

Are urgent and emergency services well-led?

Requires improvement

We rated urgent & emergency services for well-led as requires improvement because:

- The executive leadership team was not engaged in dealing with the issues of overcrowding within ED.

- There was poor staff morale due to the overcrowding issues and poor flow throughout ED which they felt was not being addressed by the executive team.
- A winter pressure plan was not in place by November 2016.
- Management had not provided new equipment in the paediatric department in a timely way.
- There was limited staff and public engagement to improve the service.

However we saw:

- A five-year improvement plan to address safety within ED was in place.
- Research took place to support innovation and quality improvement.

Leadership of service

- Senior staff told us about the divisional structure and the trust supplied us with a copy of the structure. The senior nursing team was a newly formed team who shared their concerns about the emergency department, their actions to date and their future goals. However, they told us the executive leadership was not engaged in dealing with the issues.
- Staff said they were aware of the senior team in ED and knew who the head of emergency nursing and the deputies were. Some staff had met them and others had not. All staff told us the matron had a very clear presence in the department.
- Staff felt leadership in the department was effective but told us although everyone knew overcrowding and delays were a problem, they did not feel the executive team were taking action to deal with it. They gave an example of how they had escalated long stays during a morning to the executive team very recently and although they were clear that the situation was unsafe, no additional resources or help was given.
- Staff told us they were not supplied with new equipment in the paediatric department in a timely way however, they were provided with equipment when the department became flooded.
- Senior staff told us despite the trust being in financial difficulty, they were not affected by the agency staffing cap in the department.

Vision and strategy for this service

- The trust told us that they had a five year plan which included an ambulatory care and diagnostics centre (ACAD) at Heartlands Hospital. We saw this plan on display in the ED staff room.
- Senior staff above band 7 described the plan in detail and more junior staff knew about the basic plan for a new department.

Governance, risk management and quality measurement

- Senior staff told us about the ward to board assurance report. We saw this report contained information about harm free care, infection control, tissue viability (pressure sores), falls, venous thrombosis assessments (blood clots in the leg), infections, medicines, nursing care, admissions, discharges and transfers, dementia, sepsis (severe infection), antibiotics, staffing and complaints. The ED produced this report monthly and presented it to the hospital board of directors.
- The ED produced a risk register that they reviewed each month at their directorate meeting. This contained information about the greatest concerns in the department. There were seven risks on the risk register and all senior staff told us about six of them. These risks were: overcrowding, medical staffing, nursing staffing, complaints handling, delays and recruitment. All other staff told us about four risks which were: overcrowding, medical staffing, nursing staffing, and delays.
- The risk register linked into the System Resilience Group, the remedial action plans and the ED delivery board. The trust supplied us with information relating to the delivery board.

Culture within the service

- Staff felt supported by the band 7 nurses and the matron. They said there were good communication pathways and felt able to voice concerns.
- Staff told us they pulled together as a team; however, the paediatric team felt they were isolated.
- Staff said they tried their hardest to remain patient focused but described being unable to deal with the issues related to overcrowding and just tried to cope. Senior staff told us they were concerned about staff resilience and felt it was a real issue.

- Staff appeared to have a culture of acceptance and despondency about the overcrowding situation. They felt there was nothing they could do and had to accept not being able to give the level of care to patients they would like.
- The trust had provided duty of candour training to staff and we saw the training schedule for the department. The trust audited incidents that met the duty of candour requirements. Six incidents met the criteria within the department between September 2015 and September 2016.
- There was a strong learning culture within the department.

Public engagement

- We saw a communication book in the ED staff room. This contained patient feedback such as thank you cards, patient comments from NHS choices and investigation reports. A poster was on display in the minor injuries department for patients about giving feedback.
- We saw friend and family test feedback cards in the minor injuries department and in paediatrics. The paediatric cards were child friendly.

Staff engagement

- Staff told us the managers kept them up-to-date with the communication book, the intranet, and staff meetings. They said the department had its own six weekly newsletter.
- Staff told us they had a voice and were able to give their opinion informally.

Innovation, improvement and sustainability

- The trust took part in the ambulatory care network. This was a 12 month programme to support the trust to expand ambulatory care and develop its staff.
- The research fellow based in the department had a 50/50 research/clinical split to enable the department to take part in research effectively. The department was currently involved in two projects relating to anaphylaxis which were at the publication stage. Six projects had been completed and were awaiting publication, three were at the data collection phase and one was at the grant application stage.
- Staff told us about the trust's development of the band 6 emergency nurse practitioner role to assess and treat adults with minor injury or illness. This was in response to the ongoing difficulties in medical staff recruitment.
- The trust had developed an interim winter pressures plan to address sustainability issues relating to an already overstretch emergency department. The trust had not completed the full winter plan by 1 November 2016.

Medical care (including older people's care)

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

Information about the service

We inspected this core service in 2015 and rated the core service as requires improvement. An unannounced visit in September 2016 raised some continuing concerns. Therefore, we carried out a full inspection of the service in October 2016.

During this inspection we visited all medical wards at Heartlands Hospital. Ward two gastroenterology, ward three renal medicine, ward six cardiology, ward 18 diabetes, ward 20, acute medical unit (AMU), , ward 21 elderly care, the hyper acute and acute stroke units, ward 24 respiratory care, ward 26 Adult cystic fibrosis, ward 27 and 28 infectious diseases and ward 30 elderly care specialising in dementia care.

We spoke with 42 nurses and 14 doctors both of varying grades. We spoke with 29 patients, 14 visitors/relatives. Nine allied health care professionals. A psychologist, patient liaison officer and bed manager.

Summary of findings

We rated the service overall as requires improvement because:

- Nursing and medical vacancies were high and planned staffing levels were not always being met.
- Infection control measures were not consistently applied and we saw poor levels of hand hygiene.
- Patients experienced delayed discharges not only due to lack of care in the community, but to poor discharge management and arrangements. This included insufficient patient transport (operated by another provider) and porter provision.
- There were a number of medical outliers: patients who were admitted to other wards as there was no appropriate medical bed free. Medical reviews of these patients were on some occasions being missed.

However:

- The trust had a rolling recruitment drive both nationally and internationally and were recruiting with success.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated medical care services as requires improvement for safe because:

- Medical outliers, (Medical patients placed on other wards due to lack of an appropriate medical bed) were not always reviewed by medical teams in a timely fashion. We found one of 14 medical outliers who had not been reviewed for more than six days post admission by a consultant.
- Nursing and medical vacancy levels were high in some areas, although the trust was taking steps to improve recruitment and mitigate the risk through the use of temporary staff. On the Acute Medical Unit (AMU) staffing had not met planned levels.
- The stroke unit was also of concern because the trust has designated the unit as a HASU "Hyper acute stroke unit" but staffing levels were not meeting national BASP "British association of stroke physicians" recommendations for HASU services.
- Measures to prevent and control infection were not consistently applied. We observed poor use of hand hygiene amongst nurses and medical staff.
- Assessments of risk of developing a venous thrombo-embolism (VTE) and the use of the national early warning score to aid early identification of a deteriorating condition were not consistently implemented.
- Consultants and junior doctors raised concerns about medical staffing levels at night in medical services

However;

- .
- Staff were aware of safeguarding policies and procedures and gave us examples of referrals they had made.
- Some individual services had implemented structured and targeted quality improvement plans as a result of learning from incidents, including ward 26 for adult cystic fibrosis, ward 24 respiratory medicine and the endoscopy unit.
- The service was working with local commissioners and stakeholders and engaging with staff and patients to develop and improve services.

Incidents

- Between 1st August 2015 and 31st July 2016 Heart of England NHS Foundation Trust reported no incidents which were classified as never events for medical care. 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 to have happened for an incident to be a never event.
- During the same period the trust reported 71 serious incidents (SI's) in medical care which met the reporting criteria set by NHS England. Of these, the most common type of incident reported was pressure ulcers meeting SI criteria which accounted for 74% of all incidents
- Falls were highest on the Acute Medical Unit (AMU) 2 at Heartlands hospital the average rate of falls between January and June 2016 which equated to 1000 occupied bed days was 12.25%. The AMU 2 also had the highest monthly figures for bank/agency staff at 11.20 per month. Trust recommendations were to lessen the use of agency staff.
- Each member of staff we spoke with was aware of the procedure for submitting an incident report on the hospital's incident reporting system and was confident in doing so. However, some nurses said they stopped submitting reports about staff shortages because they felt it would not result in changes. Staff shortages were on the trust's risk register. The trust was engaged in a rolling programme of recruitment for nurses, including international recruitment.
- There was evidence of improvements in practice following incident investigations. For example, the cystic fibrosis/ respiratory team conducted a root cause analysis following an incident on wards 22 and 24 which had led to action plans on priority of care, analgesia and staffing.
- We saw excellent examples of duty of candour Duty of candour to ensure patients and/or their relatives are informed when they are affected by something which went wrong and given an apology. For example relatives were encouraged post incident to record "sound bites" of how an incident had affected them and were invited to "Gold fish bowl" meetings where they could discuss how they felt with the whole nursing and medical team.

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.
- Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data from the Patient Safety Thermometer showed the trust reported a prevalence rate for medicine across the trust of 132 pressure ulcers, 41 falls with harm and 35 catheter urinary tract infections between July 2015 and August 2016. Results were available for wards on the intranet.
- Not all wards displayed the safety thermometer results, however, their performance in relation to individual components of the safety thermometer such as pressure ulcers and falls were displayed on notice boards on each ward in the form of safety metrics. The safety metrics is a means of recording the incidence of key factors influencing safety daily each month, giving information at a glance as to the frequency of these incidents.

Cleanliness, infection control and hygiene

- We noted that all wards and clinical areas visited were visibly clean.
- However we observed inconsistent use of hand washing and antibacterial gel by clinical and medical staff. During the inspection we raised a concern with the ward manager on ward two after observing lack of hand hygiene after administering eye drops and medication.
- 'I am clean' stickers were not used on clean equipment, despite the stickers being available on the wards.
- Hand gel dispensers on ward 21 entry and some on the wards were empty.
- All staff seen looked well presented in clean and smart uniforms.

Environment and equipment

- The hospital environment reflected old and new builds but all appeared to be bright and well maintained.
- All medical wards we visited were accessed via swipe card and exiting via pressing green buttons. There was a call button and intercom system for patient safety.
- Records showed staff checked the emergency equipment daily. There was a consistent process for checking the equipment across the wards we visited.
- Most wards had a visitors' quiet room which were also used for breaking bad news.
- All equipment looked clean and well maintained. Maintenance and cleaning logs were seen. Portable appliance testing (PAT) had been carried out and the equipment we checked indicated it was in date.
- All defibrillators and resuscitation trolleys were packed in a uniform way across the wards we visited at Heartlands hospital. Staff told us this was good for consistency. "Any staff who work across the hospital will know where things are if we need to resuscitate a patient".
- We were informed that broken or damaged equipment would often be replaced within 24 hours by the in house maintenance team, however pressure relieving mattresses were supplied by an independent company and could take up to 24hours to arrive. During this time patients would be without identified pressure relieving mattress.

Medicines

- We observed medicines being administered safely. Staff checked against the medicines administration record, checked the identity of the patient and remained with the patient until they had taken their medicines. We saw that nurses performing medication rounds were wearing "Do not disturb" tabards.
- Medicines were prescribed on the electronic prescribing system (EPS). The EPS had a built in safety reminder that sounded centrally if antibiotics or analgesia were more than 20 minutes overdue. The ward received a call and a reminder. The EPS had been received well by most staff but was felt to have one drawback; bank and agency staff who had not received training could not use it so were unable to administer medication.
- Administration records had been completed consistently and allergies were recorded. This indicated medicines were given as prescribed and checks were made to ensure they could be given safely.
- Patients told us they received their medicines in a timely manner and staff checked their identity prior to giving them their medicines. They also said staff explained their medicines to them.
- All medications were stored in locked trolleys. Some were attached to walls with chains and padlocks; other locked trolleys were stored padlocked to walls within locked medicine storage rooms. The nurse in charge kept the keys.

- Controlled drugs (CDs) were audited on a daily basis by two nurses, with a separate signing sheet. CDs were correctly documented in a register, which was in line with National Institute of Health and Care Excellence guidelines.

Records

- Twenty five patient records and notes were reviewed. All had legible entries, with the majority of staff grade and signature being legible.
- Initial and on-going risk assessments such as pressure ulcer risk assessments, VTE risk assessments and risk of falls assessments were completed in all records.
- There was evidence of daily ward rounds, and entries made by clinicians of different grades.
- We observed evidence of completed Do not attempt cardio pulmonary resuscitation (DNACPR) forms where appropriate with advanced decisions for care and medication. We saw some records contained 'hospital passports' detailing the patients' needs, likes, dislikes, preferred name and details about their condition should that patient be transferred to a different ward.
- We saw clear evidence that risk assessments had been performed. We saw some patients at risk of falls were cared for together in one ward area for ease of observation and at night a nurse would always sit outside the ward to offer immediate assistance.
- All notes seen were kept in locked note trolleys for confidentiality. However on the stroke unit HDSU and ASU we saw that patients' notes had been left on display.

Safeguarding

- We saw that boards containing full patient names were on display in wards, which could easily be seen by visitors. When we asked staff about this, one told us "no one looks at them and we don't have the patients details or diagnosis written up, just their names". This did not comply with trust policy.
- A member of staff told us about two safeguarding incidents reported by them; however stated they had received no feedback as to the outcome of either of these.
- A ward manager said staffing levels each day were escalated to the safe guarding matron and staff were moved according to most need across the wards.
- Staff did not know what level of safeguarding (adults and children) training they had received. . However the modules for Safeguarding Children's & Adults (levels 1, 2 & 3) for Nursing & Midwifery staff surpassed the 85% completion target. Safeguarding Children Level 3 had a 100% completion rate.
- Most staff we spoke with had a good understanding of the principles of safeguarding, including warning signs of abuse such as unexplained bruising and suspicious behaviour. Staff knew how to contact the trust's safeguarding team.
- We saw minutes from the monthly mortality meeting in August 2016. The group discussed deprivation of liberty safeguards and felt it is advisable to simply keep abreast of safeguarding generally. One doctor brought to the attention of the group the Deprivation of Liberties Safeguards (DOLS) flow chart.

Mandatory training

- Data shows that as of August 2016 out of the 19 mandatory training modules for Medical and Dental staff, only nine modules surpassed the 85% target to reach 100% completion.
- Levels of completion of mandatory training had improved since the last inspection although did not always meet the 85% trust target.
- The training matrix was seen on most wards visited. They showed some gaps but it was clear training was constantly above the trusts target of 85%.

Assessing and responding to patient risk

- An early warning score (MEWS) was used to ensure the prompt identification of patients when their condition deteriorated. Standard triggers of escalation were clear and there was the ability to adjust the trigger for individual patients to allow for differences in patients' normal readings. All patients' MEWS assessments seen had been completed correctly and on a regular basis.
- When a patient's condition required escalation, staff contacted the junior doctor for the ward or out of hours they could contact the hospital at night, nurse practitioner. Staff told us the doctors responded promptly to escalation whenever possible, and if they did not obtain a prompt response they would escalate to the registrar or consultant.
- Between September 2015 and August 2016, 44% of individuals did not move wards at Heartlands Hospital during their admission, and 56% moved once or more. This figure is higher than the national average.

Medical care (including older people's care)

- At night the medical bleep holder could see the hospital dash board which directed doctors to the place they were needed. This ensured that any deterioration of a patient would get a rapid response from the medical team 24 hours a day,

Nursing staffing

- Staffing shortages throughout the hospital had led to poor staff morale. However many nurses told us they loved their jobs and were excited about the future of their departments and hospital.
- The trust reported a vacancy rate of 15.6% across 13 specialties in medical care; the specialties with the highest vacancy rates were laboratory medicine (36.8%) and stroke medicine (23.1%). rheumatology had the lowest vacancy rate with 0.50% followed by cardiology with 1.4%.
- The staff turnover rate was 7.21% across 13 specialties in medical care; the specialties with the highest turnover rates were general medicine (13.5%) and respiratory medicine (11.6%). rheumatology and dermatology had a 0% turnover rate.
- Trust reported a sickness rate of 3.28% across 13 specialties in medical care; laboratory medicine had the highest sickness rate with 6.7%. Dermatology had the lowest sickness rate with 0.3%. Sickness absence rates had increased above the England average since January 2016.
- Nurse staffing on the hyper acute and acute stroke units were not meeting British Association of Stroke Physicians (BASP) safe staff guidelines in its current format and ratio on hyper acute dependency stroke to acute stroke beds.We saw that boards on each ward showing actual numbers versus planned staffing indicated that the stroke ward and ward 21 on the day we visited, were understaffed.
- Ward 21 had 10 WTE registered nurse vacancies and one WTE healthcare assistant vacancy. On the day of inspection, actual staffing numbers met planned levels of 4 RN's and 4 HCA's.
- Recruitment to elderly care wards was a persistent issue. The trust was holding specific elderly care recruitment days to address this.
- A member of nursing staff at a focus group told us "We no longer have the time to actually care for patients. It's not what we came into nursing for." Stroke unit staffing on the day: planned am 6 RN's (actual 5) 2 HCA's (actual 2) Planned pm 6 RN's 6 (actual 4) HCA's 2 (actual 2). Night planned RN's 5 (actual 4) HCA planned was met. There was a 4 bed 'HDU' bay on the stroke unit for thrombolysis which staff said should be staffed 1:2 but with 16 other stroke beds plus 4 HDU beds, staffing levels were insufficient to meet this.
- The stroke unit was so busy when we first visited that we were unable to speak with any staff. The HDU bay was staffed by one RN whilst the other was having a break for 20 minutes.
- We saw that boards on each wards showing actual versus planned staffing indicated that the stroke ward and ward 21 on the day we visited were understaffed.

Medical staffing

- As of August 2016, the trust reported a vacancy rate of 17.4% in medical care; junior doctors had the highest vacancy rate with 21.2% and senior & career doctors had a vacancy rate of 13.3%.
- There was a staff a turnover rate of 5.94% in medical care; this related to senior & career doctors as there is no data available for junior doctors.
- There was a sickness rate of 0.45% in medical care; junior doctors had a sickness rate of 0.47% and senior & career doctors had a sickness rate of 0.43%.
- The proportion of consultants working at the 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.
- Medical staffing skill mix was similar to the England average, with slightly more junior and middle career doctors.
- Staff told us that consultants would regularly come into the hospital on their days off to do "Step down" shifts to cover their departments rota for safety.
- Medical staff told us it was a fair system at night as work was allocated by the medical bleep holder on a rotational basis. This way no doctor was overworked. Junior doctors told us it was the best trust they have ever worked in for research and training.

Major incident awareness and training

- A major incident plan was in place dated April 2015.
- Emergency planning training was part of mandatory training. At least 70% of staff in each area of medical services had completed emergency planning training.

Medical care (including older people's care)

- Ward sisters and ward managers were aware of their role in a major incident and the action they needed to take.
- We noted there was emergency evacuation equipment near the fire exits and on some wards we noted there was an evacuation/fire plan on the wall.

Are medical care services effective?

Good

We rated medical care services for effective as good because:

- Local and national audits were used to benchmark care, treatment and practice against guidance established by a range of organisations that represented best practice. This included organisations directly involved in health and social care, such as the National Institute for Health and Care Excellence, the World Health Organisation and the Health and Care Professions Council. Audit programmes were diverse and represented a significant portfolio of practice evaluation, improvement and learning.

However:

- Nutritional assessments were not always completed and the documentation of nutrition and hydration was inconsistent. We could not be sure patients received appropriate nutrition. There were not always enough permanent staff on duty who could confirm a patient had eaten. We saw evidence of food being removed uneaten as patients had required and not received assistance to eat it.

Evidence-based care and treatment

- We saw that clinical guidelines were available on the intranet for staff to use and follow. These were based on national guidance and evidence based practice.
- The trust provided information which indicated they had completed a diverse range of audits for each specialty to compare their practice with national best practice guidance such as guidance published by the National Institute of Health and Care Excellence (NICE).
- Staff completed a self-assessment of their management of sepsis, against the recommendations of a report produced by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) in 2015 entitled 'Just Say Sepsis!'
- Between 1 February 2015 and the 31 January 2016 patients at the Heart of England NHS Foundation Trust had a higher expected risk of readmission for non-elective admissions in cardiology, geriatric and general medicine and a higher expected risk for elective admissions in gastroenterology and clinical haematology.

Pain relief

- Patients told us that staff asked if they were in pain. We observed staff administering pain relief medication. We saw that Pain scores were used to assess patients' pain levels and were documented consistently.
- Staff recorded pain scores routinely and consistently and these were up to date in the 25 patient records we looked at. We asked seven patients about pain relief. In each case they said their pain was managed well and staff asked them frequently how they were feeling.

Nutrition and hydration

- We observed the lack of a consistent approach to assessing patients' nutritional risk during our inspection. We found nutritional risk assessments had not been undertaken for all patients on admission. This meant that patients at risk of malnutrition might not be initially identified.
- Relatives of a patient on the gastroenterology ward told us they had seen a patient feeding other patients and feared their own relative had not been fed. We brought this to the attention of the ward manager who was aware of a potential problem at breakfast time. The night staff gave patients breakfast at 7.00am prior to going off duty and day staff did not come out of hand over report until 7.30am. This left no one to assist patients incapable of eating independently. Domestic staff removed trays prior to day staff coming back onto the ward, although they informed nursing staff which patients had not eaten their breakfast. Due to this, a change of practice had been proposed by the ward manager and meetings had taken place with staff. Day staff were to start giving breakfasts to patients after report at 7.30am so this problem did not continue.

- Records of patients' food and fluid intake were not consistently maintained and when the patient was not receiving intravenous fluids, we found daily totals of patients' fluid intake were not always calculated making it difficult to assess patient's food and fluid intake. It was therefore possible patients with inadequate intake would not be identified.
- All the patients we talked with said they were provided with fresh water at their bedside and they had access to hot drinks regularly.

Patient outcomes

- The trust participated in national audits relevant to the service which included the National Dementia Audit.
- There were 14 medical outliers at the time of inspection. One had not been seen since initial clerking in A&E for six days. We informed the trust of this at the time.
- Patients who were ready for discharge were taken to the discharge lounge. However a small proportion of them would be sent back to the ward as patient transport was limited; this was operated by another provider. However The Heart of England NHS Foundation Trust results were better than the England and Wales average for three of the seven standards relating to discharge.
- The hospital had lost its Joint Advisory Group (JAG) accreditation due to constantly breeching its eight week referral time. However, the trust was working very closely with JAG to regain this accreditation. JAG sets national standards for gastro-intestinal endoscopy and accreditation provides assurance that a service is meeting the required standards.
- Trust 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, in particularly Cardiology inpatient. The hospital was 100% compliant with the Myocardial Ischemia National Audit Project (MINAP).
- The trust took part in the 2015 National Diabetes Inpatient Audit. They scored better than the England average in 14 metrics such as staff awareness of diabetes and worse than the England average in 20 metrics such as able to take control of diabetic care. The indicator regarding "seen by the MDFT within 24 hours" 0% at Heart of England had the largest difference versus the England average (53%).
- The Heart of England NHS Foundation Trust took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in the most recent audit from January 2016 to March 2016. Five individual "Key performance Indicators" KPI's dropped by one grade in the latest audit for 2016. Staff were actively working to improve this. However the October 2015 audit figures show the trust scored a "B" .
- The trust scored about the same as other trusts in the 2015 CQC In-patient survey as well as the Cancer patient experience survey 2015.
- The standard risk of being readmitted was higher than the national average. However the average length of stay was lower than the national average.
- The 2015 staff survey results showed an improvement in scores compared to 2014, however the trust remained in the bottom 20% of acute trusts nationally (97th out of 99 acute trusts nationally).

Competent staff

- Bank staff told us they had clinical supervision on the ward however, no one specific held this role. One member of staff told us they were not invited to team meetings and they were often block booked for six months full time hours. In addition, we were told bank staff had no appraisals, despite being on bank for five years full time.
- Bank staff told us they could access and book training online.
- HCA staff told us there were opportunities to complete continued professional development; for example one staff member told us they had started a diploma in Adult Health and Social Care.
- A newly qualified nurse from outside of the UK described how their English speaking was limited upon arrival to England to take their role as staff nurse in the trust. However, the trust provided additional English lessons through the Educational Centre.
- Substantive staff told us they had all received appraisals on a yearly basis which were a good opportunity to receive feedback and discuss opportunities for additional training. Appraisal rates Between April 2016 and September 2016, 84.6% of staff within Medical Care at Heart of England NHS Foundation Trust had received an appraisal compared to a trust target of 85 %.
- Nursing staff told us their induction was four to six weeks during which they received training in skills such

as medical devices, cannulation, aseptic techniques and intravenous medication administration. Health care assistants HCA's told us their induction had been for two days.
- Staff we spoke to told us they were up to date with mandatory training including training such as Early Warning Scores (EWS). Staff told us that additional training would have to be approved by a manager.

Multidisciplinary working

- We observed effective multi-disciplinary relationships and cooperation between different professional groups. 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 a culture of sharing information since they had been divided into divisions across the three hospitals. This had been especially obvious in respiratory/cystic fibrosis and the endoscopy teams.
- Therapy staff, including a dietician and a therapy support assistant told us there was good multi-disciplinary working on Ward 21, with a ward handover held every morning to share information about patients. Staff from other wards also 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. The electronic patient board was visible to anyone walking past the nursing station.
- Staff spoke of a varied level of teamwork; sometimes staff worked effectively together and communicated well, at other times this was not the case.

Seven-day services

- Therapy staff told us there was cover on Ward 21 over seven days; week day hours was from 8am to 4pm, with additional cover at weekends. An out of hours on call service was provided for evenings when staff were not on site.
- Telemedicine was available on the ASU and HASU stroke wards so the on-call consultant could look at scans, blood results and offer advice overnight and weekends. The consultant lead and medical director told us "we would love a full seven day week embedded service".
- The endoscopy unit was a five day week service with waiting list initiatives on Saturdays. The matron for endoscopy told us the CEO had secured funding to double the service and hoped that would lead to a seven day service.

Access to information

- Policies and guidelines were accessible to staff via the trust intranet. We found they were easy to access and the guidelines we checked were current. However, bank staff could not gain access to the guidelines through the trust intranet but told us they were familiar with them.
- Staff reported that the IT system was unreliable with eight systems, none of which talked to each other. The trust was aware of the aging and failing computer system and was giving it a high priority.
- All patient records were available but were securely locked in note trolleys, except on the stroke units.
- Care summaries were provided 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 patients care with the most up to date information. This could be printed; however, the printed version only provided the last entry made by a staff group, therefore some context could be lost as the member of staff reading the notes would not be able to see previous entries. However, more information could be viewed by accessing this information electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act (2005) and DoLS was displayed on noticeboards within the ward areas.
- Staff had a basic understanding of capacity and consent. However, they told us when people could not make decisions about their care and treatment, a DoLS application would be made. A DoLS is not always required when a patient is unable to consent to treatment. A senior doctor told us they completed mental capacity assessments regularly.
- Permanent therapies staff demonstrated an excellent knowledge of the principles of informed and implied consent as well as the Mental Capacity Act (2005) in

relation to patients with dementia. Staff who had been recruited from outside of the UK told us they felt the induction and training on this topic was "excellent" and they felt well prepared to care for patients as a result.
- All nine DNACPR forms we looked at had been correctly completed with full documentation around lack of capacity.

Are medical care services caring?

Good

We rated medical care services as good for caring because:

- We observed many face to face caring interactions between staff and patients. Most staff we observed treated patients and relatives with dignity, respect and compassion.
- Patients told us they felt involved in their care and treatment. We observed doctors, nurses and therapists explaining tests and treatment to patients.
- The respiratory ward had its own psychologist who had devised a screening tool to ascertain if people wanted to talk about end stage care. Although this had not been audited the results and patient reactions had been very positive.
- We heard mostly good comments from patients and relatives about the care they had received. One patient told us "The nurses are so busy I just don't know how they keep so happy but they always seem to have a smile on their faces". A relative told us "even though they are so busy they have made me feel like I'm the only person on the ward".

Compassionate care

- We observed a nurse aiding a patient to swallow tablets; they presented as caring and taking their time with the patient. The nurse checked the medication had been swallowed by asking the patient to open their mouth.
- Patients told us that staff had been caring and friendly and the staff had provided excellent treatment.
- Patients told us when they press the call bell for assistance, staff arrived within minutes. However, on one ward we saw a call bell lit up for an extended period of time without being answered.
- Most patients told us they felt they had been treated with respect; and could think of no improvements for the staff to make.
- Two relatives of the same patient reported to us that they were not happy with their relatives care. They told us they felt one of the family had to be at the hospital most of the time to ensure their relative received the correct care.
- The trust participated in the NHS Friends and Family Test (FFT) and individual wards were responsible for displaying and acting on results. The Friends and Family Test response rate for Medical Care at the Heart of England NHS Foundation Trust was 36% which was better than the England average of 26% between 1st July 2015 and 31st June 2016.

Understanding and involvement of patients and those close to them

- We observed a nurse engage well with a patient's family to ask questions regarding health.
- Patients told us staff 'do not talk down to you', and doctors and consultants took time to explain medical terminology.
- We observed positive interactions between doctors, nurses and patients in some cases on ward all wards visited. We saw doctors explaining procedures and treatment plans to a patients using simple language that helped them to understand despite their confusion.
- We saw a nurse ask a relative if they would like a cup of tea as the patient had gone for a procedure and they were sat by his bed alone. The relative told us, "They didn't have to do that, I'm not the patient, but I'm so glad they did. I cannot believe how well these nurses are looking after my [relative] and me".

Emotional support

- Some services had developed their own resources to help provide emotional support to relatives. For example, older people's services used best practice guidance from the Alzheimer's Society and Dementia UK to help relatives and friends of patients understand complex mental health needs and signpost them to support.
- The respiratory and cystic fibrosis ward had their own psychologist/counsellor and social worker to give all round emotional and practical support to their patients.

Medical care (including older people's care)

Are medical care services responsive?

Requires improvement

We rated medical care services as requires improvement for responsive because:

- Access and flow to the service was often poor. Between July 2015 and June 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance.
- The endoscopy department had lost its JAG rating.
- Patient transport, late discharge medication and some nursing homes not prepared to accept patients after 4pm all caused delays to discharges. Patients sometimes went to the discharge lounge but had to return to a ward due to delays in discharge, which meant the patients had to stay an additional night in hospital.
- At the time of inspection we found fourteen medical outliers due to the lack of an appropriate medical bed.
- Complaints were not responded to in a timely manner.

However:

- The latest figures for July 2016 showed 92.1% of this group of patients were treated within 18 weeks. The average length of stay was now lower than the national average.
- The endoscopy unit and senior management had secured funding to expand the capacity of the service and were working closely with JAG to regain their accreditation.

Service planning and delivery to meet the needs of local people

- We saw minutes of weekly divisional management meetings which discussed service planning, access and flow of divisional departments and how it could be improved upon to meet the needs of local people. We saw minutes from the monthly board meetings that showed plans and ideas had been taken upwards through the organisation.

Access and flow

- Between 1st March 2015 and 2nd February 2016 the average length of stay for medical elective patients at the trust 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, which is better than the England average of 6.7 days.
- Between July 2015 and June 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall.
- Between September 2015 and August 2016, 44% of individuals did not move wards at the hospital during their admission, and 56% moved once or more, which ran the risk of poor outcomes for patients, such as disorientation especially for the holder patient.
- The matron on ward 21 (elderly care) said that the average length of stay was 13 days and that 'bed blocking' was an issue because of being unable to discharge patients to the appropriate place such as social care.
- Due to lack of forwarding care in the community patients hospital stays were lengthened causing bed blockages from between one to two weeks.
- We also found that patients in the discharge lounge awaiting patient transport were often delayed and in some cases re-admitted and not always to the same ward. Late discharge medication and some nursing homes who were unprepared to accept patients after 4pm all caused delays to discharge.
- Some nurses 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 possible. However with nursing staff shortages this was not always possible as it would leave the ward areas unsafe. In these cases appointments had to be re-booked sometimes several days later.
- The respiratory/cystic fibrosis ward had developed a discharge planning board JONAS. A triangle system was used, a forward slash indicated the patient had been seen and was having active treatment a backwards slash meant that that therapists had been required and taken up treatment and a hyphen meant the patient was ready for discharge when the triangle was complete. The board proved very effective as a discharge tool and has now been rolled out across the trust.

Meeting people's individual needs

Medical care (including older people's care)

- We spoke with a patient's daughter. The patient was Bangladeshi and spoke no English, we asked the daughter about how translation services had been arranged by the hospital. The daughter said she had been asked to stay, including overnight, to translate for her mother. No translation services were offered. The daughter said she was very tired as she felt she had to stay at the hospital well beyond visiting hours to translate.
- A ward manager told us that relatives were not used for translation of clinical related issues but this is contradictory to what a relative told us. A telephone service (Language line) was the trust's chosen method. The same manager said staff were discouraged from booking a face-face interpreter.
- We observed staff working with a patient who was at high risk of falls; when it looked like they were getting out of bed unaided, staff immediately attended to the patient to support them.
- A dietician told us a variety of food was available for patients, with different needs catered for such as vegan and vegetarian food, and food prepared according to certain cultural requirements. If a special request for a certain type of food was made, this could usually be accommodated.
- There was good information about dementia on wards for carers but we did not see this put into practice. There were 'about me' booklets but these were seen in patient notes and ran the risk of not being utilised effectively.
- Each patient had a named nurse, which was displayed on white boards for patients and family could refer to. We saw these were up-dated every shift.
- Patients' opinion of the quality of the meals was that it was "Very nice but not much of it". Of the 29 patients we talked with about their perception of the food, all told us it was good or adequate. Comments such as "The food is lovely," and "Better than I get back home," were common.

Learning from complaints and concerns

- Between August 2015 and September 2016 there were 333 complaints about medical care at the trust. The Heart of England NHS Foundation Trust took an average of 99 days to investigate and close complaints; this is not line with their complaints policy. 131 complaints related to clinical care.
- One member of staff told us they were unaware of any complaints made by patients or families, however, stated that compliments to staff were consistently reported back.
- Two family members complained that their relation had received poor care and did not feel their concerns had been listened to. They had been unaware of how to make a complaint. We saw no information on the notice board on how to make a complaint and the ward sister said she had never seen information leaflets on the ward. We contacted the patient advice and liaison service (PALS) at the hospital who informed us they had merged with complaints. Therefore new leaflets had been printed along with information posters which we later saw on most wards we visited. Information was relayed to the relatives.
- We saw many examples where there had been positive changes in protocol after receiving a complaint or concern. For example ward two had changed early morning role allocation of nursing staff to ensure patients had nurses there to assist them with breakfast and document any problems that occurred.
- Complaints resulting from falls had led to a change in practice. Once a patient has been assessed as at risk they were cohort nursed in a ward which was visible from the nurses' station. Extra staff were allocated to the bay. At night time a nurse sat outside the bay and small night lights stayed on at the side of patients' beds. One ward manager told us this had lessened the incidents of falls on her ward by 50% since it started, but there was no data to demonstrate this.

Are medical care services well-led?

Good

We rated medical services for well-led as good because:

- Some staff were aware of the board strategy to achieve financial balance and secure the long term future of the trust.
- Most senior staff we spoke with were aware of that vision and although there had been a period where they had experienced many changes, they were excited about the future of their departments and the trust as a whole.

- We were told that management was visible and accessible by most staff members. Staff told us they felt listened to.
- The trust had many plans for the improvement and sustainability of the service and had made many improvements since the last inspection. For example no 18 week breaches for referral to treatment since July 2016.

However:

- Some junior nursing staff could not tell us who the management or chief executive officer was and some did not feel supported or listened to.
- Although the trust had a rolling recruitment programme the staff vacancies on the wards were causing poor staff morale at ground level.

Leadership of service

- Five new management divisions were created in April 2016. There were two divisions covering medical care across the trust. Each division was led by a divisional director who was supported by finance, operations and nursing.
- The minutes of a divisional board meeting held in July 2016 indicated that quality and performance issues were discussed along with actions to improve. These meetings were due to take place on a three monthly basis. We saw that weekly divisional management team meetings had also been initiated.
- Staff told us they felt well supported by management at local and at senior board level. We were told management at all levels were both visible and accessible.

Vision and strategy for this service

- Staff told us they were aware of a new set of trust values but could not recall them. There was information available about these but staff said they did not get time to read it. The new trust values were displayed on wards we visited.
- No staff spoken with at ward level knew what the local or trust-wide strategy was.
- 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.

Governance, risk management and quality measurement

- The re-structuring into divisions had provided an opportunity to revise the local framework for ward to board reporting. Management were positive about the revised framework and felt it would bring medical wards even closer to the board whilst evidencing assurance of clinical quality across the organisation.
- Performance in relation to key quality and safety key performance indicators were monitored 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 we saw action plan to improve future practice.
- We saw the risk register for medicine and noted a range of risks were identified relating to the hospital. Although new risks had been added, some risks had been on the registered for over five years and it was unclear as to whether these had been reviewed regularly.

Culture within the service

- Most ward managers, matrons and sisters told us how excited they were to see the changes that were happening to their departments and were looking forward to the future.
- Medical staff said local leadership is generally good and they know more about what happens at ward level. They told us that they felt well supported and were involved in research and had training coaches which many of their colleagues based at other hospitals did not.
- However one staff member reported that in the past she would see the head nurse; but now they do not know who this was. Some junior staff said they did not know who the executive management team were.
- Most staff said they felt they were listened to and senior staff and managers were supportive. A consultant said there had been a culture change and they had seen improvement month on month, since the new management team had commenced.
- However only one junior member of staff spoken to was aware of the name of the Chief Executive.
- The 2015 staff survey results had shown an improvement in scores compared to 2014, however at the time of inspection the trust remained in the bottom 20% of acute trusts (97th out of 99 acute trusts nationally).

Medical care (including older people's care)

Public engagement

- We found examples of patient and public involvement in many of the developments within the service.
- The respiratory/ cystic fibrosis wards had developed the service after listening to patients and as a result, employed a psychologist and social worker to offer the whole care package in one unit.
- Patients' relatives and carers were invited to take part in the "Tell us what you think" campaign. Posters and comment cards were seen in corridors and on some wards. We did not have audit data about this as it had not been collated. However the friends and family audit results were higher than the national average.

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. One senior nurse told us, "If you're given a gift, you want to own it."
- Staff were invited 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 remain in the bottom 20% of acute trusts (97th out of 99 acute trusts nationally). The 2016 survey data was not yet available.

Innovation, improvement and sustainability

- Plans for local quality improvement projects were seen from the 2015/2016 Quality Champion Programme. For example to improve the interstitial lung disease service.
- Staff had improved the admission process for cystic fibrosis patients, as they returned regularly to the hospital.
- There was a plan to take part in the 'Sign up to safety – reducing harm from diabetes medication' initiative with a target of 50% harm reduction by 2018.
- For sustainability of the endoscopy service, finance was approved to double the endoscopy theatre beds at Heartlands hospital from the current two to four. This would help reduce waiting times and regain JAG accreditation.

Surgery

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

Information about the service

Birmingham Heartlands Hospital (BHH) provides a range of emergency and elective surgery to the local population. This includes general surgery and a range of specialties including thoracic surgery, vascular surgery, trauma and orthopaedics, urology and ear, nose and throat surgery.

There are nine main operating theatres and seven surgical wards.

Birmingham Heartlands Hospital (BHH) carried out 26,225 operations from April 2015 to March 2016.

We spoke with a number of people during our inspection, including 12 patients and family members, and 42 staff of various grades and positions. We reviewed 12 care plans and patient records. During the unannounced inspection, we visited four surgical wards and one theatre. In addition, during the announced inspection we visited seven surgical wards and two theatres. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed documentation from stakeholders and performance information from the trust.

Summary of findings

We rated this service as requires improvement because:

- BHH reported four never events from August 2015 to July 2016. Three of these incidents related to procedures which were carried out on the wrong site of the patient's body, indicating that learning from the first incident did not take place in a timely manner.
- Medicines were not stored safely and in line with requirements. We found some patient's controlled medicines were past their expiry date, medicines which should have been protected from the light were not, and the temperature of the refrigerators used to store medicines exceeded recommended limits at times.
- Patients with a fractured hip waited for up to 12 hours for their pressure relieving mattresses.
- Patients experienced delays in their journey from admission to discharge. This included delays in returning from the operating theatres to the wards due to a lack of available beds on the surgical wards.
- Delays in discharging patients occurred due to waits for medicines to take home (TTOs)
- Services were not always responsive to the needs of individual patients and those who were vulnerable. Staff did not always use the trust's translation service

Surgery

and instead used patients' families and friends to interpret for them when discussing patient care. There was limited provision for patients living with dementia or a learning disability.

- Staff described a lack of visibility from senior management on the wards. Most ward staff said they did not know who their senior managers were.
- Governance structures were in place but were not fully embedded. Risks were not always identified and managed appropriately.
- Staff described a blame culture when being held to account for incidents during root cause analysis (RCA) executive forum meetings.

However, we also saw:

- There was a good incident reporting culture. Managers shared learning from incidents with staff through newsletters, ward meetings, handovers, between teams and staff notice boards.
- The environment was clean throughout BHH. The wards and theatres we visited were clean, tidy and regularly maintained.
- We observed good multidisciplinary team (MDT) working relationships among staff across wards and theatres.
- A dedicated pain specialist nurse was available on the wards and staff had access to the pain team.
- Staff provided a professional, caring and compassionate service to patients within a calm ward atmosphere. Patients and families confirmed this to us, and we saw it through reviewing the comments in the NHS Friends and Family Test (FFT) questionnaire, which was positive.
- We observed good interactions between staff and patients. Staff treated patients, families and relatives respectfully and maintained their dignity. Staff also gave opportunities for families and relatives to talk about the care and they felt involved.
- Ward managers had a positive leadership culture and supported their staff in the departments by being visible, and providing an open door policy that enabled staff to access them and talk about issues. Staff also echoed this sentiment when we interviewed them.
- BHH had some innovative practices such as its hybrid vascular theatre (combined operating theatre and interventional radiology suite), which meant it could see and treat a higher volume of vascular disease patients.
- In addition, BHH provided an innovative lower limb amputation programme, which provided a holistic package of MDT working to vascular disease patients.

Surgery

Are surgery services safe?

Requires improvement

We rated effective as good because:

- BHH followed National Institute for Health and Care Excellence (NICE) guidance and nationally recognised best practice.
- The surgical directorate's engagement with national and local audits was good and used to monitor outcomes and identify opportunities for improvement.
- Nursing staff received appropriate specialist training, appraisals and effective supervision and understood their role. Staff supported clinical staff to complete their revalidation (renew their registration).
- There were good multi-disciplinary team (MDT) working relationships across both wards and theatres. Review of minutes of MDT meetings also showed good working relationships within the surgical directorate.
- Patients and families told us that referrals between specialities such as the vascular one stop surgery service were effective within the department, where patients spoke highly of receiving a complete package of care and services from staff.
- BHH had a dedicated pain specialist nurse who was available on wards every day in addition to staff who had access to the pain team.

However:

- 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.
- Patients had a higher than expected risk of readmission following elective and non-elective surgery. Elective general surgery had the largest relative risk of readmission.

Incidents

- The trust reported three surgical never events between August 2015 and July 2016. These were a surgical invasive incident in January 2016 involving a patient who required left hip aspiration (procedure where fluid is drained from a joint), consented for a right hip aspiration, and underwent a right hip aspiration. Staff reported a medication incident in March 2016, which involved the block of musculocutaneous nerve on the wrong thigh. A further incident occurred in October 2015 involving a patient where staff did not retrieve the tip of the chest catheter and a further operation was required to remove the object from their lung.
- The never events which occurred in January 2016 and March 2016 both involved procedures in which were undertaken on the wrong site, and suggested that learning from the first incident had not taken place when the second incident occurred.
- However, during the inspection we saw several 'stop before you block' (eradicate wrong sided peripheral nerve block) posters around the theatres suites to reduce the risk of wrong site surgery occurring in the future.
- The trust had an electronic incident reporting system. Staff were familiar with the system and understood how to report an incident.
- Staff and ward managers shared learning during handovers, ward meetings and weekly newsletters. A ward manager described an incident reported to them six months before, which involved a patient who had a grade 2 pressure ulcer. The ward manager showed us the action plan for tissue viability, which they displayed on the staff notice board as a way of sharing learning from the incident to staff.
- Incidents formed a standing agenda item in wards and theatres during handovers and we saw minutes of incidents discussed at team meetings.
- Staff told us they had also completed training in incident reporting awareness, and records showed 100% of staff had completed the training in August 2016 against a trust target of 85%.
- The trust reported 14 serious incidents (SIs) between August 2015 and July 2016 for the surgical division. These mainly related to healthcare associated infections (HCAI) and infection control incidents meeting SI criteria that accounted for 29% of all incidents reported. Three also related to surgical invasive procedures. We observed how staff shared learning from serious incidents through newsletters and staff notice boards.

- We saw minutes from monthly mortality and morbidity meetings, which included representatives from all the surgical specialities. The purpose of the meetings was to identify learning points and improvements in practice following patient death. For example, we noted learning following the death of a patient who had not received medication reviews. We saw how staff disseminated the learning across the sites.
- 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. Nursing staff we spoke with were aware of the need to be open and honest with patients. Ward managers were also able to show us the duty of candour form, which identified the process and responsibilities.
- Staff across wards and theatres gave examples of when they had implemented the duty of candour, such as a patient who developed a pressure sore. Staff sent out a personalised apology letter to the patient, which we observed on their patient record. Staff gave another example regarding a patient who developed a grade 3 pressure ulcer. We saw example letters of the three stages of the duty of candour to this patient, which involved an apology, outcome of the investigation and invitation to discuss with the patient the details of the investigation, and provided further support to the patient.

Safety thermometer

- The NHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism. Data from the patient safety thermometer showed that there were 82 pressure ulcers, 10 falls with harm and 16 catheter associated urinary tract infections (C.UTIs) reported in the year from August 2015 to August 2016.
- The prevalence rate (number of patients per 100 surveyed) reduced from September 2015 to August 2016 for pressure ulcers, falls and C.UTIs.
- The surgical divisions', average of harm free care from August 2015 to August 2016 was 95% and scored higher than the England average of 94%. The months of September 2015 and July 2016, scored lower than the England average with scores of 93.9% and 93% respectively. This indicated that a lower than average number of patient harms were reported on these wards for most months.
- In addition, the surgical directorates' data for prevalence of new pressure ulcers from September 2015 to August 2016, showed the prevalence of new pressure ulcers decreased from September 2015 to May 2016, after which the prevalence rate increased. The prevalence rate of C.UTI decreased from October 2015 to August 2016.
- 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. More detailed information and analysis was available to staff on the trust intranet system.
- Staff carried out 94% of venous thromboembolism VTE assessments in the surgical assessment unit (SAU) from September 2015 to August 2016.
- Staff were able to tell us how strategies were in place to mitigate the risks of developing pressure ulcers. For example, they liaised with the tissue viability lead, and drop in training sessions for staff were available. In addition, staff liaised with the medical photography team, who took pictures of any pressure ulcers if staff felt they were uncertain about correctly grading pressure ulcers.
- Staff discussed pressure relieving interventions such as repositioning patients who were at risk of developing a pressure ulcer at least every 6 hours. In addition, when patients were at high risk of developing a pressure ulcer, staff repositioned them every 4 hours. Staff checked patient's skin daily, and followed the prevention care bundle.
- We saw ward managers displayed a safety cross on their ward notice boards to record the numbers of pressure ulcers occurring on a daily basis and provided information on the prevention of pressure ulcers and falls. The safety cross records the incidence of factors that influence safety day by day on a monthly basis and show at glance the number of patients who develop a pressure ulcer or a fall.

Cleanliness, infection control and hygiene

- The environment on the wards we visited was visibly clean. Patients and their families told us the standard of cleanliness was high at all times.

- Staff completed infection control training (hand hygiene, sharps and inoculation injuries were part of this training), where records showed 90.1% of staff completed the training in August 2016 against a trust target of 85%.
- MRSA is a type of bacteria that is resistant to a number of widely used antibiotics. There were two cases of MRSA bacteraemia (blood stream infection) occurring over 48 hours after admission from 1 August 2015 to 31 July 2016, and 25 cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) post 48 hours from 1 August 2015 to 31 July 2016.
- Staff screened patients for carriage of Methicillin-resistant Staphylococcus aureus(MRSA) during the pre-admission process. Procedures were in place to enable patients that had an infection to be isolated.
- There were seven cases of Clostridium difficile (C.difficile) from August 2015 to July 2016 in surgery at BHH. When there was an increased incidence of C. difficile on a ward, enhanced environmental audits were completed on a weekly basis and wards were required to achieve 90% or more for three consecutive weeks and have no more clusters of C.difficile prior to the audit being discontinued.
- Hand gels were available across all wards and theatres when entering and leaving the wards. However, during our unannounced inspection we found ward 10 and ward 12, had dispensers, which were empty when entering the wards. However, when we pointed this out to the ward managers, they ensured staff replaced them immediately.
- We noted staff washed their hands and complied with guidance and were bare below the elbow (clinical staff adhered to having their sleeves rolled up to above the elbow with no jewellery or watches other than a plain wedding band) when in clinical areas. Ward managers and matrons were also confident in adopting a zero tolerance approach in challenging clinical staff when needed if they were not compliant.
- Patients also told us that staff were very good at infection control and always washed their hands and used hand gels for any patient contact.
- We observed in theatres a scrub nurse and two surgeons following the correct surgical hand scrub technique in line with trust policy.
- Staff maintained theatre discipline practice by wearing appropriate theatre wear and ensured effective hand hygiene and decontamination to reduce the risk occurring during a procedure. However, some staff were wearing scrub clothes in the staff canteen on the BHH site, which was against the trust policy.
- Staff completed hand hygiene audits on all the wards. Between September 2015 and September 2016, ward 5 and ward 8, scored under the trust compliance target of 95% for at least eight months and ward 12 only achieved the trust target for one month. We saw the infection control board displaying hand hygiene results and how clean your commode is results on the notice boards of all the wards we visited.
- Surgical site infection rates for patients following surgery for a fractured hip at BHH for the period between January 2016 and March 2016, was 1.2% as compared with a rate of 1.5% for all hospitals participating in the audit.

Environment and equipment

- Ward environmental health and safety audit results showed the surgical wards achieved above their target of 85% compliance from August 2016 to October 2016. We found that staff tested electrical equipment for electrical safety, within the required timeframes. We saw maintenance logs and service schedules, which confirmed that clinical staff maintained the equipment.
- We saw evidence of staff checking the resuscitation trolleys daily, where checks had been completed and documented.
- Staff had timely access to the equipment required to provide safe care, and if equipment required repair, staff reported it to the maintenance department who fixed it in a timely manner.
- We found there was lack of storage available within the treatments rooms and as a result, boxes of intravenous fluids were stored in a treatment room which caused an obstruction. There was a separate room for the storage of fluids but due to a lack of space they were stored in the treatment room. Lack of storage was a problem across the BHH site we inspected, where equipment was being stored at corridors, causing an obstruction.
- Staff from the trauma and orthopaedics speciality, told us pressure relieving mattresses were hired from an external company. If it was late at night, they were delivered the next morning. This meant that fractured patients with a fractured hip could wait up to 12 hours for pressure relieving mattresses.

- Staff also told us that there was a shortage of electric beds and bariatric beds across the wards. Staff had to spend time locating bariatric beds and equipment from other wards in the trust. This caused delays in providing the correct beds for bariatric patients and a shortage of electric beds increased moving and handling challenges for staff and patients.
- In addition, both medical and nursing staff said it was a common problem for IPAD connectivity problems when completing WHO checklists for patients. Staff were however, able to mitigate any risks by using paper copy versions of the WHO checklists when the connectivity problems occurred.

Medicines

- We observed safe practices in relation to the storage and use of medicines within theatres. Medicines were stored safely behind locked doors and only accessible to appropriate staff. Anaesthetists prepared medication on a patient-by-patient basis, such that only one patient's drugs were out at any one time.
- Nursing staff on wards were wearing red 'do not disturb' tunics whilst engaged on medication rounds, which enabled them to concentrate on the job in hand.
- During the week, a clinical pharmacist monitored the prescribing of medicines, visited the wards daily, and was readily available for advice about medicines.
- Staff told us of a monitoring system to ensure the timely administration of the first dose of antibiotics and medications for Parkinson's disease. It is particularly important that these medicines are given in a timely manner. This involved the nurse in charge holding an electronic bleep which would be activated if any of these medicines had not been given.
- Patients' records we observed also showed evidence of ward pharmacists completing antibiotic reviews.
- However, when we reviewed the documentation of fridge temperature checks across the wards, staff were not recording the maximum temperatures and were writing it out as the recommended temperature i.e. between two degrees Celsius to eight degrees Celsius. We also found in ward 12 that staff recorded the maximum temperature of 10 degrees Celsius from the period of 10 October until 19 October 2016, which staff did not escalate.
- The controlled drugs within the wards were segregated from patients own medication and medication supplied by the pharmacy department. We saw evidence logs of two staff checking and signing it daily. However, we found expired patient controlled medications dated back to August 2016, which was not disposed of correctly. Staff told us that pharmacy support has been very limited and wards tended to do their own stock rotation.
- Other issues we found included liquid medicines that had no date of opening, which meant staff did not know the date by which they must stop using it, as it was no longer safe to use.
- In ward 12, intravenous fluids (IV) were only accessible to authorised staff but were not always in the correct appropriate labelled sections increasing the risk of errors occurring. In addition, in ward 12 medicines that required protection from light were not always stored appropriately and were stored on open shelving.
- Nursing staff used Patient Group Directions (PGDs). However, the one in use for paracetamol had expired in July 2015. PGDs are a means of giving medicines without a prescription. The staff administering these PGDs and adding to the electronic record had not received any training in their use. The staff member we spoke to was not competent to administer medicines under PGDs.
- There was an electronic system to prescribe and administer medication. However, there was no mechanism within the electronic system to ensure that the site of administration medicines skin p patches were appropriately rotated in line with the manufacturer's instructions. In one case, we saw staff discontinue an opioid patch on the electronic prescription but the patch was still in on the patient. This suggested there was no record of this patient continuing to receive opioid medication.

Records

- During our unannounced inspection, we found in some wards that staff left patient note trolleys opened. We followed this up during our comprehensive inspection and found this practice continued. Ward managers told us that the trust had ordered the keypad locked trolleys to overcome the problem.
- We checked three patient care records during our unannounced inspection, which were legible and accurate, however they did not have the patients name, date of birth, height and weight. However, during our announced inspection we reviewed five bedside

documents and four patient records which were all accurate, legible and no concerns were identified. All had a nursing healthcare risk assessment booklet and care plans were completed appropriately.
- Staff were able to tell us how they were mitigating the risk of patients developing pressure ulcers. We saw three patient records in wards, which indicated that staff had checked patients repositioning, skin checks, falls bundle and catheter management.
- We also observed three patient records in theatres, which were legible, accurate, signed, and dated correctly.

Safeguarding

- The trust had a safeguarding policy, which was up to date with review dates included.
- Staff were able to tell us who the identified safeguarding lead was. When staff completed an incident related to safeguarding, it automatically alerted the safeguarding team who monitored the case.
- Safeguarding training was a mandatory subject. Staff we spoke with understood their responsibilities in relation to safeguarding both children and adults.
- The trust target for all safeguarding completion was 85%. Nursing staff completion rates for safeguarding training modules exceeded the trust target. Records from September 2016 showed nursing staff had a training completion rate of 99% for safeguarding children and adult level 1, and 98% for safeguarding children and adult level 2. Safeguarding children level 3 had a training completion rate was 94%.
- Medical staff had a training completion rate of 92% for safeguarding children and adult level 1 and 93% for safeguarding children and adult level 2.

Mandatory training

- Ward managers told us about an "easy learning" system which alerted staff when training was required to be completed. Staff across wards and theatres described easy access to training from an online system, which staff could access at home.
- Staff were required to complete mandatory training after their initial induction and probationary period. The surgical directorate's total average showed 90.5% of staff had completed their mandatory training against a trust target of 85% in August 2016.
- Modules with the lowest completion rates were waste management and safer swallowing of 55% and 79% respectively in August 2016.

Assessing and responding to patient risk

- Staff monitored patients throughout their stay in the hospital and used the national early warning system (MNEWS) to identify patients whose condition was deteriorating. By recording patient observations on the MNEWS score sheet, staff were able to recognise changes in the patient's health and based on the score staff could escalate the patient's condition to more senior or experienced staff and seek medical assistance. We reviewed patient records and found an example of staff escalating to a doctor, which staff also escalated to the outreach team.
- The trust wide metrics data for the surgical directorate for patient observations showed 97% total completion of observations in August 2016.
- Nursing handovers took place on each ward at 7.00am each day. We observed two handovers. Staff assessed and responded to patient acuity (tools used to measure estimated nursing staffing levels against a rise in patients), needs and risks and shared information about patient preferences. We also observed a safety huddle in ward 8, where the nurse in charge checked the national modified early warning score (MNEWS) charts, medications, nursing metrics, safeguarding, falls and pressure ulcers with each nurse.
- The trust reviewed compliance with the WHO checklist. This is a nationally recognised safety system in theatres to prevent never events and other serious incidents. We observed good practices in theatres for the journey of treatment from start to finish for two patients. We saw medical staff correctly following all parts of the WHO checklist for these two patients.
- The data from the WHO checklist audit from September 2015 to August 2016 showed there was a total activity of 31,675 surgical operations with staff completing 99.5% of the WHO checklists. However, the occurrence of three never events in this period, raises concerns as to the effectiveness of the audits in identifying shortfalls in practice.

Nursing staffing

- The ward managers used an e-rostering system tool to plan adequate cover of suitably qualified staff on the wards. BHH reported the establishment numbers on August 2016, which was 159.33 whole time equivalent (WTE) versus 141.79 of staff in substantive posts.
- Between May 2016 and August 2016 the surgical wards achieved their planned registered nurse staffing levels at least 91% of the time. However, agency staff usage was high on some wards.
- Between October 2015 and September 2016, the trust reported a bank and agency usage of 18% in surgical care, with BHH having the highest average bank agency and bank use of 22%. The highest average agency and bank staff use was 42% in theatres 6 and 7, and theatres Twin and ward 12 both with an average of 29%. Staff told us that there was a plan in place to reduce the numbers of agency and bank staff by employing more full time posts.
- The surgical division provided agency staff with induction training.

Staff reviewed staffing daily with a 72-hour forward look by senior management to monitor shortfalls, skill mix and for any potential risks, staff put a plan in place to mitigate the risks.

- In September 2016, the trust reported a turnover rate of 6% in surgical care with general surgery reported a turnover rate of 9% and thoracic surgery a rate of 8%. Anaesthetics, surgery management of nursing staff and vascular surgery all reported 0% turnover rate. The trust did not provide data comparative data to compare with.
- Between April 2015 and March 2016, the trust reported a sickness rate of 4% in surgical care, with urology reporting the highest sickness rate of 7% while ENT and general surgery both reported a sickness rate of 5%, and vascular surgery reported the lowest sickness rate of 1%. The trust did not provide any comparative data to compare with other trusts.
- Nurses felt the staffing levels were low on ward 8, ward 9 and ward 12. When we spoke to student nurses, they told us that it affected their work placement, as nurses were busy with patient care. Patients told us there were limited numbers of staff at night, which delayed patient needs being attended to by staff.

Surgical staffing

- Medical staffing within the surgical directorate consisted of 371 WTE posts. These consisted of 41% consultants, 20% middle career doctors (At least 3 years at senior house officer or a higher grade within their chosen speciality), 27% Registrar group and 12% junior doctors in foundation year one or two. The staffing mix differed from the average of all England average hospitals where the skill mix was 43% consultant, 10% middle career, 35% Registrar and 11% junior.
- The medical staffing levels including bank and agency for September 2016 for theatre 6 and 7 was (83.56%), theatre day surgery (89.36%), theatre main (79.23%), and theatres twin was (91.69%).
- There was a lack of FY1 and FY2 (foundation doctors) within the hospital. BHH mitigated the risks where staff grade doctors covered gaps in the rota and consultants covered registrar roles.
- FY1 and FY2 doctors told us that the trust provided them with a good induction, and staff had been welcoming and consultants were supportive. Staff told us that shortfalls in junior doctors caused delays to patient discharge due to delays in prescribing patients' (TTO'S). Therefore, patient waiting times increased, as staff delayed patient reviews due to medical staff being in theatres.
- Between April 2015 and March 2016, the trust reported a vacancy rate of 19% in surgery where junior medical staff vacancy rate was 28% and senior and career medical staff a vacancy rate of 10%.
- In September 2016, the trust reported a turnover rate of 2% in surgery where junior medical staff reported a 0% turnover and senior and career medical staff reported a turnover rate of 5%. In addition, the trust reported a 1% sickness rate in surgery in September 2016.
- Between October 2015 and September 2016, the trust wide data reported a bank and locum usage rate of 8% in surgery for trauma and orthopaedics where urology reported the highest average bank use of 21% and locum staff use of 17%. Thoracic surgery and vascular surgery reported the lowest usage of bank use of 1% and locum use of 0%.
- At the BHH site, the urology treatment centre had a full staffing establishment and used no agency staff, as it was a specialist centre. Any gap in medical staff across the surgical directorate was risk assessed and filled with bank locum posts at night and the weekends.

Major incident awareness and training

- Staff told us that they were major incident procedures in place if major incidents occurred. Ward managers

showed us their business continuity folder, which included lock down plans if they needed to relocate or evacuate. Training exercises took place on wards regarding evacuation drills.
- Staff were able to handle medical emergencies and knew the procedures involved. Staff gave us an example of a patient who stabbed themselves with a knife where staff followed emergency protocols to mitigate the risks.

Are surgery services effective?

Good

We rated effective as good because:

- BHH followed National Institute for Health and Care Excellence (NICE) guidance and nationally recognised best practice.
- The surgical directorate's engagement with national and local audits was good and used to monitor outcomes and identify opportunities for improvement.
- Nursing staff received appropriate specialist training, appraisals and effective supervision and understood their role. Staff supported clinical staff to complete their revalidation (renew their registration).
- There were good multi-disciplinary team (MDT) working relationships across both wards and theatres. Review of minutes of MDT meetings also showed good working relationships within the surgical directorate.
- Patients and families told us that referrals between specialities such as the vascular one stop surgery service were effective within the department, where patients spoke highly of receiving a complete package of care and services from staff.
- BHH had a dedicated pain specialist nurse who was available on wards every day in addition to staff who had access to the pain team.

However:

- 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.
- Patients had a higher than expected risk of readmission following elective and non-elective surgery. Elective general surgery had the largest relative risk of readmission.

Evidence-based care and treatment

- Trust policies and procedures were available on the trust intranet and staff reported they could access them easily. Staff members we spoke with were also clear on the health and safety policy and procedures. The trust reviewed and updated the trust policies and guidelines at regular intervals and they were based on NICE and Royal College guidelines.
- Staff spoke highly of their evidence based sepsis care pathway. Staff had knowledge and awareness of the pathway, and were confident to locate it on the trust intranet.
- The surgical directorate had a vascular surgery service, which operated as a one-stop 'shop' for diagnosis and treatment for venous and arterial diseases. The department involved a combination of radiology and vascular specialists working alongside each other for improved patient care and service.
- Staff from the vascular department described their major lower limb amputation pathway development, which involved reviewing and making decisions to operate on patients within 48 hours. It provided a package of holistic care including seeing a member of the diabetes team within 12 hours of admission, in addition to a dedicated pain team being available to patients before and after the operation. Staff also offered written information and counselling to patients and their family.

Pain relief

- Pain relief was assessed and recorded along with the NEWS. If the score was higher than four, staff escalated to the doctors and the outreach team. A dedicated pain specialist nurse was present on wards each day; they reviewed patient's history and wrote recommendations in their notes.
- Following surgery, patients had epidural effective pain relief where appropriate. If patients continued to experience pain staff were able to consult with the acute pain team.

- Patients told us that they received pain relief promptly. We reviewed a patient record, which showed that staff responded appropriately to refer a patient to the pain clinic.

Nutrition and hydration

- Staff assessed all patients prior to, or on admission, and monitored and recorded nutritional intake and fluid balance throughout the day. Patient records we observed contained hydration charts which were completed consistently and indicated patients were given adequate fluids
- Data provided by the trust for meal service audit between October 2015 and September 2016, indicated an average of 93% satisfaction of meals from patients.

Specialist diets and referral to dieticians were also available.

- Staff used age appropriate nutrition monitoring tools in line with British association for parenteral and enteral nutrition (BAPEN) guidance.
- Drinks and snacks were available throughout the day. If patients missed meals due to treatment sessions or if patients were hungry between meals, staff provided additional meals. Patients confirmed this to us and told us there was always plenty of drinks and food available on the wards. One patient described staff going the extra mile for them, for example, the patient did not like soup and got what they requested such as ice cream.
- Staff discussed also having a day's training in administering total parenteral nutrition (TPN) to patients who required this form of nutrition.
- BHH had a consistent approach for fasting guidelines on the length of time that patients abstained from food and fluids prior to surgery. Patients confirmed this to us, where staff gave patients clear instructions about fasting prior to admission to surgery.

Patient outcomes

- The trust participated in national audits to assess the outcomes for patients and compare them with other trusts. Following the audits they developed action plans to address the issues and improve the care provided.
- The results from the National Hip Fracture Audit (2015) for the hospital were mixed. The risk-adjusted 30-day mortality rate was 7.4% which was within the expected range, although the rate had increased from 6.6% in 2014. The proportion of patients having surgery on the day or day after admission was 62.2% which did not meet the national standard of 85% although there was an improvement from 52.3% in 2014. The length of hospital stay, although reduced from 27.4 days in 2014 to 22.8 days in 2015, fell within the worst 25% of trusts nationally.
- 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 addition, the risk adjusted 18-month temporary stoma rate in rectal cancer patients undergoing a major resection was 39%, which made the hospital a positive outlier.
- The 2015 national vascular registry (NVR) audit showed a risk-adjusted post-operative in hospital mortality rate of 0.9% for abdominal aortic aneurysms, which indicated the trust performed within expectations. Within expected carotid endarterectomy (surgical procedure to unblock a**carotid**artery), the median time from symptom to surgery was 10 days, which was better than the national standard of 14 days. The 30 days risk adjusted mortality and stroke rate was within expected range, indicating the trust performed within expectations.
- 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 two measures, amber for six measures and red for three measures. The measures which scored red and required improvement 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.

- **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.
- Theatre utilisation at BHH averaged 95% in June, 94% in July and 90% in August 2016. These figures indicated a good utilisation of theatre time.
- Between March 2015 and February 2016, patients in surgical services at the hospital had a higher than expected risk of readmission for non-elective admissions and a higher than expected risk for elective admissions. The elective speciality general surgery had the largest relative risk of readmission.
- The trust provided poor quality data for the national Oesophago-Gastric Cancer Audit (NOGCA) 2015, where more than 15% of records had the referral source missing, for age and sex adjusted proportion of patients diagnosed after an emergency admission were submitted. The 90-day postoperative mortality rate was 6.1%, which placed the trust within the expected range.

Competent staff

- The trauma and orthopaedics speciality had specific internal teaching for nurses which involved the band 5 skills programme covering topics within trauma and orthopaedics.
- Staff discussed clinical issues and outcomes in an open learning environment. They confirmed the process included professional development, the enhancement of clinical skills and encouragement to attend courses.
- The trust target was for 85% of staff to have an annual appraisal. In August 2016 the surgical division appraisal rates for ENT and thoracic surgery were above the trust target, and other specialties within the surgical division although not meeting the target, were above 82%. The divisional theatre appraisal rate was 92%.
- The appraisal rate for allied health professionals were 92% and exceeded the trust target. Staff were supported to maintain their registration with their professional body. Revalidation ensures that staff retained their skills in line with changes and improvements in clinical practice. Ward managers told us a system was in place for checking professional registration was renewed and up-to-date.

Multidisciplinary working

- Multidisciplinary (MDT) working was evident throughout the surgical services at the hospital. We saw evidence of assessments of patient needs and care planning by therapy services, dieticians, physiotherapy, occupational therapy and consultation between medical and nursing teams of different disciplines.
- Staff described a good working relationship and easy access to MDT services to support patients. We also reviewed the minutes of the MDT meetings which also showed a good working relationship within the surgical directorate.
- We saw good MDT working during a handover. MDT staff made recommendations for patients such as using the physiotherapy services for a patient. We also observed a MDT ward round, which worked well for staff and patients.

Seven-day services

- The hospital inpatient wards operated a 365 day per year service, medical cover was available at all times with consultants on call for advice, guidance or attendance when required.
- Ward rounds operated seven days per week in all surgical wards with consultant input. Emergency patients were reviewed at weekend ward rounds. There was also a consultant on call rota out of hours. Plans for patient care were also in place such as weekend cover.
- An Emergency theatre was staffed 24 hours a day, seven days a week, with staff on site. A second on call theatre team was available on call should they be required.
- The pharmacy department was open seven days a week with an out of hours cupboard containing medicines that may be required in an emergency. Staff could access medicines through the on-call pharmacist service.
- Emergency diagnostics were available seven days a week and on site outside normal working hours. Interventional radiography was also available for patients from the trust.
- The trust was working on developing an elective seven day service, but said they required further resources and financial input to deliver a full seven day service.

Access to information

- Policies, guidance and general information were available to all medical and nursing staff on the trust intranet site.

- Computer systems were password protected and each member of staff had their own login details.
- Staff told us they had information technology (IT) problems when accessing patient information and completing WHO checklists.
- Staff shared medical alerts and general information about the trust through online newsletters, and emails. We also saw how learning from incidents and minutes of team meetings were displayed on staff room notice boards.
- We saw patient notes that had evidence of care summaries sent to patients GP on discharge, which ensured continuity of care within the community. Information was also thorough in notes when referring patients between teams and services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us that both medical and nursing staff always followed correct procedures for obtaining consent. Signed consent forms were also present in the patient records we reviewed.
- Training was available for staff in Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS) which was part of their mandatory training.
- Staff we spoke with had a good knowledge of MCA and the documentation needed for mental capacity assessments and best interest decisions for those lacking capacity to make decisions. We saw a mental capacity assessment was completed for a patient on the computer, which a doctor completed. MCA patient advice leaflets were also available on the wards.
- We reviewed the enhanced observation policy document, which was a process for staff on managing patients safely that required greater observations during their stay at the hospital. Staff were able to refer mental health patients to the rapid assessment interface and discharge (RAID) team, which provided a service to adults over 16 years of age.
- BHH carried out enhanced special observations from September 2015 to August 2016, where staff reported 725 enhanced observation specials and 13 special patients. There was no information to indicate whether staff applied DoLS in these circumstances.

Are surgery services caring?

Good

We rated caring as good because:

- Staff treated patients with compassionate care across wards and theatres. We saw examples of positive interactions from staff, and patients confirmed this to us.
- There was a professional, calm ward atmosphere on all the wards and theatres. Patients and family members told us that staff treated them respectfully and maintained their dignity.
- We observed staff treating patients, family members and relatives respectfully.
- Staff gave relatives the opportunity to talk about their care and they felt involved.
- Staff being courteous, polite and friendly when interacting with patients and families.
- Feedback from patients who used the friends and family test (FFT) questionnaire was positive.
- Staff gave patients time to discuss any concerns or worries. Patients felt staff were thoughtful and listened to their needs.
- We saw examples of staff providing emotional support to patients when discussing sensitive issues about their treatment. Staff allowed patients time and space in a side room.

Compassionate care

- The Friends and Family test (FFT) was used to obtain patients' views on whether they would recommend the service to family and friends. FFT satisfaction rates were high with almost all responses being extremely likely or likely to recommend services. Patients and relatives also confirmed this to us when we spoke to them.
- The response rate in the FFT between July 2015 and July 2016 was 46%, and was better than the England average of 30%.
- However, the trusts FFT results for ward 10, ward 4 and ward 9 showed a recommendation rate of 0% between May 2016 and June 2016. Staff we spoke with told us this was due to staff not distributing the FFT cards to patients. However, they developed a system where the housekeeper gave the FFT cards to patients to increase

the response rates. Furthermore, we saw FFT cards being readily available on the wards. We viewed a comment on one of the FFT cards, which said, "Nurses day and night were so very caring and helpful".

- During our unannounced inspection, we observed how staff interacted with patients and their families. We saw many positive interactions between staff on duty, with patients and their relatives and visitors to the wards. For example, a staff member held a patient's hands to assist her to walk to the toilet whilst smiling and chatting to her. During the announced inspection, we saw a staff member plumping up the pillow for a patient so that they were more comfortable when they slept.
- There was a professional, calm ward atmosphere on all the wards and in the theatres. Patients and family members we spoke with told us that staff treated them respectfully and maintained their dignity. For example, we saw staff closing the curtains behind them when consulting with patients.
- During our unannounced inspection, we spoke to three patients who described "amazing compassionate care" from staff whilst coming through accident and emergency assessment unit to the ward. Patients described care from staff as being "faultless and supportive". Patients also echoed this sentiment during our announced inspection, who described the care from staff as "magic, excellent and provided a personalised care".

Understanding and involvement of patients and those close to them

- During our unannounced inspection, six patients told us they felt well looked after and fully informed about their plan of care. They told us they saw senior staff and doctors throughout the day and during that time, they were able to talk with them and discuss any issues.
- During our announced inspection, relatives told us they felt staff communicated effectively and were given time to talk about the care and they felt involved. For example, a relative of a patient who had dementia felt they were involved with their treatment by being part of their "this is me booklet" Patients said they liked the way staff referred to them by their nicknames, which we also observed staff doing. Patients described staff approaching them with big smiles. One patient described how staff supported him and talked him through everything when he was anxious before his operation.

Emotional support

- Patients and relatives told us that staff treated them compassionately and in a thoughtful way. Staff allowed patients time to talk and discuss their worries and concerns.
- Patient said staff provided emotional support to them when receiving sensitive information about their treatment. During our unannounced inspection, one patient described staff providing emotional support when he received bad news. Staff hugged him, allowed him to talk, and were there for him. During our follow up inspection, we saw doctors used a side room to discuss sensitive information with a patient. Staff gave the patient as much time and space as they needed.
- Staff provided emotional support to depressed patients by referring them to the mental health team. We saw a staff member talking to a patient living with dementia who was anxious due to being among other patients in the discharge lounge. The staff member sat her down behind reception until she became calmer.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were delays at various points of the patient's journey. Staff told us there were delays in managing the flow from theatres to wards. Delays in discharging patients created a backlog of theatre / recovery patients waiting for a bed to be available on the wards.
- Although a telephone translation service was available, staff used families and relatives to act as interpreters for patients when discussing patient care.
- There was 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. Staff felt access to specialist advice was not readily available.
- The facilities were not always suitable for patient needs. The shower and toilet facilities on some wards had no lockable doors or curtains to maintain privacy and dignity. A ward we also visited had open bay for patients with no doors, causing concerns from staff of infection control issues.

Surgery

- The trust took up to 134 days to investigate and close complaints, which did not follow the complaints policy, which states complaints, should be investigated and closed within 30 days.

However, we also saw:

- The trust met the needs of local people by providing a vascular one stop diagnosis service provided by a team of vascular and radiologist specialists.
- The trust was responsive to our concerns in one of the wards during our unannounced visit. They were able to respond, put in place a refurbished separate toilet, and shower facility for patients.

Service planning and delivery to meet the needs of local people

- BHH provides a wide range of specialist surgical services to people in the Birmingham region. BHH maintains services local to patients by working with other hospitals and care bodies. BHH provides a vascular service, which meets the needs of local people by offering a one stop diagnosis and treatment for venous and arterial diseases.
- The wards we visited across the specialisms provided single sex bay accommodation, to maintain patient's privacy and dignity. The toilet facilities were also separate for male and female patients.
- Accessibility to kitchen facilities was available to patients, families and relatives on the wards to enable them to make drinks and snacks while at the hospital. This gave flexibility to family members and relatives to relax and take a break from the emotion of being on the wards.

Access and flow

- Staff felt there were delays in managing the flow through theatres onto the wards. Staff felt there were not enough beds to manage with the increased demands of population activities at the hospital.
- Delays occurred in the discharge process due to waits for take home medicines. In addition, staff on ward 5 told us they regularly discharged patients at night in order to make beds available to medical patients from the accident and emergency department (medical outliers)
- On ward 8, we observed on 19 October 2016, the trauma and orthopaedics department had five medical outliers displayed on their system. This impacted on the admission of surgical patients.
- The main concerns for discharge were related to the availability of medicines for patient to take home (TTOs). Medical staff did not prescribe TTOs until the day of discharge and there were delays in pharmacy due to queries relating to the prescriptions for patients. As a result the discharge lounge was not able to be utilised as effectively as possible as the criteria for admission was that TTOs should be available prior to patients being transferred to the discharge lounge and this was not always adhered to by staff. Furthermore, staff told us there were delays in social service home care packages not being ready on time, which meant that patients could miss transport and returned to the wards.
- We observed the electronic discharge computer system across wards and found staff did not discharge patients according to the KPI targets. Ward managers told us that they were not meeting the target of discharging three patients before lunchtime and discharging 10 patients per day. The trust did not undertake any audits to monitor any improvements in discharge, and could not provide data on how many patients they discharged before lunchtime.
- Staff told us and we also saw on the risk register that there was a delay to clinical treatment due to shortages of FY1 and FY2 doctors.
- 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 for June 2016 and July 2016 was 91% of this group of patients were treated within the 18 week target time.
- The percentage of patients whose operations were cancelled and not treated within 28 days was between zero and three. The highest numbers of cancelled operations were recorded as three in quarter two 2014/15, and in quarter one 2015/16. Staff reported zero cancellations from quarter three 2015/16 to quarter one 2016/17.
- Cancelled operations as percentage of elective admissions were mostly better than the England average. However, during quarter one 2015/16 and quarter two 2015/16 trust percentages were worse than the England average.
- From April 2015 to March 2016, the average length of stay for surgery elective patients at the trust was 3.2

days, compared to 3.3 days for the England average. For surgical non-elective patients, 4.4 days was the average length of stay compared to 5.1 for the England average. Data from BHH, showed the average length of stay for patients with fractured hip, was higher than the England average, with scores of 21.1 versus 20.7 from August 2015 to July 2016.

- Elective operations were cancelled at times when emergency procedures were prioritised. Staff made an instant decision to prevent delays for urgent operations by cancelling low risk and low priority patients. If low priority patients suffered three cancellations, staff had systems in place to treat them as a priority so that they did not get any further cancellations.
- The average bed occupancy rates for surgical wards were very high from September 2015 to September 2016, for ward 10 (95%), ward 9 (96%) and ward 2 (98%).
- Staff described a good working relationship with patients' GP's.

Meeting people's individual needs

- Staff told us the trust had access to translation services through a telephone line and also used their own staff who had a diverse background in languages. However, staff said they rarely used the telephone translation service and, instead used patient's relatives and families to interpret. Staff told us that booked face-to-face interpreters did not always arrive and this meant some patient's treatment had to be cancelled or postponed. BHH could not provide information on how often this happened and it was not on the risk register.
- Staff described how they responded to support patients with a physical or learning disability. For example, ward 12 responded to the needs of a deaf patient by developing pain cards, which assisted with communication.
- However, across wards and theatres, staff were not clear on whom to report to if they needed advice and guidance on supporting patients with a learning disability. People with a learning disability frequently have a document often called a hospital passport to provide additional information for staff on the person's care and support needs and their personal preferences. Staff did not complete such a document with the person and their carer if they did not come in with one.
- Staff felt although there were learning disability nurses available within the trust, it was difficult to access a learning disability nurse, which they could have benefitted from.
- The doctors completed a dementia diagnostic assessment, which the ward manager showed us on the computer screen. However, staff were not able to tell us if there was a clear structure on who to approach for internal advice when responding to and understanding patients living with dementia. BHH did not take advantage of learning from the dementia outreach team in Solihull, which was a dedicated team specialising in the care of patients living with dementia.
- During the unannounced visit, we witnessed patients waiting for long periods for staff to respond to patient call bells on the wards. However, when we followed this up during our inspection, we found staff responded to calls much more quickly. In addition, when we spoke with patients they had no concerns other than at night when they said it did take longer to respond to call bells.
- During our unannounced visit, we saw in ward 11 that there was only one bathroom in use due to refurbishment of a bathroom, which potentially represented a mix sex breach. Staff could not tell us when it was due for completion and told us this situation had been in place for several weeks. However, our announced visit confirmed that the trust had completed the changes to the ward and we found that there was a refurbished separate toilet and shower facility for male and female patients.
- The shower facilities on some wards did not have curtains or lockable doors for patients. Furthermore, when we visited the ENT department there were bays with no doors, which the ward manager felt was a potential infection control issue. The ward manager told us they had raised the issue but had not been able to progress it.

Learning from complaints and concerns

- From September 2015 to August 2016, there were 322 complaints about surgical care services across the trust. The trust took an average of 134 days to investigate and close complaints, which was not in line with their complaints policy, which states complaints, should be investigated and closed within 30 days.

Surgery

- 54% of the complaints related to clinical care and a further 15% related to communication and information problems. Staff when interviewed said, communication was a theme for complaints from patients.
- Staff discussed complaints at monthly governance meetings and shared them with team members at their local team meetings and through newsletters and emails. We saw minutes of these meetings and staff confirmed that senior staff shared lessons learned.
- Staff gave an example of learning from complaints and concerns. Patients were not happy with nursing staff completing their notes outside the bays. Staff responded by having the notes trolley within each bay and allocated a table and chair within each bay so that nurses could do their notes and be visible to patients.
- Ward managers discussed how they try to deal with initial complaints prior to going to patient advice liaison service (PALS. Staff were able to tell us how to locate the PALS information if patients needed to make a complaint further. However, when we spoke to patients they felt they did not know the process of how to make a complaint, nor did they know the names of whom the ward managers were.

Are surgery services well-led?

Requires improvement

We rated well led as requires improvement because:

- Staff from BHH surgical division were not clear about the vision and strategy for the trust. Staff felt this was due to so many changes in the management structure over the years having an impact on BHH.
- Staff felt senior management including the chief nurse and executive team were not visible on wards and most staff did not know who they were.
- Risks were not always recognised and managed in a timely way. Some risks were on the risk register for over 12 months and were not actioned.
- Staff described a culture of being accountable for incidents following on from root cause analysis (RCA) executive forum meetings. However, staff felt they did not accomplish anything from attending the meetings.

However:

- Staff described a positive leadership culture and felt supported by their ward managers who were visible in the departments and provided an open door policy (encourage staff to be open and transparent).
- There were examples of innovative practices; staff were proud of their hybrid vascular theatre being one of three only in the United Kingdom. In addition, the general surgery ward won a “pride of nursing” award for providing good care to a young mother who was underweight and had a genetic disorder. The vascular surgery department were proud of their major lower limb amputation pathway development, providing a complete MDT package to patients.

Leadership of service

- Staff across all wards described ward managers as supportive, approachable and visible on wards. They said there was good leadership from ward managers, which we also observed during our inspection. Staff were confident that their managers understood them, were aware of their strengths, weaknesses and supported them to improve.
- However, staff and ward managers described the matrons and the executive team as not visible on wards and most clinical staff did not know who the senior management were. Staff described the senior management as being visible only when things went wrong, and felt the senior management should be visible on wards when positive outcomes occurred with patients.

Vision and strategy for this service

- Staff told us that the appraisal process was effective and linked to the trust vision and values. Documents we reviewed corroborated this.
- However, despite the vision being part of the appraisal, staff did not have a clear understanding of what the vision and strategy was for the trust. Staff described the uncertainty created by the changes to the executive team in recent years.
- 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 initiated.

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 meeting 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.
- Staff discussed and identified incidents and trends at their monthly governance meetings. We reviewed the minutes of the governance meetings, which confirmed this. Managers shared information by sharing feedback with staff through posting lessons of the month on staff room notice boards, highlighting trends and themes.
- Staff told us during RCA executive meetings, staff discussed incidents and investigations took place to identify ways to reduce patient incidents occurring. Ward managers described the meetings as quite challenging and felt they were held to account rather than any learning outcomes being developed. A ward manager said for example that when an infection control incident was discussed, they would be the only representative and there was no input from the lead for infection control.
- Staff were not confident about the governance arrangements and described entering risks on the risk register and the risks remaining on the register for years. For example, the risk register showed that staff raised inadequate staffing levels in 2013 for ward 12, ward 8 and ward 9, with no timescale for completion dates.
- Other risks which staff told us about and we saw that had been on the risk register for more than two years were insufficient ward bed capacity in thoracic surgery and vascular surgery. In addition, lack of theatre capacity at times of increased activity within trauma and orthopaedics, and the urology department. Furthermore, staff described a lack of electric beds across the trust, which staff did not highlight as a risk on the register.
- Ward managers discussed the nursing quality matrix data, which consisted of key performance indicators, that staff audited and reported monthly for each surgical ward. From March 2016 to August 2016, BHH achieved a score of 95% and above, and met the target of 95%. If a ward scored below 95%, the matron would be involved and the quality improvement framework was followed.
- The nursing harm free care metrics for ward 12 were below the 95% targets for nursing metrics. We reviewed the ward improvement plan, which highlighted that the ward improved their performance for all nursing metrics, from 80% in May 2016 to 94% in August 2016. The area for concerns for September 2016 were meal audits, peripheral venous catheter (PVC) audits, hospital acquired infection (HAI), blood glucose documentation, tissue viability and nutrition assessment.
- We reviewed the minutes for the surgical directorates nursing care quality and efficiency meetings, which were represented by a varied range of senior management. Each surgical directorate from BHH and Good Hope Hospital provided an update of the governance issues and care quality metrics data for each site, which clinical staff discussed monthly.

Culture within the service

- Staff described a culture of good teamwork, a friendly environment and staff felt well supported by ward managers. There was good morale and staff from some wards said having an established team helped with good teamwork.

Surgery

- Staff described previously a division between the three different hospital sites who worked differently from each other. Staff, now felt the unity of divisions worked better and there was a positive culture among staff who viewed themselves as working for one trust.
- Staff told us they felt listened to and could raise issues and discuss them individually or as a team. In addition, staff could raise concerns through effective ward supervision, and during safety huddles.

Public and staff engagement

- Patients and visitors were encouraged to express their views on the NHS choices website or leave feedback cards.
- Managers gave staff feedback from the FFT during weekly staff meetings. Managers also displayed the FFT information on staff notice boards addressing the problems raised by patients and what measures they put in place such as introducing meal co-ordinators on wards to improve meal satisfaction among patients, which did previously affect the FFT results.
- Staff said communication from monthly divisional meetings was more established, which increased contact with other staff from the divisions by allowing staff to make suggestions for improvements and changes for the service.
- However, staff were not told of the future merger and felt communication should have been better internally rather than having to find out through social media.

Innovation, improvement and sustainability

- Staff from the general surgery ward, were proud to be nominated by the Birmingham Mail and won a “pride of nursing” award in 2015 for providing good care to a young mother who was underweight and had a genetic disorder.
- BHH was proud of their hybrid vascular theatre, which we were told was the busiest custom made endovascular service in Europe. The service was also a useful educational platform for training purposes for staff.
- Staff from the vascular department were proud of their innovative major limb amputation pathway development, which provided a holistic package and multi-disciplinary pathway to patients.
- BHH was also proud of their urology treatment centre, which provided patient centred care to both cancer and non-cancer related patients.

Critical care

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

Information about the service

Critical care services at Heartlands Hospital consisted of an intensive care unit, a high dependency unit and a critical care outreach service. The intensive care unit (ITU) has11 level 3 beds (beds for critically ill patients, who have complex care requirements and require ventilation). The separate high dependency unit (HDU) has eight level 2 beds (high dependency beds, for non-ventilated patients). Patients were admitted to the both ITU and HDU from the emergency department, theatres, wards and other departments in the hospital. The trust had another critical care unit at Good Hope Hospital and when needed patients may be admitted from Heartlands Hospital to Good Hope.

The intensive care and high dependency units at Heartlands Hospital admitted 1,407 patients between 1 September 2015 and 31 August 2016.

The trust is a member of the regional critical care network which means that the critical care units have peer review audits and support from other critical care services within the West Midlands.

We visited both ITU and HDU during our unannounced inspection on 6 September 2016. We spoke with three patients, two relatives and 15 staff: nurses, doctors, therapists, and managers. We observed care and treatment, and looked at the records of seven patients on both ITU and HDU. Before the inspection, we reviewed performance information about Heartlands Hospital critical care services. We last inspected critical care services at Heartlands Hospital in November 2013 when we rated critical care services as good.

Summary of findings

- We found that overall critical care services at Heartlands Hospital were rated as good.
- Staff were caring and compassionate.
- There were sufficient and competent medical and nursing staff available to provide care and treatment for patients seven days a week. However the availability of other health professionals such as physiotherapists did not meet intensive care core standards.
- The leadership, governance and culture of critical care services promoted the delivery of safe, high quality person-centred care.

However we also saw that:

- The critical care units (ITU and HDU) did not meet the needs of a modern service. There were no toilet or bathroom facilities within either ITU or HDU.
- Heartlands Hospital is a regional infection diseases centre. There were three side rooms within the intensive care unit (none within the high dependency unit), which could be used for critically ill patients with infections. However, none had modern facilities (negative pressure to contain any bacteria within the room) to reduce the risk of cross infection to other patients.

Critical care

Are critical care services safe?

Good

We rated critical care services as good for safe because:

- There were appropriate systems in place to highlight risks, incidents and near misses and appropriate actions taken to ensure lessons were learnt.
- There were sufficient medical and nursing staff available to provide patients with timely care and treatment.
- There were mostly appropriate arrangements for the safe administration and storage of medicines.
- Records were appropriately completed and identified the patient's treatment plan and the care and treatment they had received.

However we also saw that:

- Whilst we observed that staff consistently washed their hands to minimise the risk of cross-infection and met hand hygiene standards, hand hygiene audit results did not consistently meet the trust target.
- The management of peripheral venous catheters (PVC) between 3 March and 13 September 2016 within both ITU and HDU did not consistently comply with the required standards and put patients at increased risk of cross infection. The environment of Heartlands Hospital critical care units (both ITU and HDU) was not sufficient to meet the needs of a regional infectious diseases centre.
- Information submitted to Intensive Care National Audit and Research Centre showed that Heartlands hospital had a 'higher than expected' mortality rate. Medical staff reviewed all patient deaths to check they had received appropriate care and treatment.

Incidents

- There were eight serious incidents reported to the Strategic Executive Information System (STEIS) between July 2015 and July 2016. Four incidents related to patients with grade 3 pressure ulcers, and three patient infections. Senior staff told us that every serious incident was investigated through a root cause analysis (RCA) investigation process. We looked at a selection of RCA investigations, which included pressure ulcers and incidence of infections and saw that when required actions were identified, they were being addressed.
- The trust had an established system for reporting incidents and near misses through a centralised electronic reporting system. The critical care units (intensive care and high dependency) had reported 486 incidents between 12 September 2015 and 12 September 2016. The highest number of incident reports made included: tissue viability (245), medication (43), admission transfer discharge (36) and medical devices and equipment (30). The matron told us that a senior nurse or doctor reviewed each incident and the investigation was proportionate to the grading and any harm to the patient.
- Staff (both medical and nursing staff) said they had reported incidents, such as pressure ulcers, medication errors or general concerns about care. Staff told us they had mostly received feedback about the incident they had raised.
- The intensive care unit (ITU) and high dependency unit (HDU) had a weekly staff update called 'Burgers'. Staff told us and we saw that the weekly update identified and shared learning from incidents with staff, such as the use of inappropriate equipment to secure patient breathing equipment.
- There were no Never Events in the twelve months prior to our inspection. 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.
- Information provided by the trust identified there had been 15 Duty of Candour incidents that related to critical care services (ITU, HDU and critical care outreach). The majority of incidents related to hospital acquired pressure ulcers (12). Staff we spoke with said they had received information about 'Duty of Candour' and said it was about being honest and telling the patient or their representative if things went wrong. The matron discussed actions they had undertaken following two Duty of Candour incidents, which included patients who had developed a grade 3 pressure ulcer. We found that appropriate actions had been undertaken.

Critical care

Safety thermometer

- The Safety thermometer between 1 July 2015 and 31 July 2016 identified there were seven pressure ulcers and one urinary infection reported within ITU and HDU. There had been no falls with harm between 1 July 2015 and 31 July 2016.
- Records we looked at showed that staff completed risk assessments for patient pressure ulcers and venous thromboembolism (VTE) at the time of the patient's admission and were then reviewed appropriately. However, information provided by the trust identified that the VTE risk assessment target of 95% was not met for 11 months between Sept 2015 to August 2016 with scores from 74% and an average of 85%. However, the target was met in October 2015 when 96% of patients were assessed for their risk of a VTE.

Cleanliness, infection control and hygiene

- The intensive care (ITU) and high dependency (HDU) units were both visibly clean and tidy. There were cleaning plans in place, which identified the frequency that cleaning should take place. We saw that staff completed audits to check the cleanliness of both units. The audits identified ITU cleanliness between 98% and 100% which met the required cleanliness standards between January 2016 and March 2016. HDU compliance was between 92% and 99% meeting the trust targets in all but one period reported (January to March 2016).
- Hand sanitising gel was available at both ITU and HDU entrances, at each bed space and throughout the units. However, in ITU the hand gel was not immediately visible when you went through the door which may mean that staff and visitors do not use it to ensure appropriate hand hygiene. Signs to remind both staff and visitors about hand hygiene were visible throughout the unit.
- We observed that the staff washed their hands appropriately and wore appropriate personal protective equipment (PPE). Staff used different coloured aprons for each bed space to show they only used the apron within that bed space area. Effective hand washing alongside the use of gloves and aprons reduces the risk of cross-infection.
- A senior nurse checked staff compliance with hand hygiene. Monthly handwashing audits between 3 March and 13 September 2016 showed compliance in ITU was between 70% and 90% and in HDU compliance was 70% to 100%. The trust target of 95% was not met for two months for ITU and five months for HDU. The matron told us that feedback was given to staff who did not comply with appropriate hand hygiene and hand hygiene audits were shared within the monthly critical newsletter.
- Critical care services (ITU and HDU) at Heartlands Hospital audited the management of peripheral venous catheters (PVC) and urinary catheter insertion to minimise the risk of hospital acquired infection. We saw that critical care services (both ITU and HDU) met the required standard for catheter management most of the time. However, ITU did not meet the required PVC standard for four months between 3 March and 13 September 2016 and HDU for three months with compliance between 60 and 100%. A failure to comply with required standards may put patients at increased risk of cross infection. We saw that this information was shared with staff. However there was no corresponding increase in either catheter or peripheral venous infections
- One incidence of methicillin-resistant staphylococcus aureus (MRSA) and two cases of Clostridium difficile (C.diff) infections within critical care at Heartlands Hospital since 1 April 2016 had been reported.
- Staff told us and records we looked at confirmed that patients admitted for planned surgery were screened for MRSA infection.

Environment and equipment

- Staff told us that there was appropriate equipment to meet patients' needs. We found that medical equipment identified the required checks had been undertaken. Staff told us that any broken or faulty equipment was sent for repair and was returned in a timely manner.
- We saw that staff checked the resuscitation equipment daily and, when needed, it was restocked. There was a record of when the equipment was checked and by whom. The monthly environment audit also included a review of the checks.
- We saw that staff completed environmental health and safety audit checks of both ITU and HDU. The audits identified ITU had met the required environment standards between 1 March 2016 and 12 September

2016. However, HDU in June and August 2016 had not met the required standard and an action plan was in place. We saw that action plans were identified to improve and required actions had been undertaken.

- Heartlands Hospital is a regional infection diseases centre, which means it may take patients with infectious diseases from across the Midlands. The ITU had three side rooms, which could be used for infective patients. None of the side rooms were negative pressure rooms, which reduce the risk of, cross infection to other patients. Staff told us that critical care infectious patients were usually transferred to Good Hope Hospital, which had all critical care single rooms. Staff told us that the lack of critical care negative pressure rooms was a challenge. Staff told us that the day before our inspection the unit had a highly infections patient in a side ward alongside another patient who was highly susceptible to infection.
- Staff raised concerns about the environment of both ITU and HDU. They told us and we observed that there was limited storage or space available which around bed spaces, which may be problematic during an emergency.
- A buzzer system was used to enter the ITU to identify visitors and staff, and ensure that patients were kept safe.

Medicines

- Medicines were securely stored. The medicines refrigerator temperatures, including the minimum and maximum temperatures were recorded daily. A regular check on temperature provided assurance that medicines are stored safely, and their effectiveness was not adversely affected. However we found that the room temperature where medicines were stored was not being recorded so staff could not be assured that other medicines were being kept within their recommended temperature conditions.
- A CQC Pharmacist reviewed the arrangements for controlled medication during the announced inspection and found that the medication and associated paperwork were appropriately completed and safely stored.
- We found that there were no date of openings on liquid medicines therefore staff could not be assured that they were within their use by date and therefore safe to use.
- The critical care units (ITU and HDU) used a paper-based medical prescribing and medication administration record system for patients. We saw that nursing staff signed to confirm that medicines had been given or the reason they were not given. We checked five sets of patient medication charts. All the medication records we checked were completed correctly.
- A senior pharmacist visited the critical care units (ITU and HDU) Monday to Friday to check patient's medicines and provide advice to doctors when required. There was a top up medicine service for stock and other medicines were ordered on an individual basis. Staff reported that there was an effective on-call service, out of hours. This meant that patients had access to the medicines they needed.

Records

- Critical care units (ITU and HDU) at Heartlands Hospital used paper based patient records. Records were completed and filed in a consistent manner to enable staff to locate required information about the patient, their treatment and care needs.
- We looked at five patients records during our announced visit. We saw that the records were clear and identified the treatment that patients had received and any further treatment or follow-up plans.
- The intensive care and high dependency units used paper-based nursing documentation, which was present at each bed space. Each record covered 24 hours and included the frequency and type of observations and risk assessments required. These included pressure ulcer risk, nutrition risk, coma scale, and delirium assessments. We saw that observations were checked and recorded at the required frequency, any deviation from expected results were escalated to medical staff.
- There were clear records of the treatment that patients had received and any further treatment or follow-up they required.

Safeguarding

- The trust policies and procedures were in place for safeguarding children and vulnerable adults. Staff we spoke with knew how to access safeguarding policies and procedures on the trust's intranet. Critical care staff working on ITU, HDU and critical care outreach gave us

examples of safeguarding concerns they had raised. Information provided by the trust identified that critical care staff had made 18 safeguarding referrals that required further investigation.

- The trust wide target for compliance with level 1 and level 2 safeguarding training was 85%. Information we received from the trust identified that 99.5% of staff had received safeguarding children and adults level 1, 95% had received level 2 safeguarding children and adults training, Staff confirmed that they had received safeguarding awareness training, and confirmed actions that would be undertaken to keep people safe.
- The trust's ' Safeguarding Learning and Development Strategy' specified that all band 7 and above nurses working within critical care should have level 3 safeguarding vulnerable adults training by 31 March 2017. Information provided by the trust on the 13 September 2016 identified that 55% of nurses had received this training and this training was on-going.

Mandatory training

- Mandatory training included both computer training and a classroom session for practical skills. The trust had a target of 85% of staff having received required mandatory training. Information provided by the trust showed that the percentage of staff who had completed mandatory training in August 2016 was 95% of all critical care staff (all staff covering both Birmingham Heartlands Hospital and Good Hope Hospital).
- Mandatory training included: blood transfusion (all parts completed 98% of staff ; resuscitation (86%); equality and diversity (82%); falls awareness (100%); fire safety (86%), food hygiene awareness (100%); health and safety awareness (100%); incident reporting awareness (100%); infection control including hand hygiene (99%); information governance (99%);manual handling both theory and practice (completion of both parts (98%); medicines management (100%); safeguarding (reported within safeguarding above); safer swallowing (97%;, violence and aggression (100%); venous thrombosis embolism (VTE) (100%); waste management 73%.
- The matron and the practice education nurses monitored mandatory training attendance for nursing staff.

Assessing and responding to patient risk

- Staff told us and we observed that a safety briefing was conducted daily. This enabled staff to be updated about changes to patients' needs and discuss ongoing nurse requirements.
- The hospital used an early warning score to identify acutely ill or deteriorating adult patients. Staff recorded the early warning score before the patient left critical care units as a baseline for the wards. An early warning score was not recorded for critical care patients due to the on-going observation of the patient by both medical and nursing staff.
- Heartlands hospital had a critical care outreach service, which was available 24 hours a day. There were usually two critical care outreach staff on duty during the day and one on duty at night. Staff told us there were times when critical care outreach staff were not available for the hospital when they provided care for other ward patients when no critical care bed was available. This meant that there may be a delay in the review of the deteriorating patients.
- Critical care outreach staff triaged doctors' bleep' calls. This enabled doctors to identify and prioritise the sickest patients throughout the hospital and ensure they were quickly reviewed.
- The critical care outreach team provided advice to wards when they had concerns about patients who were deteriorating and ensured appropriate actions were undertaken, and followed up patients following their discharge from critical care services.
- Information provided by the trust identified that 111 critical care staff had received advanced life support training, 37 staff had intermediate life support training and 192 had basic life support training.

Nursing staffing

- Senior nursing staff completed the safer nursing staffing tool daily for the critical care units at both Heartlands and Good Hope Hospital. The trust used an electronic rostering system with oversight by a senior nurse who managed nursing staff rotas to ensure that there were sufficient and appropriate nurses on duty.
- We saw that the trust had one rota for critical care nurses covering both Heartlands and Good Hope Hospital. Nursing staff rotated between Heartlands and Good Hope Hospitals.
- We found that nurse-staffing numbers met core standards for intensive care units. Nurses on the ITU

were allocated one level 3 patient to care for. One nurse provided care for up to two level 2 patients on both ITU and HDU. Healthcare assistants were also on duty to provide assistance with personal care.

- We observed that the number of staff on each shift was not displayed at the time of our unannounced inspection. The matron told us that the trust had purchased boards to enable the numbers of required and actual staff on duty to be displayed.
- Information provided by the trust identified that there had been an on-going shortfall of planned to actual qualified nurse staffing between April and August 2016. The shortfall was identified between 64% (in July 2016) to 90.8% (in April 2016); ITU was flagged as red (a risk) between May and August 2016. The matron told us that nurse staffing was a major concern although demand for beds had been less during the summer months and they had been able to meet patients' needs with available staff. The trust had recently recruited into the vacant posts but the critical care units had several staff on maternity leave and long-term sick leave.
- Senior staff told us that as they were one group of staff working between two sites they had the flexibility to move staff when required. When critical care shifts could not be fully staffed from, their own staff working their contracted hours, critical care staff could worked additional hours on the hospital bank. Senior staff told us that this flexibility had assisted them to ensure sufficient staff were available.
- The matron told us that the critical care units used experienced critical care agency nurses if staffing could not be met by the trusts own staff. Senior nurses told us and we confirmed that there were no more than 20% of agency nurses on each shift within ITU and HDU.
- All shifts within both the ITU and HDU had supernumerary senior nurses (band 6 or 7). The matron was also supernumerary when on shift. We found that the availability of supernumerary nurses met best practice guidelines (Core standards for Intensive Care Units, 2013).
- Nursing staff working within ITU and HDU told us that they had a handover at least twice a day during which they discussed all patients' needs and treatment. Staff told us they then had a more detailed handover from the nurse who had been caring for their identified patient(s) during the previous shift. We observed that a detailed handover took place discussing all patients, their needs, treatment and results of observations or tests. This ensured that staff were aware of any changes to ensure that actions were undertaken to minimise the risks to patients.

Medical staffing

- Nine intensive care consultants provided medical care for critical care service (ITU and HDU) at Heartlands Hospital. Critical care consultants rotated between Heartlands Hospital and Good Hope Hospital there were 15 consultants in total covering both sites.
- There was one consultant on duty in ITU between 8am and 6pm and another consultant on duty for the HDU for the same period. The consultant to patient ratio was one consultant for up to 11 intensive care patients and one consultant to every eight HDU patients. This met the national recommendations of not having more than 15 patients to each consultant.
- There were eight critical care practitioners (CCP) and a consultant nurse working within the trust. The CCPs and consultant nurse had extensive advanced training in physical assessment, diagnosis and contributed to managing patient treatment plans. The CCPs and consultant nurse performed many traditional medical roles whilst maintaining a nursing focus. We spoke to one CCP who told us they performed a similar role to a junior doctor but provided continuity of care, as they did not rotate to other specialities.
- The intensive care consultant supported by two CCPs and a specialist registrar in intensive care medicine (SpR) provided medical cover within ITU between 8am and 6pm. During the same period a HDU consultant supported by one critical care practitioner, a SPR and a senior house officer who provided medical cover in HDU.
- During the evening and night, a consultant was on-call from home and provided medical cover for ITU and HDU. Whilst on call, consultants would also come into the hospital when required. There was also a SPR on duty within the hospital with a CCP. Staff told us they were able to contact consultants and medical staff if they had any patient concerns.
- Consultants worked in five-day blocks (Monday to Friday) within both ITU and HDU, with a different consultant on call at night and over the weekend. This met best practice guidelines to assist in the continuity of patient care.

Critical care

- Doctors told us that that doctors (including CCPs) who were currently working, or who had previously worked within critical care within the trust mainly covered absences. If services could not be covered from this staff group then locum doctors would be with a critical care consultant, CCP or consultant nurse to support them.
- Staff told us and records we looked at confirmed that the consultants had handovers and ward rounds twice daily. This meant that doctors regularly assessed patients' health and recovery to ensure they received appropriate and timely treatment.

Major incident awareness and training

- The major incident policy for the trust contained relevant sections relating to the roles of critical care staff, to ensure preparedness for a major incident. We observed that there was signposting in the hospital directing visitors and the media in the event of a major incident.
- Staff told us that critical care managers had received training in the management of a major incident. The matron told us that a 'mock' major incident was planned to ensure required actions were in place to deal with large numbers of casualties who may be critically ill or injured.
- The trust had a business continuity plan to ensure that they had a clear process in response to a serious event that may affect the delivery of essential services. Staff told us that to ensure that critical care patients received required care in cases of extreme weather conditions or large-scale staff sickness they should always try to get into the hospital or another hospital base, which may be closer to them.

Are critical care services effective?

Good

We rated this service as good for effective because:

- People have good outcomes because they receive effective care and treatment that meets their needs and best practice guidelines.
- There were clinical audit programmes in place to monitor adherence with guidance and comparison with other critical care units.
- There were suitable arrangements for ensuring that patients received timely pain relief and had appropriate nutrition and fluids.
- There were appropriate arrangements in place to ensure that both nursing and medical staff had appropriate training and development opportunities. Critical care medical staff had excellent research support opportunities available.
- Seven-day working was in place for medical and nursing staff. Physiotherapy was also available over the weekend but may only include respiratory physiotherapy.
- There were appropriate systems in place to consent to treatment. Staff understood their responsibilities around the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- There were good systems in place to ensure that staff could access information to provide effective and high quality patient care
- Critical care staff had an application 'app' that provided a discussion medium and an opportunity to share information such as new innovations, research articles, mandatory study days and other developments within the trust.

However we also saw that:

- The handovers and ward rounds did not include the multidisciplinary team. Multidisciplinary working can improve patient outcomes and provide effective patient care.
- Physiotherapy support available to critical care patients did not reflect core standard guidelines.

Evidence-based care and treatment

- Critical care services provided care in line with the Association of Anaesthetics of Great Britain and Ireland (AAGBI), The Royal Colleges and of National Institute for Health and Care Excellence (NICE), Intensive Care Society, Faculty of Intensive Care Medicine (FICM), and the Nursing and Midwifery Council (NMC). Local policies were written using national guidelines to determine the treatment critical care units provided.
- ITU and HDUs participated in patient's records audit to assess that, patients received care and treatment in accordance with both national and local recommendations.

Critical care

- The hospital had appropriate arrangements in place for deteriorating patients to be reviewed by the critical care outreach team. The availability of the outreach team and timely review of patients meets the requirements of NICE guidance using the local guideline modified early warning score and CG35 Prediction and Detection of Impending Critical Illness in Adults.
- The critical care service contributed data to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- Information submitted to ICNARC showed that Heartlands hospital was not a statistical outlier and mortality was within the expected range. Staff discussed the mortality rates within the bi monthly mortality meetings. The meetings reviewed patient deaths to check they had received appropriate care and treatment. In addition, there were bi monthly meetings that presented audit findings and presentation of case studies, which included discussion around 'difficult cases'. The minutes and outcome of the meetings were discussed at the directorate meeting and escalated to the divisional meeting when required.
- We found that critical care services had active research and development with an on-going research programme. Information provided by the trust gave us examples of five research programmes, which focused on improving patient care and outcomes. These included a review of the use of non-invasive ventilation as a strategy' to 'wean patients off a ventilator, a study which looks at preventing critical care admissions by improving awareness of acute kidney injury and 'debriefing' for staff following cardiopulmonary resuscitation.

Pain relief

- A pain-scoring tool was used in both ITU and HDU. The pain assessment included patients own scoring of their pain between zero (no pain) to three severe pain.
- We saw that patients pain and effective pain control was discussed during the consultants and nurses handovers. We saw that all patients had an individualised pain relief plan, which was appropriate to their clinical condition, was effective, safe and flexible.
- Staff used an alternative pain-scoring tool for those patients who were unable to tell staff the amount of pain they experienced. The pain assessment included a check on non-verbal responses, or changes to the patient's observations.
- The records we looked at confirmed that patients had regular pain relief. Patients we spoke with told us staff ensured they had the pain relief they needed and they were kept comfortable.
- Staff told us that a pain relief audit was undertaken as part of the nursing matrix. The audit identified that 100% of the patient records audited between October 2015 and August 2016 required pain relief was prescribed and administered.

Nutrition and hydration

- We saw records that showed patients had their risk of dehydration and poor nutrition assessed and when a risk was identified appropriate actions were taken.
- Staff told us that there were policies in place to enable patients who were unable to take oral nutrition or fluids to be given specialist feeds until a dietician could see them. We saw that staff followed these policies. This meant that patients were protected against the risk of malnourishment and dehydration.
- Staff told us that a dietician would visit the critical care units Monday to Friday to assess any patients who needed dietetic input.
- We observed that drinks were accessible for those patients who were able to have fluids. Two patients told us that the food was, "very nice".
- The nursing matrix included information about completion of nutritional risk assessment. The audit identified that 100% of the patient records audited between October 2015 and August 2016 had their risk of malnourishment and dehydration assessed and appropriate actions were undertaken.

Patient outcomes

- The critical care units at Heartlands Hospital contributed to the Intensive Care National Audit and Research Centre (ICNARC) patient outcomes database. The data demonstrated that the Heartlands Hospital performed similarly to other comparable hospitals with the exception of 'risk adjusted hospital mortality rate which was identified as higher than the expected range.
- Information provided by the trust identified between 1 September 2015 and 31 August 2016 there had been 19

unplanned readmissions to the critical care units within 48 hours of discharge at Heartlands Hospitals. This was a readmission rate of less than 1.4% of all critical care admissions.

- Information provided by the trust identified that critical care units had undertaken several audits since 2015 to check the care and treatment patients had received. The audits had included: patients discharge from ITU, tracheostomy insertion care, the implementation of lung protection ventilation, admission of haematology patients to ITU and death confirmation audits. Information provided by the trust identified that the findings of the audit such as poor record keeping and documentation had been shared with other staff and there were plans in place to undertake further audits.

Competent staff

- All band 6 and above nurses had a post registration qualification in critical care. The critical care units (ITU and HDU) at Heartlands Hospital met the required standard of at least 50% of nursing staff with a post registration award in critical care nursing.
- All critical care medical staff received a hospital and critical care induction. Junior doctors we spoke with said they felt supported by their mentor and other staff.
- All new critical care nursing staff had a hospital and local induction in critical care. They had a six-week supernumerary period although a longer induction and support was available for nurses who had not previously worked within critical care services. New staff received support from the clinical educators and a mentor of an experienced critical care nurse.
- Staff told us and we saw that all critical care nurses completed competency booklets developed to meet the Critical Care Network standards. The competency booklets supported the training, development and nurse's competency was assessed against the required standards. This meant that there were assurances in place to ensure appropriate staff practice and competency.
- Staff told us that opportunities for them to develop were available and were identified as part of their appraisal**.** Senior staff told us that nursing staff used the appraisal process as evidence to revalidate their practice and retain their nursing registration. All staff we spoke with confirmed that they received an annual appraisal. The trust target for appraisal was 85% of staff. Information provided by the trust identified that 93.7% (August 2016) of critical care staff had an appraisal.
- We spoke with a relatively new critical care consultant. They were positive about the support they had received from the trust and other critical care consultants. They told us that written guidelines were in place for new consultants. Doctors told us that several doctors had received their training with the trust and had chosen to remain in critical care.
- We observed that academic presence within critical care services was excellent and doctors told us they welcomed it.
- We found that the research and development department had four substantive academic medical posts within critical care and peri-operative care. Information provided by the trust identified that the role of the professors and doctors within the research department included not only leading research studies and securing research grants but also supporting other staff to undertake research to improve patient acre and outcomes.

Multidisciplinary working

- Staff told us that critical care ward rounds took place twice a day. We observed one ward round it included doctors and some nursing input. Staff told us that there was also occasional physiotherapy input. We observed during the ward round all patients were reviewed by the staff present.
- During handover we observed on our unannounced visit we saw that handovers took place from nurse to nurse or doctor to doctor. We observed that both doctors and nurses fully discussed the patient, tests received and on-going treatment plan. There was lack of coordinated multidisciplinary working during both ward rounds and handovers with discussions from other professionals such as physiotherapists, dieticians, pharmacist etc. Multidisciplinary working can improve patient outcomes and provide effective patient care.
- There were visits to both ITU and HDU five days a week by a pharmacist during which they received patients' medicines. Staff told us that a microbiologist visited the units Monday to Friday to provide specialist advice about patient infection and possible treatment. At other

times, staff could obtain telephone advice. This meant that advice was provided which reflected changing recommendations and immediate changes to treatment could be made in response to national guidelines.
- The critical care units had one physiotherapist with critical care experience; a further critical care physiotherapist was on maternity leave. Whilst essential physiotherapy respiratory care was provided by other physiotherapists rehabilitation to support the patients recovery could not be provided when the critical care physiotherapist was not available and requirements of NICE standard 83 was not consistently met. A core standard for Intensive care units recommend that there is one full time physiotherapist for every four critical care patients this core standard was not being met.
- Staff could request a speech and language therapist if required for advice or review of patients with swallowing and communication difficulties.
- There were at least two critical care outreach staff available during the day and mostly at least one critical care member of staff available at night. Monday to Friday a critical care outreach worker worked between 1pm and 1am. The critical care outreach team reviewed all patients discharged from critical care as well as providing other services frequently provided by junior doctors.

Seven-day services

- A least one intensive care consultant was present within the hospital between 8am and 6pm seven days a week and there was on call cover overnight.
- The physiotherapist told us that respiratory physiotherapy was provided seven-days a week for critical care. However the physiotherapist on duty may not have critical care experience and be unable to provide a rehabilitation plan and treatment.
- Doctors told us that they could request x-rays and scans seven days a week and during the evening and overnight
- The hospital pharmacy was open seven days a week, although for reduced hours at the weekend. Staff could obtain urgent medicines by request to the by senior staff on-call.
- Staff told us that speech and language therapists and dieticians were available five days a week.

Access to information

- On both ITU and HDU we observed that nursing notes were kept at the patient's bedside and were accessible by staff at all times. Medical notes were also available on the units when required.
- Staff told and showed us how they could access care and treatment policies and procedures at all times on the trust's intranet.
- Critical care staff had an application 'app' that provided a discussion medium and an opportunity to share information such as new innovations, research articles, mandatory study days and other developments within the trust.
- There was a fortnightly weekly critical care update previously called 'Nuggets' (of information) and now referred to as 'Burgers'). The update included outcome of audits and included actions when improvement was required, any changes of practice and sharing of findings of investigation and approved practice such as the use of a specialised tape to secure patient intubation tubes.
- A quarterly critical care newsletter provided information about the team and on-going research within critical care.
- Senior staff identified key messages for and in addition to the previous initiatives these messages were put on the back of staff toilet doors and were referred to as ;'Loo News'.

Consent and Mental Capacity Act

- Medical and nursing staff told us and we saw that they assessed patient's mental capacity twice a day. This ensured staff were aware of patient's mental capacity and when treatment should be provided in their best interests.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent, including those people who lacked capacity to consent to their care and treatment.
- Nursing staff told us they had received training about the Mental Capacity Act (2005), as part of their safeguarding vulnerable adults training level 2 training. Information provided by the trust at the time of our unannounced inspection showed that 75% of senior nurses (band 7 and above) working within critical care services had received additional training in the Mental Capacity Act and Deprivation of Liberty safeguards.
- The clinical educator told us they recognised that staff had required further training in the Mental Capacity Act,

this was being included within the annual critical care mandatory update, and more than 50% of staff had received this additional training at the time of our unannounced inspection. Staff understood their responsibilities under the Act and what actions to take in patients best interests.
- Staff told us that there were no patients with a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form in place at the time of our unannounced inspection. Staff told us that were made aware of patients' resuscitation status during handover when necessary.

Are critical care services caring?

Good

We have rated this service as good for caring because:

- Staff treated patients with care and compassion, and mostly spoke with patients in a respectful manner.
- We saw that patients and relatives were given good emotional support.
- Whenever possible patients and relatives were consulted and informed about treatment, they or their relative would receive.
- The use of 'patient diaries' assisted patients to reflect on their experience of critical illness.

Compassionate care

- Patients we spoke with were positive about staff and the care they received. One person told us: "They have been very good both during the day and at night".
- Throughout our inspection, we saw patients treated with compassion, dignity and respect. We saw one confused patient trying to get out of bed, the nurse looking after them was patient and reassuring helping them to get back into bed safely whilst ensuring they were covered up and their dignity was maintained.
- We observed staff talking to patients and relatives in a respectful and friendly manner. However, we observed one staff member speaking loudly to a patient from behind the nurses table at the foot of the patient's bed.
- The national Friends and Family test (FFT) is used to obtain patients' views on whether they would recommend the service to family and friends and is given to patients on discharge. We saw that the friends and family questionnaire were used outside ITU and around the hospital; however staff did not feel that the survey applied to critical care patients and did not collect this data. We asked the trust for information about Friends and Family test results. The trust told us that the response rate for critical care had been poor as these patients were normally transferred to base wards prior to discharge.
- A patient experience audit was launched the week commencing 5 of September 2016. This aimed to assess patient's experience in critical care with issues relating to pain control, communication, privacy, dignity etc.

Understanding and involvement of patients and those close to them

- The nature of the care provided in a critical care unit meant that patients could not always be involved in decisions about their care. However, whenever possible, staff told us they consulted relatives on the patient's preferences and they took their views were taken into account.
- We observed that whenever possible, staff asked patients for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.
- Staff completed 'patient diaries' within critical care. The diaries assisted patients to retrospectively reflect on their experience of critical illness.

Emotional support

- Staff told us they built up trusting relationships with patients and their relatives by working in an open and supportive way. We observed that patients and relatives were given good emotional support.
- One staff member provided follow up one day a week after the patients discharge from critical care but whilst they remained in hospital. Patients were able to speak about their critical care experiences and discuss unpleasant ongoing symptoms, such as hallucinations.
- A chaplaincy service was available, which provided valuable support to patients and relatives.

Critical care

Are critical care services responsive?

Requires improvement

We rated this service as requires improvement for responsive because:

- The critical care unit lacked capacity to care for some patients who needed critical care and some patients requiring elective surgery were cancelled due to the lack of a critical care bed which they would need for a period time following their operation.
- The critical care units did not meet the needs of individual patients. There were no toilet or bathroom facilities in both ITU and HDU, which did not meet patient needs. Heartlands Hospital is a regional infection diseases centre; critical care had three side rooms, which could be used for critically ill patients with infections but none had modern facilities (negative pressure to contain any bacteria within the room) to reduce the risk of, cross infection to other patients.
- There was a limited follow up service for patients following their discharge from critical care. However the service was not sufficient and did not meet Core Standards for Intensive Care Units.
- The critical care units had portable privacy screens, which they wheeled around patients when they provided personal care or doctors were examining the patient. We observed that these screens did not afford sufficient privacy as there was a gap at the fold that you could see into the bed space.

However we also saw that:

- Arrangements were in place to ensure that when possible, patients received timely admission into the critical care units.
- Within the critical care units, support for patients living with physical and learning disabilities, dementia, or those who had communication difficulties, was available, if needed.
- Staff told us there was an translation service available for patients and their families whose first language was not English.

Service planning and delivery to meet the needs of local people

- Critical care services at Heartlands Hospitals included an 11-bedded Intensive Care unit (ITU) which could accommodate up to 11 level 3 patients (patients who may be ventilated). There was a high dependency unit (HDU) which could accommodate up to eight level 2 patients (high dependency needs but not ventilated).
- The ITU and HDU were staffed to accommodate patients seven days a week twenty-four hours a day.

Meeting people's individual needs

- Support for patients living with physical disability, learning disability or dementia was available if needed. Staff told us that relatives were able to stay with patients living with dementia or a learning disability. If the admission was planned, they would ensure, as much information was available prior to the patient's admission. The critical care units used the 'This is me booklet' which gave staff information about the person including their likes and dislikes. Staff asked relatives and other people such as carers who knew the person well, to complete the booklet.
- Patients in critical care units may be unconscious, confused and disorientated. We saw that the critical care units at Heartlands Hospital used 'patient diaries' that detailed the patient's day for reference by both the patient and their relatives. Staff told us that the patient diaries had been invaluable to explain some unpleasant effects of treatment.
- Staff showed us the 'bereavement box'. Staff explained that the bereavement box contained items, which enabled staff to support bereaved relatives and give them mementoes of their loved one such as a small gift or a handprint.
- Staff told us there was an translation service available for patients and their families whose first language was not English.
- Critical care staff worked alongside the organ donation team to raise awareness and facilitate organ donation for those patients who were suitable and had requested to do so.
- A peer review of the critical care units ITU and HDU) by the Critical Care Network undertaken on 1 February 2016 identified: "There is still an urgent need to improve the infra structure at the Heartlands (critical care) site.

Both the ITU & HDU on this site had limited space and there are no bathroom or toilet facilities on either unit for patient use or sufficient space to protect their privacy & dignity."

- We found that there were no patient toilet or bathroom facilities within either ITU or HDU and both units had limited space. Staff told us that there was a plan to rebuild a new critical care unit although there was no date for this at the time of our inspection.
- Staff also showed us the ITU waiting room, which was located within another department. Staff told us that as the waiting area was so small that frequently relatives were in the corridor. The other department provided emergency treatment and access may be difficult if staff needed to get the patient on a trolley in an emergency.
- The Department of Health required all providers of NHS funded care to confirm by 1 April 2011 that they were compliant with mixed sex accommodation except where it was in the patient's best interests or reflected their choice. A breach of 'mixed sex accommodation' refers to not only sleeping arrangements but also bathrooms and toilets and the need for patients to pass through areas for the opposite sex to reach their own facilities. Staff told us that senior managers supported them to ensure patients were discharged from the critical care units (ITU and HDU) within four hours to avoid a 'mixed sex breach'. Information provided by the trust identified that there had been 29 mixed sex breaches between 1 July 2015 and 31 August 2016.
- The critical care units (ITU and HDU) had portable privacy screens, which staff wheeled around patient's beds when care was provided or doctors were examining the patient. We observed that these screens did not afford sufficient privacy as there was a gap in the fold of the screens which enabled limited sight of the patient's bed space.
- There was a small relative's waiting room situated within another department outside ITU. Staff told us that frequently this room would be full with one family which meant that other (frequently bereaved) relatives were left standing in the corridor and blocking access as patients were moved on trolleys for emergency treatment.
- There were two overnight visitor rooms. However, we found them to be sparse unwelcoming. The rooms had no toilet or shower facilities, which were available separately along the main corridor. Hot drinks and snacks were available from the vending machines on the main corridor. We spoke with one family who lived some distance away they told us they were staying in a local hotel and that staff had been very helpful arranging this for them. In addition, there was a quiet room adjacent to ITU, which could be used to break difficult news.
- Core standards for Intensive Care Units identify that following a period of critical illness, patients should be offered the support of a specialised critical care follow-up clinic, and this was not met. A nurse visited patients on the ward post discharge from ITU and from HDU if their stay had been longer than 24 hours to discuss their critical care experience. The service was limited to one nurse available one day a week and not all patients were seen. From the 1 September 2015 to 31 August 2016, 303 patients were seen by the follow up nurse. This meant that less than 21% of all patients who had been admitted to critical care received a visit from the follow up nurse following their discharge. There were no separate arrangements to review patients following their discharge from hospital. Follow up clinics support the recovery and review the progress of patients who have been critically ill and provide an opportunity to discuss any on-going problems.

Access and flow

- Patients could be admitted to ITU either from accident and emergency, theatre or from the wards. HDU provided care mostly for surgical patients who required high dependency care after their surgery but could also admit level 2 patients from accident and emergency or patients who may have deteriorated on the wards.
- Staff told us and records we looked at confirmed that the decision to admit a patient was made by the consultant(s) who covered the critical care units.
- Admission to critical care units should occur within four hours of making the decision to admit the patient. Core standards for Intensive Care Units identify that: "Minimising delays to definitive treatment is associated with better outcomes. In the critically ill this is best delivered on the intensive care unit"**.** Information provided by the trust identified that 98.2%% of patients were admitted into critical care (ITU or HDU) within four hours of referral to critical care.
- Between 1 September 2015 and 31 August 2016, information provided by the trust showed that the bed

occupancy for the critical care units was 90%. The national average critical care bed occupancy was 86%. Persistent bed occupancy of more than 85% could suggest a unit is too small.

- There were regular bed management meetings that reviewed both elective and emergency hospital admissions, the demands of the critical care units and patients' risks. Between 1 September 2015 and 31 August 2016, 17 operations were cancelled due to the lack of availability of critical care beds.
- Staff told us that matching demand with capacity was an on-going challenge. Staff told us there were occasions, which required patients to be cared for outside critical care such as within recovery or on a ward with the support of a clinical outreach nurse. Information provided by the trust identified between 1 September 2015 and 31 August 2016 50 patients were cared for outside ITU/HDU for more than four hours when a need for a critical care was identified.
- The critical care services at Heartlands Hospital worked closely with the critical care unit at Good Hope Hospital (also within the Heart of England Trust) when there was no suitable critical care bed available at Heartlands Hospital.
- The Intensive Care National Audit and Research Centre (ICNARC) data for critical care services at Heartlands Hospitals GCCU showed that non-clinical transfer, delayed discharges from and out of hour's discharges were comparable with the national average. Information provided by the trust showed that between 1 September 205 and 31 August 2016:
- Four patients were transferred to other hospitals for non-clinical reason,
- 1063 patients whose discharge from critical care was delayed by more than four hours
- 205 patients discharged out of hours (between 10pm and 6.59am)
- The critical care outreach service had a remit to: facilitate timely admission and discharge from critical care units, prevent readmission to critical care and promote continuity of care for patients who had been critically ill. Information provided by the trust identified that the outreach reach saw 1525 patients and there were 5101 critical care outreach patient reviews undertaken.

Learning from complaints and concerns

- There had been four complaints (one related to ITU and three related to HDU) about critical care services between 1 September 2015 and 31 August 2016. We discussed the complaints received with the matron and clinical director and found that there had been an appropriate response to the complaints received. Matron had investigated the complaints, discussed complaints face-to-face with the complainants and had provided feedback on the outcome of the complaint.
- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.

Are critical care services well-led?

Good

Critical care services were well led.

- The leadership, governance and culture of critical care services promoted the delivery of safe, high quality person-centred care.
- Performance issues were escalated to the relevant managers and quality assurance meetings and to the board through clear structures and processes.
- The leadership ensured that there was continuous improvement in patient care by having an active research and development presence within critical care services, sharing good practice and highlighting audit findings with staff and when improvements were needed.
- Staff working in critical care services were aware of the trust's vision and demonstrated commitment to its objectives and values.
- Staff were supported by managers and were positive about the care they provided and that their achievements were recognised.
- Staff told us there was a culture of openness and transparency and they felt able to challenge poor practice if required.

However we also saw that

- There was a process in place to identify and monitor and current and risks. However, we found that not all identified risks were recorded and there was no information on the risk register about actions undertaken to mitigate risks.

Leadership of service

- Critical care services were part of Division 1. The senior management team consisted of a Group Manager and Clinical Director supported by an Operational Manager, Matron and Consultant Nurse/ Advanced Critical Care Practitioner.
- Critical care services (ITU, HDU and critical care outreach) had a consultant intensivist who was the medical clinical lead for critical care. This meets intensive care core standards.
- Critical care services had a modern matron (band 8) who had a specialist qualification in critical care in addition to a management qualification and had overall responsibility for the nursing elements of the services. This met core intensive care standards.
- The consultant nurse provided effective leadership to critical care practitioners (CCPs).
- We found that the leadership team were highly motivated and enthusiastic about providing high quality, safe and effective critical illness care.
- There were supernumerary band 6 or 7 nurses in charge of each shift within both ITU and HDU.
- The leadership team ensured that there was continuous improvement in intensive patient care by through an active research and development presence within critical care, sharing good practice and highlighting audit findings when improvements were needed.
- Matron told us about changes to the appraisal process and mentoring teams. They told us that the previous mentoring and appraisal systems had become less effective as staff rotated between hospitals and now staff received their appraisal by a senior nurse who had regularly worked alongside them and was aware of their practice. This enabled critical care services to complete 94% of staff appraisals.

Vision and strategy for this service

- Staff were aware of, and understood, the vision and values of the trust and the behaviours that would demonstrate these values. Staff told us that their vision was to provide high quality critical care to meet the needs of patients.
- Staff told us that the trust was now managed by the executive team of another local trust and there were plans to rebuild the intensive care unit and merge the two critical care teams (ITU and HDU). The trust had not identified a date for this.
- Staff told us they aimed to increase the number of critical care advanced nurse practitioners to provide additional support to nursing and medical teams working within critical care.
- A new patient survey into the quality of care will provide valuable information about improving the service.

Governance, risk management and quality measurement

- Governance and performance management arrangements were reviewed to identify risks and the needs of the service. Information provided by the trust identified there were monthly divisional and directorate meetings where governance and quality issues could be escalated either up to the board or down to critical care staff. There was also an in-depth quality and safety review of the performance of the division, which was undertaken annually.
- The critical care morbidity and mortality meetings were held every three months and every patient death was reviewed and discussed. In addition, there were bi monthly meeting that presented audit finding and presentation of case studies, which included discussion around 'difficult cases'. The minutes and outcome of the meetings were discussed at the directorate meeting and escalated to the divisional meeting when required.
- Governance meetings where complaints, incidents and the risk register were reviewed were held at least three monthly. Any findings were then shared with the directorate meeting for further action when required. Staff told us that any outcomes such as learning from complaints or incidents were then shared with them. The outcomes of these meetings were fed back to staff.

- The division's risk profile dated 1 September 2016 identified risks inherent in the delivery of safe care. There were four trust wide critical risks that would include a risk to Heartlands critical care units and included :
- Inadequate resources (staffing) identified 27/11/2014,
- Poor standards of Do Not Attempt Resuscitation (DNAR) decision making and documentation which risk legal action identified 5/9/2014,
- Resuscitation standards gap identified 27/11/2014
- Discontinuation of an identified defibrillator warranty service and parts identified 15/4/2014.
- Information provided did not identify actions undertaken to minimise the risk or the reason why some risks continued to be on-going and remained on the risk register for almost two years. We also found that concerns about the environment and management of infective patients within critical care were not identified within the risk register.

Culture within the service

- Staff spoke positively about working within critical care services. Staff told us they would recommend it as a place to work.
- Staff told us that they felt respected, valued, supported and that their achievements were recognised. Staff told us there was a culture of openness and transparency and they felt able challenge poor practice if required.
- Staff commented that they were "a good team". Managers told us that they were proud of their team and their commitment to high quality patient care.
- There had been changes to critical care staff working arrangements, which included both doctors and nurses rotating between Heartlands Hospital and Good Hope Hospital sites. This change of practice had been on-going but had not been popular with all staff and as result, some staff had left. However, we found that staff we spoke with understood the need for change and flexibility of the service.
- Information we saw in staff newsletters highlighted the critical care staff recognition awards acknowledging achievements of individual team members including compassion awards, (low) sickness, mentor of the year award, excellence in clinical practice, patient/relative nominated awards, etc.

Public engagement

- There had been limited public engagement with critical care services. The new critical care patient survey will provide greater opportunity for feedback.
- We saw that there was information available for patients and relatives about critical care and organ donation.

Staff engagement

- Staff told and we observed that managers used a combination of face-to-face meetings, email, intranet messages, newsletters and social media to engage with critical care staff.
- Staff told us that managers were present within critical care most days when they were on duty and engaged with staff.

Innovation, improvement and sustainability

- There were appropriate systems in place to review service delivery and, when needed, ensure that lessons were learned and appropriate actions taken. Learning was shared from medication errors, untoward incidents and this information was shared within the 'Burgers newsletter'.
- We found that critical care had an active research and development department, which had five on-going research programmes, which focused on improving patient care and outcomes. These included a review of the use of non-invasive ventilation as a strategy' for help patients come off a ventilator.
- Staff told and we saw information that confirmed that critical care had taken part in a major incident table top exercise on 23 September 2016.The purpose of this was to ensure that staff had 'practised' actions to undertaken in the event of a major event and highlight where possible improvement could be made to enhance patient care and outcomes.
- Critical care services used an incident form (2) which identified excellence in practice and highlighted when something had been done well. This system is available to all staff to report electronically. Later versions will link in to the trust's reporting system. The system had recently been introduced and will be reported and shared via the team's governance structure.
- The use of Critical Care Practitioners (CCPs) within hospitals is not unique. However the trust told us and we observed during our unannounced inspection, that they utilise CCPs far more extensively than other critical

care services. The CCPs were embedded within the medical team rota. Senior staff told us that there were plans expand the use of CCPs team to support other sites within the trust.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient services are provided by Heart of England NHS Foundation Trust, which include diabetes and endocrinology, cardiology, ophthalmology, urology, gastroenterology, oncology, rheumatology and elderly medicine.

Between April 2015 and March 2016 there were 420,926 outpatient appointments held at Heartlands Hospital.

The diagnostic imaging department provides diagnostic services to the patients of Birmingham Heartlands Hospital including general x-ray procedures, ultrasound, and nuclear medicine.

During our inspection on 19 October 2016, we visited the outpatient and diagnostic imaging departments and spoke with 10 patients, 32 staff and we reviewed 40 patient records.

We observed care and received comments directly from staff, patients, and the public at our focus groups. We also reviewed the systems and management of the departments including the performance information.

We requested data from the trust specific to each separate hospital site. Where the trust did not provide this data we have included trust-wide information.

Summary of findings

We rated this service as good because:

- Staff in the outpatient and diagnostic imaging departments were caring and treated patients with dignity and respect.
- Staff involved patients in decisions about their care and treatment.
- Staff at all levels had a good understanding of the trust's electronic incident reporting system and showed us how they would use it.
- Senior staff investigated incidents and shared feedback and lessons learned from incidents with teams at their morning meetings.
- Staff followed National Institute for Health and Care Excellence (NICE) guidelines for the management of medications in outpatients and diagnostic imaging services.
- Radiology staff followed the Ionising radiation (medical exposure) regulations 2000 (IR(ME)ER) when taking x-rays.
- Diagnostic imaging had radiation protection supervisors in place whose responsibility was to assist the line manager in ensuring relevant staff read, understood, and followed the local rules.

Outpatients and diagnostic imaging

- There was a telephone translation service available for patients whose first language was not English. Staff could arrange a translator in advance if required.
- The trust set a mandatory target of 85% for completion of mandatory safeguarding training. Data (trust wide) provided by the trust showed 100% of nursing, medical and dental staff in outpatients and diagnostic imaging had completed their mandatory safeguarding adults and children level one and two training.
- We saw an example of outstanding practice in the imaging department. The induction pack in imaging was excellent and innovative especially for reflective practice.
- Staff we spoke with felt supported and listened to by their line managers

However:-

- The main outpatient's areas were outdated and in need of refurbishment.
- Not all staff complied with hand hygiene processes in the outpatients department.
- Several outpatient staff found the trust's electronic patient records unsuitable for their needs and problems with the IT systems could cause clinic delays.
- The radiology clinic had an open reception area and it was possible to overhear confidential patient information.
- Outpatient staff told us they did not know who the executive team were and they were not visible in the department.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Resuscitation equipment in outpatients was readily accessible throughout the department. Staff checked them daily and records on resuscitation trolleys were up-to-date.
- The waiting rooms and clinics in outpatients were visibly clean and cleaning records showed the cleaning of clinic rooms was up-to-date. Patients we spoke with had no concerns regarding cleanliness in the department.
- Staff at all levels had a good understanding of the trust's electronic incident reporting system and showed us how they would use it.
- Senior staff investigated incidents and shared feedback and lessons learned from incidents with teams at their morning meetings.
- There were no never events in the outpatients department between August 2015 and July 2016.
- We observed all medications and prescription pads were securely stored in a locked cupboard.
- The majority of outpatient staff understood their responsibilities to comply with the duty of candour regulation and their roles in relation to safeguarding.
- Staff followed National Institute for Health and Care Excellence (NICE) guidelines for the management of medications in outpatients and diagnostic imaging services.
- Radiology staff followed the Ionising radiation (medical exposure) regulations 2000 (IR(ME)ER) when taking x-rays.

However:

- Some staff compliance with hand hygiene processes in the outpatients department was variable.
- Some diagnostic imaging equipment was outdated and up to 20 years old. When equipment failed this could cause delays to patient appointments. This was on the diagnostic imaging risk register.

- Some seating in the main outpatients and phlebotomy waiting areas were torn or broken. This meant that they would be more difficult to clean; and potentially pose an increased infection risk.
- However, in the plaster room we saw the service date for a fan had expired over 18 months before our inspection and two plaster saws did not have stickers to show they were up-to-date with electrical testing.

Incidents

Outpatients

- Staff at all levels had a good understanding of the trust's electronic incident reporting system and showed us how they would use it. Staff knew when to escalate incidents to their senior managers.
- Senior staff investigated incidents and shared feedback and lessons learned from incidents with teams at their morning meetings. We saw minutes of these meetings during our inspection.
- There were no never events in the outpatients department 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.
- The trust reported 313 incidents in outpatients at Heartland's Hospital between September 2015 and September 2016. Of these, 271 resulted in no harm, 38 low harm, three moderate harm, and one was severe harm.
- There were no serious incidents (SIs) reported by the trust for outpatients which met the reporting criteria set by NHS England between August 2015 and July 2016 in accordance with the Serious Incident Framework 2015 (STEIS).
- We reviewed a serious incident report dated October 2016 where endoscopy staff had sent patient samples to the pathology laboratory for testing with incorrect documentation. Senior staff used the tool to understand why the incident had occurred in line with the National Patient Safety Agency(NPSA) guidelines.
- Outpatient staff at all levels understood their responsibilities to comply with the duty of candour regulation. The aim of the regulation is to ensure trusts are open and transparent with people who use their services, inform, and apologise to them when things go wrong with their care and treatment.
- Staff told us duty of candour training was not mandatory; information was easily accessible on the trust's intranet.
- An outpatient staff member explained duty of candour meant being "open and honest" and could explain the duty in detail. However, staff could not give an example of when they had put this duty into practice.
- However, staff in the phlebotomy clinic did not demonstrate an understanding of the duty of candour. Phlebotomy is the practice of drawing blood from patients and taking blood specimens to the laboratory to prepare for testing. However, when staff had to recall some patients to have blood samples retaken due to a problem with wrongly labelled samples, they explained the situation to patients in detail.

Diagnostic Imaging

- Staff at all levels knew how to report incidents using the hospital incident reporting system. This was easily accessible on the trust's intranet.
- There were no 'never events' in the radiology department between August 2015 and July 2016.
- The trust reported 313 incidents in diagnostic imaging at Heartlands Hospital between September 2015 and September 2016. The number of no harm incidents was 274, 34 were low harm, three moderate harm, and two were graded as severe harm.
- There was a serious incident reported by the trust for diagnostics, which met STEIS reporting criteria in July 2016. Senior staff conducted a thorough investigation and carried out a root cause analysis (RCA).
- We saw senior staff in radiology had conducted a RCA for an incident dated July 2016.This was due to a radiographer giving a patient an additional, unnecessary x-ray. Staff had learned a number of lessons from this incident: to check the area of interest with the patient, compare the details to the request card and a discussion between the radiographer and the patient should have taken place before carrying out the x-ray.
- The diagnostic imaging department had reported a breast scanning incident to the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) CQC team

where a patient had been booked in to have an ultrasound scan but incorrectly received a mammogram instead. The trust was currently investigating the incident and had completed a RCA.
- Staff at all levels understood the duty of candour regulation and gave some examples of incidents where staff had followed the duty. The trust's incident reporting system had prompts for duty of candour.
- We saw a letter dated September 2016 from the trust to a patient about a severe incident that involved the misdiagnosis of cancer. The trust correctly followed the duty of candour regulation as the letter included a clear explanation and an apology to the patient.

Cleanliness, infection control and hygiene

Outpatients

- The waiting rooms and clinics in outpatients were visibly clean and cleaning records showed the cleaning of clinic rooms was up-to-date. Patients we spoke with had no concerns regarding cleanliness in the department.
- Some seating in the main outpatients and phlebotomy waiting areas were torn or broken. This meant that they would be more difficult to clean; and potentially pose an increased infection risk. Staff told us they had raised this with senior management. The minutes from an outpatient team meeting in July 2016 noted this as an issue.
- Staff were responsible for maintaining the cleanliness of the clinical rooms in accordance with infection prevention and control (IPC) standards. Staff told us and cleaning schedules confirmed, nursing staff cleaned clinical rooms between seeing patients. An external company cleaned communal areas such as the toilets in the mornings and carried out a more thorough clean in the evenings.
- Staff demonstrated a knowledge and understanding of cleanliness and infection control.
- Equipment in the clinic rooms was visibly clean and 'I am clean' stickers confirmed staff had recently cleaned equipment.
- We saw a poster displayed on the noticeboard in the diabetes department advertising hand hygiene training on the 25 October 2016. A staff nurse carried out monthly handwashing audits in the diabetes clinics.
- There were sufficient hand-washing facilities and hand gels in consulting rooms. However, we did not see any notices displayed in the outpatients waiting areas encouraging visitors to wash their hands and showing the steps to wash hands effectively.
- We saw personal protective equipment (PPE) such as gloves and aprons were available for staff in line with the trust's infection prevention and control policy.
- The outpatient department monitored cleanliness, hygiene and infection control on a monthly basis. We saw the results of a hand hygiene audit for April 2015 to March 2016. The results ranged from 50% compliance in June 2015 to 93.3 %, compared to the trust target of 85%.
- We observed some good hand hygiene practice by staff in patient consultations in the diabetes, speech, and language therapy and physiotherapy clinics. We saw staff washed their hands before and after patient appointments.
- A physiotherapist put on gloves before manipulating a wrist injury during a consultation. The physiotherapy service also had patient feedback forms, which included a question about whether patients had seen the physiotherapist gel their hands before and after treatment.
- However, we saw a consultant did not wash or gel their hands or wear gloves between the three patients we observed being treated.
- We saw staff complied with the trust policy of being bare below the elbow. Clinical staff had their sleeves rolled up to above the elbow with no jewellery or watches other than a plain wedding band. In addition, we saw staff followed the infection control policy by tying hair up if it fell below the collar, and fastening up a long fringe.
- The outpatient department monitored cleanliness, hygiene and infection control on a monthly basis.
- Staff told us if a patient had any form of infection in the diabetes department such as MRSA, staff closed the clinic room, and an external company cleaned it before it was re-used. MRSA is a type of bacteria that is resistant to a number of widely used antibiotics; this means that MRSA infections can be more difficult to treat than bacterial infections.

Diagnostic Imaging

- The diagnostic imaging department was clean and tidy.

- There were plenty of changing gowns for patients to use. Patient changing cubicles were clean and tidy and had boxes for clean and dirty gowns.
- Staff told us patients with an infectious disease would have their scan at the end of the patient list. Cleaning staff would deep clean the room following this appointment in line with the trusts infection control policies. There were no patients with an infection having an x-ray on the day of our inspection so we did not see this in practice.

Environment and equipment

Outpatients

- The diabetes building was secure as it had swipe card access and security coded doors. There was also CCTV at the front of the building.
- The outpatient clinic rooms were well maintained, free from clutter and provided a suitable environment for treating patients. The waiting area in the ear, nose, and throat department (ENT) had toys and books for children to play with. Staff cleaned these daily.
- We observed the main outpatients areas were outdated and in need of refurbishment. However, the diabetes and endocrinology centre was modern, fit for purpose, and well lit.
- The majority of electrical safety testing of equipment we checked in outpatients was up-to-date. Staff told us and records confirmed an external company tested equipment.
- However, in the plaster room we saw the service date for a fan had expired over 18 months before our inspection and two plaster saws did not have stickers to show they were up-to-date with electrical testing.
- All resuscitation trolleys we checked were visibly clean and ready for use. Records confirmed staff checked the equipment daily.
- Speech and language therapy staff told us accommodation and equipment was a long-standing concern, and this was on the ENT risk register. The service had submitted a capital bid for endoscopy equipment as their staff often borrowed equipment from ENT. The lack of portable equipment restricted access to the service for patients who were unable to attend the clinic.
- We saw good evidence of the management of waste and clinical samples. This included appropriate segregation, labelling, handling, treatment, and disposal of waste.

Diagnostic Imaging

- The diagnostic imaging department was very clean and tidy.
- However, the outpatients' waiting room was sometimes hectic as staff sent patients from different clinics at the same time. There were not enough chairs available and the area was too small. The service was hoping to address this in the service transformation programme.
- Regulations known, as 'local rules' stated instructions must be visible to keep patients and staff in radiology departments safe. We saw staff had recently reviewed these. They were up-to-date and were appropriate for each room.
- Cleaning rotas were fully completed and up-to-date.
- The department had a quality assurance programme in place. An external company serviced equipment every four months. This was in line with the trust's quality assurance programme.
- Some equipment was outdated and up to 20 years old and when it broke down this caused patient delays. This was on the diagnostic imaging risk register.
- The medical physics team were happy with the training they received to use equipment and thought equipment was well maintained.
- Senior managers told us there had been little investment in radiology over the last few years. However, a good capital programme to replace equipment had improved this.
- The department had a training matrix that included a record of what equipment staff had received training on.
- We saw the department held up-to-date Environment Agency licences and adhered to the guidance for the disposal of radiopharmaceutical waste from the nuclear medicine department. Radiopharmaceuticals are drugs that contain radioactive materials called radioisotopes. Patients can have them put into their vein, take them by mouth, or place them into 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 needs an Environment Agency licence outlining the type and amount of radioisotopes the service used.
- There was a secure enclosed bunker to store waste safely. An external waste company collected this waste in 10 days, which complied with the maximum two-week recommendation.

- The service had a radiation protection committee in line with the trust's radiation safety policy. We saw the radiation protection committee for diagnostic imaging monitored the radiation protection programme.

Medicines

Outpatients and Diagnostic Imaging

- Boots Alliance delivered a dispensing service for outpatient prescriptions Monday to Friday 9am to 8pm and Saturdays 9am to midday.
- There were robust systems in place for managing and dispensing medication to patients who attended the outpatient and diagnostic departments. These were in line with the trust's 'medicines policy for prescribing, supply, administration, and control of medicines.'
- Staff followed National Institute for Health and Care Excellence (NICE) guidelines for the management of medications in outpatients and diagnostic imaging services.
- We observed all medications and prescription pads were securely stored in a locked cupboard.
- The outpatient department stored few medications and no controlled drugs. It stored a small amount of medication in a locked cupboard; only two members of staff held the keys.
- An on-site pharmacy located near to the main outpatients department dispensed medications to patients.
- All medication we checked was in date. Staff in the fracture clinic told us if medications were out-of- date, they would return them to the pharmacy to dispose of them safely.
- Phlebotomy staff conducted good record checks with medications used and they were securely stored at night.
- In ophthalmology, staff used Patient Group Directions (PGDs) where staff can supply and administer certain medicines to patients without a doctor being present. The department's pharmacist was always involved with PGDs and consultants would sign them off. Records we checked during our inspection confirmed this.
- In the speech therapy clinic, we saw staff checked what medication a patient was currently taking to ensure their records were up-to-date.

Records

Outpatients

- We reviewed 40 sets of patient records across all areas of outpatient and diagnostic imaging services. All paper records were legible, signed, dated, and contained the relevant information including up-to-date typed letters, completed consent forms, and patient allergies. There was also evidence of patient engagement.
- The outpatient department used both paper and electronic records. Clinicians reported no problems accessing either version. Audits of availability of notes for outpatient clinics at Heartlands Hospital showed that out of the 613,101 medical notes requested between September 2015 and August 2016, 853 records were not found.
- Staff told us if patient records were not available, they made every attempt to locate the record. Staff made a temporary record if the patient notes were lost or unavailable. They would add this to the patient's file when found which minimised the impact to patients.
- Staff demonstrated this in the ENT department where a consultant did not have the patient paper records. The consultant completed an attendance record form and told us staff would file this with the original medical record. The consultant had full access to the patient's notes on the trust's electronic care record and this did not affect the patient's care.
- Staff in the fracture clinic told us if patient records and referral letters were not available, they would rebook appointments for patients.
- One member of physiotherapy staff told us electronic records were not as suitable for their clinics as paper records as they did not include a body chart. This made it more difficult to document the location of a patient's injury or pain.
- The electronic system in physiotherapy and speech and language clinics sometimes froze or was very slow at loading the patient records. This meant staff could be delayed causing clinics to run late, especially for 20-minute appointment slots. Senior staff told us problems with the IT system was on their risk register.
- Records in the diabetes clinic were securely stored in a locked room and staff removed patient notes on the day of the appointment. However, in the main outpatient department we saw staff had left records unsecured with the name of the patient visible. Minutes from the October 2016 outpatient staff meeting reminded staff to place medical notes face down when on the trolleys to maintain patient confidentiality.

- Records were audited monthly and actions taken accordingly.

Diagnostic Imaging

- Diagnostic images were electronically stored on a picture archiving and communication system (PACS). This allowed staff to share images throughout the trust.
- An on-site registrar reported CT images overnight to avoid patient appointment delays.
- The department used an internal e-requesting system. However, A and E were still using a paper based system and information could not be shared with them. The trust was addressing this to ensure staff could share information between departments.

Safeguarding

Outpatients and Diagnostic Imaging

- Staff in all of the outpatient clinics understood their safeguarding roles and responsibilities in relation to protecting children and vulnerable adults.
- Staff in ENT and the fracture clinic were able to give an example of when they had contacted the safeguarding team.
- The trust set a mandatory target of 85% for completion of mandatory safeguarding training. Data (trust wide) provided by the trust showed 100% of nursing, medical and dental staff in outpatients and diagnostic imaging had completed their mandatory safeguarding adults and children level one and two training. The service ensured staff updated their training annually and was in line with the Department for Education's guidance for people working with children in England,Working Together to Safeguard Children (2015).
- All staff we spoke with knew who to contact locally to raise safeguarding concerns and we saw the names and contact details of the trust's safeguarding leads on the trust intranet. We also observed there were external links to the Birmingham Safeguarding Board and referral phone numbers to Birmingham and Solihull social care safeguarding teams on the trust's intranet.
- Staff told us, and we saw the safeguarding policies for both adults and children were easily accessible on the trust's intranet.
- We saw a poster on a noticeboard showing the hospital was holding an adult safeguarding conference.
- The radiology manager told us all radiographers had completed safeguarding children and adults levels one and two training. Senior staff told us three paediatric lead radiographers trained to safeguarding children and adults level three would soon be joining the department.

Mandatory training

Outpatients and Diagnostic Imaging

- Records demonstrated staff had completed their mandatory training in outpatients. The trust target stated 85% of staff should have completed their mandatory training. The trust did not collect this data for outpatients and diagnostics for each separate hospital.
- 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%).
- Senior staff said and records confirmed, all staff in the speech and language therapy team was up-to-date with their mandatory training at 100% compliance. Staff told us they always attended training, as they could easily arrange it around patient appointments and it was very flexible.
- Staff in the fracture clinic showed us that mandatory training was easily accessible on the easy learning electronic system. Staff told us they received reminder emails when training was due which were also sent to their manager.
- Staff conducted mandatory training on an annual basis, which consisted of some practical face-to-face training such as fire training in addition to online learning.
- All staff working in Imaging had their training records documented and signed. All staff who could request x-ray examinations such as doctors, some specialist

nurses and physiotherapists, received radiation awareness training when they first joined the trust. Radiographers received this training during their three-year training. The induction pack in Imaging was excellent and innovative especially for reflective practice.

Assessing and responding to patient risk

Outpatients

- The trust had clear guidance for staff to follow should a patient's condition deteriorate whilst under the care of the outpatients department. We saw a 'lesson of the month' for August 2016 shared by the trust with all staff. This included deteriorating patient information.
- Resuscitation equipment in outpatients was readily accessible throughout the department. Staff checked the equipment daily and records on resuscitation trolleys were up-to-date.
- The trust's resuscitation policy was easily accessible on the trust's policy website.
- Each clinic room in the diabetes centre had a call button for medical emergencies. Staff told us when the button was activated this flashed up on the screen at the reception desk. If the emergency team was needed it could be accessed by phone.
- Staff told us if a patient had any form of infection in the diabetes department such as MRSA, staff closed the clinic room, and an external company cleaned it before it was re-used.

Diagnostic Imaging

- Staff adhered to diagnostic imaging policies and procedures written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME) R. The service used a password protected electronic system to enable staff to access the right information at the right time.
- Diagnostic imaging had radiation protection supervisors in place. Their responsibility was to assist the line manager in ensuring that relevant staff read, understood, and followed local rules. They had all received training from the medical physics team at UHB. They also completed review training every five years in line with the national guidelines.
- Supervisors attended regular radiation protection committee meetings; we reviewed the minutes from these meetings.
- Staff in the medical physics clinics reviewed dose reference levels each year and senior staff shared the report with imaging staff. This ensured they used as low a radiation dose as possible to produce a diagnostic image.
- Staff used the World Health Organisation (WHO) checklist for radiology as recommended by the Royal College of Radiologists. In addition, the service had a radiation safety policy in place.
- We observed radiology staff worked to patient group directions (PGDs) for contrast injections.
- The department had a dose optimisation strategy in place and they were in the process of changing or reducing the exposures for paediatric CT head scans.
- All necessary Ionising Radiation (Medical Exposure) Regulations (IRMER) procedures were in place and up-to-date.
- Staff reviewed dose reference levels each year and we saw a report of the findings. We saw there was a dose optimisation strategy in place and the department was in the process of reducing the exposure for children receiving computerised tomography (CT) scans. CT scans use X-rays and a computer to create detailed images of the inside of the body.

Nursing staffing

Outpatients and Diagnostic Imaging

- There were no measures of planned versus actual staffing as the clinic resource was spread according to the acuity level of the clinics.
- The trust reported a vacancy rate of 26% in outpatients, radiology was the only unit included in 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 in 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 trust reported a turnover rate of 77% in outpatients (as of September 2016). Radiology is the only unit included in 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%.

Outpatients and diagnostic imaging

- Between October 2015 and September 2016 Heartlands Hospital reported a bank and agency usage rate of 2% and 5%.
- On the day of our inspection on 19 October 2016, the fracture clinic had all staff in post. Senior staff told us they would use staff from other sites if short staffed and they only used agency health care assistants (HCAs). Staff told us they were currently advertising for a part time band two post.
- Staff told us they planned rotas in the fracture clinic on a four weekly basis. We saw the staff rota for 24 October 2016 to 20 November 2016, which confirmed this.
- Staff told us agency staff filled staff shortages for non-administrative roles in the diabetes clinic. The service used the trust's bank staff for consistency of the service as they had received the trust's full induction.
- Staff felt positive about the e-rostering system management in outpatients had introduced, as this should be more efficient. A staff member in outpatients stated: "it's very exciting."

Medical staffing

Outpatients

- 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 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.
- 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%.
- Staff in the ophthalmology department told us they had a consultant from the University Hospital, Birmingham (UHB) who was a consultant lead and laser adviser.
- There were no vacancies in the physiotherapy department and all staff were permanent.
- The therapy clinical team leader told us there were two vacancies in the orthotics department and the service used locums to cover these shortages. However, due to the inconsistency of staff, patient complaints had increased as a result.

Diagnostic Imaging

- There were five radiologist vacancies and seven radiographer vacancies and this was on the service's risk register. The department used five agency locums to cover staff shortfalls.
- Interventional radiology was on the risk register as the department only had 2.5 whole time equivalent (WTE) radiologists. However, they still maintained an on-call service as radiological colleagues from a neighbouring trust had joined their out-of-hours service.
- Senior radiology staff explained the department struggled to recruit into these roles. There was a shortage of trained radiologists nationwide.

Major incident awareness and training

Outpatients and Diagnostic Imaging

- Staff in both outpatients and diagnostic imaging services understood their roles and responsibilities should a major incident occur. Staff knew who to contact and what processes to follow during an emergency.
- The trust had a major incident 'lockdown plan' and business contingency policy. The trust also had a robust overview of emergency planning arrangements policy. For the diabetes department this included the number of staff and security.
- Outpatient staff told us when the accident and emergency department (A and E) was flooded in June 2016; the trust had sent regular email alert updates. The trust used the outpatient department as an alternative area of the hospital to treat patients.
- The trust induction and annual mandatory training included major incident training. We also saw trust representatives attended training events in relation to major incidents. This included a trauma conference based around the 2015 Paris attacks as part of a trauma network conference.

Are outpatient and diagnostic imaging services effective?

Outpatients and diagnostic imaging

Not sufficient evidence to rate

During our inspection, we inspected the department but did not rate it. This is because we are currently not confident we are collecting enough evidence to rate the effectiveness of outpatients and diagnostic imaging services.

- Staff followed National Institute for Health and Care Excellence (NICE) guidelines in outpatient and diagnostic services.
- Radiology staff followed the Ionising radiation (medical exposure) regulations 2000 (IR(ME)ER) when taking x-rays.
- The weight management clinic was one of the main sites involved in a 'By-Band-Sleeve study' aimed at finding out what type of surgery was most effective at helping patients with severe obesity to lose weight.
- The diagnostic imaging directorate held monthly clinical risk and quality assurance meetings. This aimed to improve the quality of services the service provided and took into account evidence-based practice and guidelines in development.
- Each speciality completed its own audits and put action plans in place when change to current practice was required.
- In the outpatients and diagnostic imaging departments, patients could receive pain relief when needed.
- We saw good examples of team working across all specialities to ensure smooth running of clinics.
- Staff could access the information they needed to deliver effective care and treatment to patients.

However:

- Staff told us inputting data onto a number of different systems could be time consuming and it was not possible to share some information between the systems. This could cause delays to clinics.
- Not all staff received dementia training.

Evidence-based care and treatment

Outpatients

- Staff used evidence-based national guidance when caring for patients. Best practice guidelines were easily accessible on the trust's intranet.
- Each clinic in outpatients carried out their own audits to assess whether they were following National Institute for Health and Care Excellence (NICE) guidelines.
- The weight management clinic was one of the main sites involved in a 'By-Band-Sleeve study' aimed at finding out what type of surgery was most effective at helping patients with severe obesity to lose weight. The National Institute of Health Research (NIHR) funded the study and the Clinical Trials and Evaluation Unit at the University of Bristol led the programme. Following the study, staff wanted to be able tell patients what treatment to have based on clinical evidence and to be able to advise patients what operation would be most effective for them.

Diagnostic Imaging

- We saw staff followed the trust's local policies and procedures to provide safe and effective care to patients. Staff used evidence-based guidance when treating patients. For example, the department's referral criteria followed NICE guidelines for the stroke pathway.
- Radiology staff followed the Ionising radiation (medical exposure) regulations 2000 (IR(ME)ER) when taking x-rays.
- The IR(ME)R regulations specify the service has to conduct audits to ensure safe exposure and practice. Staff audited dose reference levels, which complied with IR(ME)R regulations, and records showed senior staff reviewed them regularly.
- 'Local rules' were available to staff on the trust's intranet. These explained the radiation protection measures in place to ensure patient safety. All imaging staff had to sign a document stating they had read and understood the local rules.
- The radiography service was working towards obtaining the Imaging Services Accreditation Scheme (ISAS) standard. The ISAS scheme is a patient focused assessment and accreditation programme to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- The diagnostic imaging directorate held monthly clinical risk and quality assurance meetings. This aimed to improve the quality of services the service provided and took into account evidence-based practice and guidelines in development.

Pain relief

Outpatients and diagnostic imaging

Outpatients and Diagnostics Imaging

- The trust did not have a policy for pain management but there was a pain management team on site.
- Nursing staff did not administer pain relief in outpatient clinics.
- In the outpatients department and diagnostic imaging, doctors assessed patient's pain and provided pain relief when patients needed it. Doctors documented this in patients' notes.

Nutrition

Outpatients and Diagnostics Imaging

- Staff in the diabetes clinic had facilities to make tea, coffee, and sandwiches for patients if required. However, staff encouraged patients to bring their own food to appointments if possible.
- There were a number of cafes and restaurants at the hospital providing hot and cold meals.
- There were plans in the main outpatients waiting area to have a water fountain.

Patient outcomes

Outpatients and Diagnostics Imaging

- The follow up to new ratio at Heartlands Hospital from April 2015 to March 2016 was similar to the England average.
- Each speciality completed its own audits and put action plans in place when change to current practice was required.
- The departments audited staff adherence to the trust's hand hygiene policy.
- The imaging department had annual equipment and radiation dose audits. The service compared these to national audit levels.
- The speech and language therapy team had worked to prevent patients who had undergone throat surgery from having to have feeding tubes fitted. Staff told us they reduced the number of patients who had tubes by half over a seven-year period and had improved patient outcomes.

Competent staff

Outpatients and Diagnostic Imaging

- Staff told us they were up-to-date with their appraisals and knew when their next ones were due.
- Data provided showed between April 2016 and September 2016 across the trust, 83% of staff in 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.
- In outpatients, staff told us e-rostering was causing delays to the appraisal programme; however, they were all booked in.
- Radiology staff who administered radiation received appropriate training and supervision.
- The induction pack in imaging was excellent and innovative especially for reflective practice.
- Radiologists were up-to-date with their appraisals between April 2016 and September 2016.
- Of the 26 consultants who worked in the department, 24 had received their appraisal, one had been delayed due to sickness, and managers had one planned for December 2016.

Multidisciplinary working

Outpatients

- We saw all staff including consultants and volunteers worked together effectively so that the clinics ran smoothly.
- Staff in the fracture clinic had regular informal meetings throughout the day as to share relevant information. Staff worked closely with physiotherapists, x-ray staff, administrators, and ambulance staff.
- Senior staff held directorate meetings bimonthly. Staff told us they discussed performance, complaints, incidents, finance, and human resource at these meetings.
- A manager in the diabetes told us they attended a weekly heads of department team brief to discuss and share information such as incidents. Staff also discussed patients with over 18 and 52 weeks referral to treatment times (RTT) at an outpatient group.
- The diabetes directorate had built up a good relationship with GPs over a long period. Overall, there was good MDT working with all staff including consultants, cleaners, and porters.
- A consultant in the diabetes team told us they participated in joint clinics with the obstetric team where there was good MDT working.

- Senior diabetes staff attended a variety of meetings such as a diabetic eye screening meeting, which Public Health England commissioned, board meetings with commissioners, and directorate monthly meetings.
- A band seven speech therapist attended weekly ENT MDT meetings. Staff discussed any changes to patient's conditions or diagnosis. A video link with consultant surgeons and the nursing team at UHB was set up so they could be included in the meeting. They also had good links with Coventry hospital and MDT meetings included a video link to the hospital.
- The asthma team held MDT meetings and nurses, psychologists and physiotherapists all attended. It was a requirement of the respiratory asthma hub to hold regular meetings.
- The physiotherapy team told us they had strong links with universities in Birmingham and Coventry and attended training days at the universities up to twice a year.

Diagnostic Imaging

- Radiology staff provided an out-of-hours interventional radiology service with the help of University Hospitals Birmingham. This covered a one in five rota.
- The department outsourced image reporting to an external company. Advanced practitioner staff also helped to report images for the service.
- The radiology team's speciality and site leads and clinical director held a weekly meeting to discuss standardisation of the service.
- The senior leadership team met every month and discussed performance delivery.
- The CT service had a good relationship with the hospital's A and E department. A and E staff told us the CT team treated extra emergency and urgent patients from A and E each day.

Seven-day services

Outpatients and Diagnostic Imaging

- Staff told us the fracture clinic ran from 8.30am to 5.15pm from Monday to Friday. They were not open for weekend clinics or bank holidays.
- The MRI service, general radiology, CT, and ultrasound ran from 8am - 8pm Monday to Sunday. The service added some weekend clinics if needed.
- Medical cover for radiology is provided Monday to Friday between 9am and 5pm. A doctor and consultant cover out-of-hours at all other times and report cases for all three hospital sites. The consultant is on call from home and can view images remotely. The consultant is available to attend site if contacted directly by a clinician. At weekends, there are two consultants on duty in the daytime.
- There is a separate rota for interventional radiology which provided a 24/7 service based at BHH, this service is currently compromised and is provided by University Hospitals Birmingham (UHB) on some nights. There is a procedure in place for clinicians to contact UHB and to transfer patients if required.
- Radiology staff also provided some out-of-hours services with the help of UHB. This provided a one in five rota. The service plans to offer seven-day services for all clinics as part of the service transformation planned.
- The opening hours of the outpatient clinics varied. Some were open at weekends if needed.

Access to information

Outpatients and Diagnostic Imaging

- Staff could access the information they needed to deliver effective care and treatment to patients.
- Outpatient and diagnostic imaging services used paper and electronic records to access patient information.
- Patients who had received imaging in other hospitals and then attended Heartlands Hospital could have their images transferred via an image exchange portal.
- The trust's policies and procedures were available to staff on the trust's intranet. Staff could therefore access them easily when required.
- Staff accessed records electronically but told us inputting data onto a number of different systems could be time consuming and it was not possible to share some information between the systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients and Diagnostic Imaging

- The trust had consent for examination of treatment policy, which provided staff with information for obtaining consent from patients.
- Staff understood the legal guidelines around consent. Records confirmed staff completed consent forms correctly.

Outpatients and diagnostic imaging

- We saw a consultant asked for a patient's consent before providing care that was more intimate. Staff documented this in patient notes.
- The trust told us Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not included in staff mandatory training. However, the adult safeguarding team trained staff either face- to-face or via e learning, the trust had developed. From April 2016, the trust had prioritised some band five and band six staff to complete the MCA and DoLS training, such as in Elderly Care.
- Policies on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were available on the trust's intranet to support staff.
- Learning disability, conflict resolution, and dementia training also covered the Mental Capacity Act.
- However, some outpatient's staff told us they did not receive any specific dementia training.
- Senior staff had highlighted the importance of the MCA to staff following an incident in the department.
- Staff in the weight management team ensured patients who were about to have bariatric surgery attended group or individual sessions. This was to ensure patients fully understood and consented to the treatment.
- Senior staff shared learning from an incident that involved the Mental Capacity Act 2005 to diagnostic imaging staff at a weekly staff meeting.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff in outpatient and diagnostic imaging departments were caring and treated patients with dignity and respect.
- Staff in outpatients answered patient's questions and took time to respond so they could understand.
- Patients were actively involved in their own care and could make decisions about their treatment received.
- Patients could have a chaperone if requested for an appointment.
- The multi-faith chaplaincy team offered religious, spiritual, and pastoral care to patients, visitors, and hospital staff 24 hours a day, seven days a week.
- Psychologists provided emotional support to diabetes patients and psychiatrists were available for patients undertaking weight management surgery.
- Oncology patients could have psychological support from University Hospitals Birmingham.

However:

- The radiology clinic had an open reception area and it was possible to overhear confidential patient information.

Compassionate care

Outpatients and Diagnostic Imaging

- We observed staff were caring and helpful and ensured patients were comfortable and warm. Three patients we spoke with in outpatients were happy with the care they received. A patient in the diabetes clinic described staff as "friendly." A patient we spoke with in the speech and language clinic said: "everything was explained well and staff are very good".
- A local radiology audit showed during the period of October 2015 to October 2016, 100% of patients would recommend the radiology service to friends and family for nine of those months.
- Patients could have a chaperone if requested for an appointment. The outpatient service used nurses to act as chaperones. Staff documented in a patient's notes with an accompanying staff signature and badge number if a patient had a chaperone.
- Eight staff formed the multi-faith chaplaincy team and offered religious, spiritual, and pastoral care to patients, visitors, and hospital staff. They were available to provide support 24 hours a day.
- Patients told us and we observed staff treated patients with dignity and respect.
- The radiology clinic had an open reception area and it was possible to overhear confidential patient information. Senior staff were aware of the issue and plans to refurbish the whole area to accommodate new equipment would resolve this.
- The multi-faith chaplaincy service was available to support patients, staff, and visitors in outpatients and diagnostic imaging services 24 hours a day, seven days a week.
- Friends and Family Test (FFT) data was not available from the trust for radiology and 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. For September 2015, out of 158 respondents in ophthalmology 92 said they were extremely likely to recommend the service to family and friends, 47 respondents said this in the ENT clinic, as did 30 out of 49 respondents in physiotherapy.

Understanding and involvement of patients and those close to them

Outpatients and Diagnostic Imaging

- Staff in outpatients answered patient's questions and took time to respond so they could understand.
- Staff involved patients in decisions about their care and treatment.
- In an ENT appointment, we saw a consultant discussed various treatment options with a patient.
- Information leaflets and useful information was available on noticeboards in outpatients.
- A patient in the diabetes department confirmed staff "explain well and go through all the information." However, a patient in the fracture clinic told us they were unsure which medical problem they had come to the clinic for that day.
- In speech and language therapy, we saw staff used diagrams and a model to explain to a patient how equipment worked to help their condition. Staff gave options to the patient so they felt fully involved in choices about what products they would prefer to use.
- Individual clinics obtained opinions from patients to improve and monitor services. For example, the outpatient physiotherapy service had their own patient feedback cards.
- In the diabetes clinic, staff trained patients to check their own blood pressures. This was a good example of shared care between patients and staff.
- Staff introduced themselves to patients and clearly explained what they were going to do.
- During patient appointments, we saw staff introduced themselves and fully explained any care and procedures.

Emotional support

Outpatients and Diagnostic Imaging

- Diabetes staff told us psychologists provided emotional support to diabetes patients and psychiatrists were available for patients undertaking weight management surgery.
- Staff reassured patients about their care and treatment.
- Oncology patients could receive psychological support from UHB.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- The physiotherapy department held early and late clinics during the week and opened on Saturdays.
- There was an evening diabetic clinic and adolescent clinic held once a month.
- Outpatients and diagnostic imaging departments were well signposted.
- The department had separate inpatient and outpatient waiting areas. This included a children's play area.
- The diabetes centre was a 'one stop' clinic with access to multi-disciplinary care all in one building.
- There was a telephone translation service available for patients whose first language was not English. Staff could arrange a translator in advance if required.
- We saw a good selection of patient information leaflets readily available in outpatients waiting areas. Some were available in a number of different languages.
- The diabetes and endocrinology service ran specialist clinics such as a foot service and renal clinic for diabetes patients. It also had a weight management clinic supported by the dietetic team.
- Radiology staff were writing a business case to support the need for specific software to report CT images out-of-hours from home so the service would then not need to use a third party off site company.
- Information about dementia was readily available to patients and their carers.
- An on-site registrar or occasionally agency staff reported CT images overnight to avoid patient appointment delays.

However:

Outpatients and diagnostic imaging

- Phlebotomy staff told us they would sometimes ask relatives to translate as it was difficult to use the telephone interpreter system in this department as staff and patients had to leave the area and set up elsewhere. This is not best practice.
- On the day of our inspection, some patients experienced long delays in the fracture clinic and had not received updates from staff.
- The radiology department was not always meeting the 35 minute CT stroke pathway turnaround times.
- Diabetes staff told us patients could sometimes wait up to four hours for the patient transport service to arrive.
- Staff told us the physiotherapy and fracture clinic shared a reception and staff were sometimes unaware when their patients had arrived and this could cause delays.

Service planning and delivery to meet the needs of local people

Outpatients

- There was a coffee shop situated near to the main outpatient area.
- Diabetes clinic staff told us if consultants did not to see patients in person, they conducted virtual clinics. The consultant would view any results and contact the patient directly via telephone or letter.
- Phlebotomy staff recorded did not attend (DNA) rates and patient cancellations. The directorate manager monitored results and the department was trialling sending a text message reminder to patients in an attempt to reduce DNAs.
- The physiotherapy department had audited DNAs against national guidelines. Senior staff wanted to know who and why patients did not attend appointments.
- The physiotherapy department held early and late clinics during the week and opened on Saturdays. There was an evening diabetic clinic and adolescent clinic held once a month.
- There was a separate children's outpatients department for children under the age of 16. We did not inspect this.
- Outpatients and diagnostic imaging departments were well signposted.
- The hospital had good public transport links. A clear map of the hospital showing all the different departments was on the trust's website.
- Patients and staff told us it could be difficult to find a car parking space at the hospital. Information about parking was available on the trust internet site. Parking tickets were available from the hospital parking office for between three and 28 days. There was also a 20 day exit carnet available to certain patient groups suffering from a serious long-term condition who needed to attend the hospital on a regular basis. This was valid for use for 90 days. Patients receiving certain income -related benefits could park free of charge at the hospital if they provided proof at the parking office.

Diagnostic Imaging

- The department had separate inpatient and outpatient waiting areas. This included a children's play area.
- Some clinics had separate male and female changing areas for patients.
- The department had their own porter who brought patients to their appointment and took them away from the department quickly and easily.
- The service recorded DNA's each month. Clerical staff contacted patients who had missed more than one appointment and arranged appointments over the phone.

Access and flow

Outpatients

- The total number of outpatient's appointments at Heartlands hospital between April 2015 and March 2016 was 420,926.
- From July 2014 to June 2015, the specialties with the highest attendance rates at Heartlands Hospital were therapies (12%) diabetes & endocrinology (10%) and ophthalmology (10%).
- Guidelines state 95% of non-admitted patients should start consultant-led treatment in 18 weeks of referral. The trust's referral to treatment time (RTT) for non-admitted patients in outpatient's was below the England average from August 2015 to July 2016. The latest figures for July 2016 showed the service treated 89% of patients in 18 weeks compared to the England average of 91%.
- The trust monitored call-answering rates in outpatient departments. The trust outpatient departments achieved a call-answering rate of between 90% and 91% for the period from March 2016 and August 2016.
- Did not attend rates for outpatients at Heartlands Hospital for first and follow up attendances combined between April 2015 and March 2016 were either 11% or 12% for all of this period.

Outpatients and diagnostic imaging

In total, 50,765 patients did not attend their appointments; this was higher than the England average.

- 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 in two weeks of an urgent GP referral (trust wide/all cancers) was 93.27%.This was slightly worse than the England average of 93.67%.
- Cancer waiting time data (trust wide) from April 2016 to June 2016 showed that the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was 87%.This was better than the England average set at 81%. First definitive treatment is the first clinical intervention intended to manage a patient's disease, condition, or injury and avoid further clinical interventions.
- 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.
- The trust were unable to provide data for the percentage of patients seen in outpatients at each hospital without full medical records being available. If records were not available, staff used a temporary set of records. This included 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).
- The percentage of clinics cancelled at the Heart of England NHS foundation trust in a six week period as of September 2016 was 7%; 19% of cancelations 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.
- We saw staff recorded late running appointments on the outpatient management system and escalated late running clinics to the senior sister. Noticeboards in each area displayed where there were delays with the name of associated consultant.
- Staff told us they only recorded late running clinics as an incident if it related to an incident in another department.
- Staff told us they notified patients of any delays by updating the clinic boards and speaking to patients directly.
- However, on the day of our inspection, we spoke to two patients in the fracture clinic who had both experienced a delay of over an hour. Staff had not informed them of a delay until they had already been waiting for an hour after their specified appointment time despite checking in with reception. A patient told us, "I saw nothing on the board to say why it was late."
- The diabetes centre was a 'one stop' clinic with access to multi-disciplinary care all in one building. Patients could access specialist diabetes clinics such as for eye health.
- The diabetes service had one admission avoidance appointment each day. Patients were either referred from A and E or the acute medical unit (AMU.)
- Phlebotomy told us patients could often wait for an hour to have blood taken.
- Therapy staff covered clinics if a staff member was off work due to ill health. On the day of our inspection, a member of staff was off work sick. Another member of the therapy team was able to step in and cover the appointment meaning the appointment could still go ahead.

Diagnostic Imaging

- The CT department was open 8am to 8pm, Monday to Friday and had staff on call for urgent scans.
- Radiographers kept patients up-to-date with waiting times by updating a white board in the waiting area every 30 minutes.
- Patient referral to treatment waiting times were in the six-week diagnostic target. Staff told us they sometimes had to use a mobile MRI unit to meet this deadline.
- The radiology department tried to meet the turnaround times for the CT stroke pathway reduced from one hour to 35 minutes. Staff were finding this hard to meet.
- An on-site registrar or occasionally agency staff reported CT images overnight to avoid patient appointment delays. Management had reviewed this system as workload out-of-hours had increased by five per cent and the service may need to employ more staff.

Meeting people's individual needs

Outpatients and diagnostic imaging

Outpatients

- There were six clearly defined waiting areas in the main outpatient area.
- The outpatient service was well sign posted from the main hospital area. Patients we spoke with told us they found the department easily.
- Staff told us the physiotherapy and fracture clinic shared a reception and staff were sometimes unaware when their patients had arrived and this could cause delays. This was because patients did not always book themselves in.
- We saw a good selection of patient information leaflets readily available in outpatient waiting areas.
- There was an eye-screening poster written in several different languages in the diabetes centre.
- We saw and outpatient staff confirmed there was a telephone interpreter service available. Staff told us this system generally worked well.
- However, phlebotomy staff told us relatives sometimes translated as it was difficult to use the telephone interpreter system in this department as staff and patients had to leave the area and set up elsewhere. This is not best practice.
- In the physiotherapy department, staff also told us the telephone translation service was not suitable for their clinics. If a patient required a translator staff would book them before the appointment.
- Diabetes staff told us if a patient required transport, they used a patient transport service (PTS) who they had a contract with. The centre had their own porter to transfer patients to other hospital areas. Patients were required to arrange their own transport to the centre but could arrange for PTS to transport patients home following the appointment if required.
- Diabetes staff told us patients could sometimes wait up to four hours for the PTS to arrive.
- Phlebotomy staff had raised a complaint to the PTS patient advice and liaison service (PALS), as a patient who had a pre-booked pick up had to wait five and a half hours for collection. The PTS apologised to both the patient and staff in writing and stated the delay was due to the volume of work.
- In the fracture clinic, staff told us relatives usually accompanied patients with a learning disability.
- The diabetes team told us they treat all patients as individuals and try to meet all patients' needs. Staff were able to give examples of how they supported patients who found it difficult to wait for their appointments in the waiting area.
- The diabetes team gave an example of assisting people from the travelling community as they may not have an address to send an appointment letter to so they provided them with a new appointment date at the end of their appointment.
- The multi-faith chaplaincy team at the hospital offered religious, spiritual, and pastoral support to patients, visitors, and staff 24 hours a day, 7 days a week. This included a Pentecostal Chaplain, Roman Catholic Priest, and both a male and female Muslim imam (priest).
- There was a Christian chapel in addition to a Muslim prayer room segregated into male and female areas. The chaplaincy team encouraged staff to use this area as a quiet space for time for reflection.
- Guidance for all religions was available including details of religious festivals displayed on the noticeboard.
- The diabetes and endocrinology service was a centre for excellence for bariatric surgery. It ran specialist clinics such as a foot service and renal clinic for diabetes patients. It also had a weight management clinic supported by the dietetic team. Staff told us patients travelled from all over the country for to attend the weight management service.
- In phlebotomy, staff did not receive specific dementia training. However, some staff told us they had experience of treating dementia sufferers through personal experience. The physiotherapy team cared for dementia patients in the community.
- We saw 'Let's talk' dementia sessions advertised in outpatients. Trust leaflets were also available to patients and their carers called: 'Dementia: Your Key to Understanding Me.' This also had links to useful organisations such as Age UK and the Alzheimer's Society.
- The speech and language therapy team held a clinic each week for patients with Parkinson's Disease. Staff told us they had good links with the community teams.
- We saw the trust had patient information leaflets about dementia on the patient information system. This included for example, guidance on eating and drinking for patients with dementia called 'dementia: eating, drinking, and supporting people with dementia.'

Outpatients and diagnostic imaging

- Staff in the speech and language therapy team told us they used picture cards for dementia patients to help them communicate and make sure patients consented to treatment.
- We saw speech and language therapy staff supported a patients' condition following a procedure to remove part of their throat by suggesting they keep a food diary to reduce some problematic symptoms.
- Several consulting rooms in the diabetes centre had bariatric beds and chairs.
- In the ENT clinic, we saw information boards with leaflets for patients such as 'learning to lip-read' and 'life with hearing aids.' This department also had two representatives who attended the hospitals domestic abuse support system meeting every four to six weeks.

Diagnostic Imaging

- We saw there were separate waiting areas for inpatients and outpatients.
- Staff in the radiology department were writing a business case to support the need for specific software to report CT images out-of-hours from home so the service would then not need to use a third party off site company.
- Consultants had computers at home to review general x-ray images.

Learning from complaints and concerns

Outpatients

- Staff in the fracture clinic told us they would try to resolve complaints locally before escalating to their management team. Written patient complaints received a response in writing from the trust.
- Staff recorded formal complaints in the fracture clinic. However, the service did not record informal patient complaints.
- Between August 2015 and September 2016, there were 12 complaints about Outpatients services. The trust took an average of 73.5 days to investigate and close complaints. This is not in line with their complaints policy, which states managers, should investigate complaints, and close them within 30 days. Complaints about clinical care accounted for 42% of all complaints received followed by appointments, delay or cancellation (21%) and communication / information problem (21%)
- The hospital's Patient Advice and Liaison Service (PALS) logged formal complaints received in outpatients.
- Phlebotomy staff we spoke with told us they do not receive any written complaints and most patients expected to wait up to an hour in phlebotomy.
- A complaints policy was easily accessible for staff on the trust's intranet.
- The main outpatients department had "tell us what you think about our service" leaflets. They provided useful information about when you should report a concern and who to contact with any feedback and suggestions.

Diagnostic Imaging

- Staff told us most complaints came through PALS. PALS sent all complaints to the relevant governance lead for investigation.
- Records showed senior staff discussed complaints at team meetings. The management team ensured staff learned lessons from complaints and circulated the meeting minutes to staff to stop them happening again.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- There was an excellent induction document written by one of the senior imaging managers. This related to reflective practice and gave the radiographers innovative ways of thinking about how they work.
- Staff in outpatients were positive about the planned merger and said the trust had communicated this to staff well.
- Imaging staff were had a good knowledge of the department's vision and values.
- We saw the physiotherapy service also collected feedback cards asking patients to act as 'patient champions' to help towards improving the physiotherapy services for the future. It also included a section for patients to give feedback about the services opening hours and any other comments about appointment times and service delivery.
- Individual departmental risk registers were in place and managers regularly reviewed them.

- Staff felt well supported by their managers and were confident to discuss concerns with them.
- The service held cost improvement programme meetings each month to ensure there was no loss of quality when reducing costs.
- Staff told us the trust was supportive and made adjustments and allowances for carers leave, emergency annual leave, or swap shifts if necessary.
- The physiotherapy team held team development days where senior staff spoke to the physiotherapists directly. Staff also used this as an opportunity to benchmark their procedures with the University Hospitals Birmingham.

However:

- Outpatient staff awareness of the trust's values and behaviours was variable.
- Some staff told us the executive team were not visible.
- In the radiology department, managers told us there had been problems with regular changes in the executive team and senior managers. This had meant lack of consistency of standards of the trust. Staff told us the trust management team was more stable now.

Leadership of service

Outpatients

- The majority of staff told us managers and their leaders were visible. However, a consultant told us the executive team were not visible.
- Phlebotomy staff told us the management support was very good "we work together well and managers are very responsive."
- A number of staff in outpatients told us they did not know who the executive team were and they were not visible in the department.

Diagnostic Imaging

- In the radiology department, managers told us there had been problems with regular changes in the executive team and senior managers. This had meant lack of consistency of standards of the trust. Staff told us the trust management team was more stable now.
- In the CT department, staff had felt 'leaderless' as the band seven post was vacant. However, the trust had recruited a replacement due to start in November 2016.
- Staff were positive about the merger with University Hospitals, Birmingham (UHB). They hoped this would help their service by having clearer pathways between the two trusts.
- The service had a new senior leadership team in place. Staff told us this was working well.
- We saw minutes from senior leadership and operational meetings that showed they managed the service well. The directorate executive team also held regular meetings. Senior staff told us and we saw minutes from meetings that showed the directorate management meetings were robust.

Vision and strategy for this service

Outpatients

- There were recent plans for Heart of England NHS Foundation Trust to combine with University Hospitals Birmingham NHS Foundation Trust (UHB) to become a single organisation.
- Staff in outpatients were positive about the planned merger and said the trust had communicated this to staff well.
- Senior staff in physiotherapy said the merger would help share best practice. They held an open forum with their own team so staff could give their opinions about the merger.
- Staff in speech and language therapy said the merger could be positive for their patients to make it an easier pathway with reduced barriers between the trusts.
- Staff awareness of the trust's values and behaviours was variable.

Diagnostics Imaging

- Senior imaging staff had given a presentation to all imaging staff in April 2016. This included the service's mission, vision, behaviours, and service objectives.
- The imaging directorate 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.
- Staff also knew the vision and values for the imaging service and could quote them. Staff told us they were pleased to have the trust's 'six standards of care' to provide a consistent service.

- Senior staff discussed the service's values and key positive behaviours with staff. Staff had accepted them and demonstrated they worked in them.
- Senior staff were encouraged to be open and honest with each other and the service leads. Staff took accountability for their own actions.
- The directorate had recently moved to a new management and senior leadership team model aimed at providing clearer roles, responsibilities, accountability, and reporting routes for staff.

Governance, risk management and quality measurement

Outpatients

- The trust had separated the outpatient directorate into five divisions in April 2016.
- The radiology leads from each hospital site met each weekly to discuss the performance any issues. Monthly error meetings also took place in an attempt to improve the standard of radiology techniques across the service.
- A manager in the diabetes team told us they attended a weekly heads of department team brief to discuss and share information such as incidents.
- Individual departmental risk registers were in place and managers regularly reviewed them. They reflected the risks clinical staff were concerned about. For example, lack of capacity of follow up appointments in the department was on their risk register. Directorate managers were aware of this problem and they discussed the backlog at weekly patient tracking list meetings and monitored them each month.
- The outpatient clinics documented risks on a local risk register. This included the level of risk, action plans, and review dates.
- The trust provided conflict resolution training for staff as part of the mandatory training.

Diagnostic Imaging

- One of the department's CT scanners was on the trust's risk register. The service was planning to replace this in 2017/2018.
- Trust guidance was in place to ensure staff asked women of childbearing age who were to undergo radiographic examination(s) above the knee or below the diaphragm and all nuclear medicine exposures if they could be pregnant or were currently breastfeeding before they had any radiation exposure.
- We saw there was an effective governance structure for the service. This ensured senior staff knew and discussed the risks to the service.
- The service held clinical risk and quality assurance meetings each month to ensure staff followed governance processes.
- The service held a cost improvement programme meetings each month where senior staff discussed how to ensure there was no loss of quality when reducing costs. The imaging leads were accountable for ensuring the service did not introduce unmanageable risks.

Culture in the service

Outpatients

- Nursing staff in the diabetes clinic told us they had a good team network.
- Outpatient staff felt well supported by the matron and operations manager who were visible. Staff at all levels felt valued and supported by their managers. Some staff had worked at the trust for over 20 years.
- Outpatient staff told us the executive team were not visible at ward level however, they would be confident to contact them over the phone.
- Staff felt managers listened to their ideas. For example, staff in the fracture clinic had requested a water dispenser for the department and managers had obtained a quote.
- Staff told us the trust was supportive and made adjustments and allowances for carers leave, emergency annual leave, or swap shifts if necessary.
- If there was staff conflict, managers would try to resolve with the individuals directly or escalate to the matron if required. There was a trust grievance and disciplinary policy to support this process.
- Fracture clinic staff told us: "Staff do not go above and beyond what is required, however what they do they do well with a smile on their face and they are always polite and helpful."
- The diabetes manager felt they could telephone anyone and they would help. Staff were proud of the unit and what staff had achieved.
- A consultant in the diabetes clinic felt the management team listened to staff and there was an open culture.
- A porter in outpatients was pleased to work for the trust although they felt it could be challenging.

Outpatients and diagnostic imaging

- A new member of staff in outpatients stated: "Everyone has been very supportive". It is a lovely team to work with."
- The ENT were very proud of their head and neck service.

Diagnostic Imaging

- Staff we spoke with felt supported and listened to by their line managers and lead radiographers.
- In the CT department, some staff had felt "leaderless" since the lead radiographer had left the service six months ago.
- Recent changes in management for the service gave more stability to the team.

Public engagement

Outpatients and Diagnostic Imaging

- The trust encouraged patient feedback through a variety of different methods including a patient survey, local audits and FFT. Staff in outpatients told us they did not see the results. A staff member in outpatients stated: "we are hoping patients mention the state of the chairs as then something will be done."
- We saw both services had FFT forms easily accessible in their waiting areas. We also saw posters inviting patients to give their opinion on what they thought about the service.
- We saw trust 'Tell us what you think about our services' leaflets in outpatients. They included guidance and a form for giving feedback or reporting a concern to the trust.
- We saw in the August 2016 edition of the trust's newspaper, the elderly care division had been running a project called 'Eat, Drink, Move' since March 2016. The therapies division and nursing division led this to 'encourage elderly patients to eat, drink, and move around to aid in their recovery.' This projected also aimed to return patients back home more quickly and to avoid rapid hospital re-admission.'
- We saw patient feedback cards in physiotherapy asking patients to act as 'patient champions' to help towards improving the physiotherapy services for the future. It also included a section for patients to give feedback about the services opening hours and any other comments about appointment times and service delivery.
- In August 2016, the outpatient pharmacy team carried out a survey to find out how they were performing. Of the over 160 patients and carers who took part, 84% told us we were performing well and 16% said we were performing satisfactorily.
- The dietetic team gave patients a specific dietetic feedback form. They collected these and regularly reviewed the results.
- We saw the physiotherapy service collected feedback cards asking patients to act as 'patient champions' to help towards improving the physiotherapy services for the future. It also included a section for patients to give feedback about the services opening hours and any other comments about appointment times and service delivery.
- There were patient feedback forms available in all departments. Senior imaging staff read the comments and discussed them at staff meetings.

Staff engagement

Outpatients and Diagnostic Imaging

- On a noticeboard in the nutrition and diabetic department, we saw there was a 'slim staff programme' run by the bariatric team and dietetic staff. This aimed to give staff advice about adopting a healthier lifestyle.
- In June 2016, the trust conducted a staff survey where approximately 2,500 staff were invited to participate in a Staff Friends and Family test. The test asked staff: 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. The results showed that 73% of staff (response rate was 31%) would recommend the trust for care and treatment. The results from the Staff Friends and Family test were published in the August 2016 edition of the trust newspaper.
- Dieticians set up stands at the hospital during 'Healthy Eating Week' to give staff and visitors information about healthy eating.
- The physiotherapy team held team development days where senior staff spoke to the physiotherapists directly. Staff also used this as an opportunity to benchmark their procedures with the UHB.
- Staff were encouraged to offer different ways of working in the department to ensure the patient experience was efficient, accurate, and effective. Senior staff documented this in the staff meeting minutes.

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

Outpatients

- The fracture clinic had struggled to recruit orthopaedic practitioners when externally advertised. They set up a new trainee orthopaedic practitioner post to 'grow their own' staff. This involved a five-week residential course at the Royal National Orthopaedic Hospital, Middlesex.
- The diabetes and endocrinology team told us they were shortlisted for an award for the greatest improvement in the management of patient blood glucose levels
- Diabetes staff asked patients if they would like to be involved in a study being ran by an external researchers and were given a small cash payment for volunteering. The study focussed on developing blood glucose monitoring systems for people living with diabetes.
- The physiotherapy department was running a study to use radial shockwave therapy injuries to determine if patient outcomes were improved. This treatment involved applying shockwaves to an area that needed treatment to speed up the body's own healing process.
- The speech therapy team conducted a study with the asthma team for how speech and language therapy could assist patients with problems with their vocal chords. This resulted in a £10,000 - £15,000 saving per year for the service. The weight management clinic was one of the main sites involved in a 'By-Band-Sleeve study' aimed at finding out what type of surgery was most effective at helping patients with severe obesity to lose weight. The National Institute for Health Research (NIHR) funded the study and the Clinical Trials and Evaluation Unit at the University of Bristol led the programme.
- The weight management service was a UK centre of excellence for bariatric surgery and was internationally renowned.

Diagnostic Imaging

- The service had a number of Society of Radiographer representatives in post.
- There was an excellent induction document introduced by senior imaging managers. This gave radiographers opportunities to reflect on their practice and innovative ways of thinking about how they work. After staff had completed the induction, a discussion took place between the radiographer and the on-site lead. This also ensured staff had the necessary knowledge to practice safely.

Outstanding practice and areas for improvement

Outstanding practice

BHH 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.
- The nurse educator told us in detail about the training plans for the ED nurses.

BHH OPD DI

- We saw an example of outstanding practice in the imaging department. There was an excellent induction document introduced by senior imaging managers. This gave radiographers opportunities to reflect on their practice and innovative ways of thinking about how they work.After staff had completed the induction, a discussion took place between the radiographer and the on-site lead. This also ensured staff had the necessary knowledge to practice safely.

Areas for improvement

Action the hospital MUST take to improve

BHH ED

- The trust must ensure that the premises is suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time.
- The trust must ensure it is doing all that is reasonably practicable to mitigate any risks in relation to patients waiting in the corridors, delays in triage and ambulance handover times.
- The trust must ensure infection control procedures including hand washing, the use of protective clothing and cleaning procedures meet the requirements to prevent the spread of infections.
- There must be effective systems to make sure that all complaints are investigated without delay.

BHH Surgery

- The trust must consistently ensure medicines are stored appropriately and are suitable for use.
- The trust must ensure staff are trained and competent to administer medicines under PGDs.

Action the hospital SHOULD take to improve

BHH ED

- The trust should consider that patients have a pain assessment and are provided with pain relief which is timely

BHH Surgery

- The trust should mitigate and action risks on the risk register by regularly reviewing the risks in a timely manner.
- The trust should consider a review of the appraisal system to ensure that they are all meaningful and that those areas with low completion rates, staff review and target.
- The trust should consider having a clear system across all departments for staff to seek advice when managing patients with learning disability patients and dementia.
- The trust should review its systems of flow and management of bed capacity by managing discharge of patients in a more robust manner.
- The trust should improve sufficient staffing levels in general surgery and the trauma and orthopaedics department. The risk of low staffing on these areas has been a risk on the risk register a while now.

BHH OPD DI

- The trust should ensure there is a robust system in place to monitor infection control and hand hygiene compliance in the main outpatient clinics.

Outstanding practice and areas for improvement

- The trust should ensure all equipment in the outpatient department is up-to-date with electrical safety testing.
- 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.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe Care and Treatment - Regulation 12 2 (d, g, h)** 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; (g) the proper and safe management of medicines (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; **How the regulations were not being met:** The three side rooms in intensive care did not have negative pressure to contain any bacteria within the room to reduce the risk of cross infection to other patients. Regulation 12 (2) (h) The environment in ED did not meet the needs of patients waiting. Having patients waiting in the corridor compromised their safety, resulted in ambulance waits and prolonged handover waits. Regulation 12(2) (d) Staff did not store and manage medicines safely in the surgical department. Expired controlled medicines for patients were not disposed of correctly. Staff did not record fridge temperatures accurately and temperatures

Requirement notices

exceeded recommended limits. Staff supplied and administered medicines under Patient Group Directions (PGD) when they were not trained to do so. Regulation 12 (2) (g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Receiving and acting on complaints 16 (1) (2)** 16.—(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. (2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. **How the regulations were not being met:** The trust did not respond to complaints in a timely fashion. This caused undue distress to people making complaints.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and Equipment 1(c)**

This section is primarily information for the provider

Requirement notices

All premises and equipment used by the service provider must be-

(c) Suitable for the purpose for which they are being used

How the regulations were not being met:

- The premises in ED was not suitable for the service provided, including the layout and size to accommodate the potential number of people using the service at any one time.

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...