

# University Hospitals Birmingham NHS Foundation Trust

## Quality Report

Queen Elizabeth Medical Centre  
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Birmingham  
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This report describes our judgement of the quality of care at this trust. 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

<b>Overall rating for this trust</b>	<b>Good</b>	
Are services at this trust safe?	<b>Good</b>	
Are services at this trust effective?	<b>Good</b>	
Are services at this trust caring?	<b>Good</b>	
Are services at this trust responsive?	<b>Good</b>	
Are services at this trust well-led?	<b>Outstanding</b>	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

University Hospitals Birmingham NHS Foundation Trust is large teaching hospital with a reputation for quality of care, information technology, clinical training and research. It provides care from the Queen Elizabeth Medical Centre which is a new hospital on the site of the original. At the time of our inspection some wards in the old Queen Elizabeth hospital building were open. The trust also provides sexual health services from a number of locations across Birmingham.

The new Queen Elizabeth Medical Centre opened in June 2010 and was constructed under the public sector private finance initiative.

The Trust provides direct clinical services to over 900,000 patients every year, serving a regional, national and international population. It is a level 1 trauma centre, and is a regional centre for cancer, trauma, renal dialysis, burns and plastics; and provides a series of highly specialist cardiac, liver, oncology and neurosurgery services to patients from across the UK.

We inspected this service in January 2015 as part of the comprehensive inspection programme.

We visited the trust on 28, 29 and 30 January 2015 as part of our announced inspection. We also visited unannounced to the trust until Friday 13 February. This included visits to critical care and Medical Care services.

We inspected all core services provided by the trust (note the trust does not provide maternity nor children's services). We also inspected sexual health services under our community services methodology.

We saw that Leadership of services at the trust was outstanding at both a local and an executive level.

Overall we saw that services were caring and responsive to patient's needs. We saw services that were effective.

We saw a number of areas that required improvement for them to be assessed as safe.

Overall we have rated this trust as Good. We saw a number of areas that we rated as outstanding in the services they provided.

Our key findings were as follows:

- Services in the trust had strong clinical and managerial leadership at many levels.
  - Staff were highly engaged with the trust and felt valued. This gave them a strong sense of purpose during their clinical interactions with patients.
  - A culture of local and national audit and analysis was encouraged. This led to change and improvements in practice and care.
  - The trust did not have a safeguarding children's lead at the time of our inspection.

We saw several areas of outstanding practice including:

- We saw that the trust had robust governance processes.
- We saw a powerful culture of innovation which encouraged staff to take opportunities to enhance the services provided by the trust.
- We saw strong recruitment practices, where teams were encouraged to over recruit when good candidates presented at interview to secure capable individuals when they were available
- We saw examples of where the trust had engaged with patients over previous problems and changed practice; such as complementary hearing aid boxes and sleep masks and ear plugs provide to all inpatients.
- We considered the use of theatre technicians to support trauma teams in the Emergency Department as an example of outstanding practice and indicative of the trust wide multidisciplinary working. The practice provided support to the duty anaesthetist for more complex patients and allowed learning between disciplines and departments.
- The Emergency Department clinical quality and safety newsletter enabled safety and governance messages to be passed to staff in the department in one concise document which provided a summary of relevant points and hyperlinks to original documents or sources of information. The system reduced the number of emails to staff freeing up time.

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

Importantly, the trust must:

# Summary of findings

- Improve infection control and hygiene, particularly in Urgent and Emergency Care services.
- Investigate and resolve the long waiting times in outpatient services.
- Ensure sufficient consultation time is available for patients with complex conditions
- Review progress on its 31 day cancer target, especially where radiotherapy is part of the pathway.
- Ensure appointment to the Children's safeguarding lead post is made.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to University Hospitals Birmingham NHS Foundation Trust

The Queen Elizabeth Medical Centre provides 1,151 beds consisting of 1,084 general and acute medicine beds and 67 critical care beds with flexibility for up to 80 beds. The trust does not provide maternity services, which are provided by Birmingham Women's Hospital which is situated on the same campus. These hospitals share some resources.

University Hospitals Birmingham is an NHS Foundation Trust.

The Queen Elizabeth Medical Centre opened as a purpose built hospital in 2010 and most services from the Queen Elizabeth Hospital and the Selly Oak Hospital were to be provided from one new location. In spring 2013 the

trust reopened four wards in the original Queen Elizabeth Hospital building nearby to accommodate winter pressures. These medical wards remained open and refurbished at the time of our inspection.

The Birmingham District is characterised by a higher proportion of non-White residents (42.1%) than is observed across all of England (14.5%). The Asian population in Birmingham accounts for 26.6% of all residents, and includes a sizable Pakistani (13.5%) and Indian (6%) communities. Birmingham District ranked 9 out of 326 Local Authorities in the indices of Multiple Deprivation (where one is the most deprived).

We inspected this hospital as part of the comprehensive inspection programme. The trust provides some adult community health services and of these, we inspected sexual health services.

## Our inspection team

Our inspection team was led by:

**Chair:** Yasmin Chaudhry, Previous CEO and National Director.

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

The team included CQC inspectors and a variety of specialists, including:

A trust Executive, Specialist in Orthopaedics; an Associate Director of Governance; a Head of clinical governance and quality; a Commercial Director - Estates and Facilities; a Safeguarding Adults and Children specialist; a Professor of Gynaecological Research with special expertise in oncology; a Physician in Haematology and former Medical Director and Clinical Director of Cancer Services; a Fellow of the RCP and a sexual health consultant; a Consultant Trauma & Orthopaedic Surgeon; a Consultant Neurologist; a Consultant in Anaesthesia

and Intensive Care - Responsible for cardiac and thoracic anaesthesia and intensive care; a Consultant in Clinical Oncology; a Physician in Elderly Care, Renal Medicine, Internal Medicine and Medical Education; a Consultant Colorectal Surgeon; a Consultant in Anaesthesia & Intensive Care with a special interest in Intensive Care Medicine; a Junior Doctor in Genitourinary and HIV Medicine; a Radiographer who manages an acute hospitals radiology service; a Head of Outpatients services; a Theatre Specialist retired Nurse; an ED Lead Nurse; A Head of Nursing, Emergency Department, Acute Admissions; a Senior Staff Nurse Cardiology; a newly graduated Nurse.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

# Summary of findings

## How we carried out this inspection

We inspected this service in January 2015 as part of the comprehensive inspection programme.

We visited the trust on 28, 29 and 30 January 2015 as part of our announced inspection. We also visited unannounced to the trust until Friday 13 February. Our unannounced visit included A&E, Medical Care Services and Critical Care.

We held three listening events before the inspection; one for the general public on 20 January 2015; one specifically for people with visual impairment at Cares Sandwell on 12 January 2015 and one specifically aimed at the Lesbian, Gay, Transgender and Bi-sexual community in Birmingham on 12 January 2015.

During our visits to the trust we held planned focus groups to allow staff to share their views with the

inspection team. These included all of the professional clinical and non-clinical staff in seven groups. For example, one for consultants with 55 attendees and one for nurses with 123 attendees.

We met with the trusts governors, with the chairman, chief executive and the executive team individually. We met with ward and service managers; divisional leaders and clinical staff of all grades. We spoke to non-clinical staff and volunteers. We spoke to patients and carers we met during the inspection.

We visited many of the trusts clinical areas (some more than once) and observed direct patients care and treatment.

## What people who use the trust's services say

The CQC Inpatient Survey (10 areas) found the trust Comparable with other Trusts (2013).

The Friends & Family Test (inpatient) rated the trust above the England average (2013/14); The Friends & Family Test (A&E): found the trust tracks the England average (2013/14).

The Cancer Patient Experience rated the trust as Comparable with other Trusts (2013/14).

From our public listening events we heard praise for the trusts services from a number of people. We heard that services in many areas met people's needs.

We also heard from some people who had challenges with service provision and where services did not meet their needs.

We used all of this information to help direct the inspection team and focus the inspection on areas important to users of the service.

## Facts and data about this trust

As at October 2014 the trust employed 7,572 (WTE) staff; 2,313 nursing, 1,076 medical and 4,183 other staff.

The trust had revenue of £692,400,000; an operating budget surplus in 2013/14 of just under £5m.

For 2013/14 inpatient admissions were 132,280, outpatients attendances were 729,695 and emergency department attendances were 97,298

During 2013/14 there were three Never Events reported. There were 204 serious incidents reported, of which 69%

were pressure ulcers. There were 11,364 incidents reported via the NRLS (national Reporting and Learning Service) included: no deaths, 81.9% 'no harm', 16.8% 'low harm'. This trust reports more cases to NRLS, which is often an indicator of a strong incident reporting culture.

In the period April 2013 to September 2014 there were 116 cases C-Diff (which was consistently above the England average) and six MRSA cases.

Additionally

# Summary of findings

- A&E 4-hour standard: Below standard/England average (Aug-Sep/14);
- 4-12 hour (time from decision to admit, to admission): Better than the England average (Dec/13-Aug/14);
- A&E 'patients who left without being seen': Higher than England average (Feb-May/14);
- 18-week RTT (surgery): Consistently below the standard (Jul/13-Jun/14);

NHS Staff Survey (2013) of 30 indicators: 17 positive findings; 2 negative.

Sickness absence rates are below England average (Jan/12-Jun/14).

The Chief Executive, Dame Julie Moore, was appointed in 2006; The Board has 6.7% BME and 46.7% female representation (source: PIR).

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p><b>Summary</b></p> <p>We saw that the trust had a robust incident reporting system, good rates of reporting and a strong process of learning from incidents.</p> <p>The trust has met its Duty of Candour responsibilities, and had been doing this for some time before this became mandatory in November 2014.</p> <p>The trust encouraged over recruitment of staff (above the agreed establishment) this meant that vacant shifts were more easily covered.</p> <p>The trust did not have a safeguarding children's lead at the time of our inspection. The person covering this role did not hold all of the necessary qualifications to enable them to discharge this duty effectively. The trust was in the process of appointing to this role with an appropriately qualified nurse in April 2015.</p> <p>We saw some poor examples of infection control in the trust, both in ward kitchen areas and in A&amp;E.</p> <p>Three never events had occurred at the trust since April 2013.</p> <p><b>Duty of Candour</b></p> <ul style="list-style-type: none"><li>• The leadership understood their responsibility regarding duty of candour. NHS hospitals had to comply with this regulation from November 2014. The regulation compels Trusts' to inform patients and or relatives when care has not been optimum even if the patient or relative was not aware of an incident or near miss.</li><li>• We noted that the trust had in place for a number of years (were told since 2011) the principles upon which Duty of Candour is based. The trust described examples of where they had shared information with patients and relatives in an attempt to be open about incidents.</li><li>• When the duty of candour regulations came into force, the trust reviewed its policy and made the necessary changes to ensure it remained compliant with the new regulations.</li><li>• We noted within the complaints policy (version 6) a section regarding being open with people which encouraged staff to adopt this philosophy.</li><li>• We saw examples where the trust was open with patients when things went wrong and were proactive in sharing information.</li></ul>	<p><b>Good</b> </p>

# Summary of findings

- We heard examples of how lessons were learnt through discussing poor care and changing practice. One incident, where a patient had suffered due to poor care had resulted in the consultant displaying a duty of candour by giving an apology to the patient and their relatives. We were told that an open, honest explanation had been given and they had described lessons learnt. This was subsequently discussed in a ward meeting and practice had changed.

## Incidents

- A robust process was in place to review mortality and morbidity information. The Hospital Standardised Mortality Ratios (HSMR) and standard hospital mortality index (SHMI) were presented to the Board and used to compare mortality data. Information was gathered from each hospital division and submitted to the medical director. Any death requiring an investigation was reviewed by the medical directors quality group; the quality committee was made up of members of the executive board. The trust reported between five and seven deaths per day which was less than the national average.
- Three never events had occurred at the trust since April 2013. Two were in surgery. The trust was not an outlier nationally in this area. A full root cause analysis had followed each one, and these were reviewed at the executive led safety meetings and shared with colleagues across the trust.
- There was an effective incident reporting culture in the trust. Staff felt confident to report incidents.
- The rate of incidents reported is higher for this trust than the national average; of these, 98.7% were no or low harm. This supports the view of a culture of encouraging staff to report incidents.
- Reviews of incidents were robust and challenging, but not designed to discourage reporting; an open (no initial blame) culture existed.
- Staff were invited to attend a root cause analysis (RCA) executive meetings to discuss untoward incidents such as missed doses, or poor performance. Although many staff told us they found this a daunting experience, the majority of staff agreed it improved patient care and provided a strong link between staff and the executive team.

## Safety Thermometer

- Each unit had access to informatics regarding measures of patient care, all of which was targeted to reduce the number of patient harm incidents. Data was held on the trust IT system and accessible to all staff.

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- The rate of C.diff was above the England average (which is 0.1 cases per 10,000 bed days). The trend had been falling over the past 12 months.
- MRSA cases peaked three times above the England average (0.01 cases per 10,000 bed days) in Dec 13, March and September 14. Other than this it remained at zero.
- Data suggested that the rate of pressure ulcers was rising in the trust since April 2014- July 2014. Over two thirds (69%) of all serious incidents were grade three and four pressure ulcers. However, the trust has informed us that the prevalence has improved.
- Data showed the rate of falls in the trust was reducing.
- The trust had a pharmacist as controlled drugs (CD) accountable officer

## Safeguarding

- The executive chief nurse told us the trust had enhanced the team in order to manage safeguarding children and vulnerable adults. This included identifying a lead nurse for safeguarding. The clinical commissioning group (CCG) conducted themed reviews of the trusts safeguarding incidents.
- At the time of our visit the safeguarding lead for adults was covering as safeguarding children's lead and did not hold a health visiting or RSCN qualification. The nurse was supported by the CCG (named nurse) with supervision and support. A named nurse for safeguarding children was due to take up post in April 2015. The children's emergency department did not have a liaison health visitor / nurse cover. Each of these risks had been identified by the trust and recorded on the trust At Risk Register.
- Safeguarding systems and process in place for adults showed there had been some good innovative work put into practice. For example a designated safeguarding intranet web-site, an electronic multi-agency safeguarding referral form which enabled safeguarding alerts to be emailed to social services in a timely manner and also a monitored safeguarding adults data base.
- Staff told us that the installation of a designated computer for safeguarding in the emergency department had promoted effective and time efficient working, where staff had fast and easy access to information as required.
- The safeguarding lead told us the trust had achieved all safeguarding training targets for safeguarding adult's year ending March 2015 and that there was good partnership working externally with agencies, stakeholders and internally across the trust.

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- However, we identified that the safeguarding procedures for safeguarding adults at risk needed to be more robust as they lacked clarity and needed updating to reflect the most recent case law.
- We did not find evidence through trust policy or safeguarding training to demonstrate how the care management and needs of people with learning disabilities or living with dementia were being promoted and met.
- The trust had a safeguarding group which met at two monthly intervals. We saw minutes of meetings which showed how incidents were collated and monitored.

## Infection Control

- We looked at the regeneration kitchens on a sample of two wards and found variable standards of hygiene and evidence of hygiene systems. We raised this with the trust during our visit, and they took action to improve standards.
- Within the emergency department and critical care there was a practice which involved staff leaving bloods samples on top of the sharps box for extended periods of time. Staff said it was done in case they needed more blood from the patient. This is poor infection control practice and also increased the risk of incorrect labelling.

## Environment and Equipment

- The new Queen Elizabeth Hospital is less than four years old. We saw a building that was clean, bright and airy. Much thought had been put into the building.
- We saw the building was regularly cleaned during our visit. Our inspection team had been to the trust in the weeks leading up to the visit, and had seen the same standards of cleanliness then.
- We noted traffic congestion at the main entrance to the hospital. We observed the situation on a Friday morning for 90 minutes. Parking attendants told us that Fridays were less busy than the rest of the week.
- We observed that the drop off area was in constant use by vehicles, spaces for disabled drivers were in constant use and taxis did not use the allocated taxi drop off area.
- Parking attendants told us black cab taxi's that have wheelchair ramps cannot alight passengers in the designated taxi drop off zone because the cab ramp was on the nearside exit from the taxi and this would put passenger into the middle of the road with buses.

# Summary of findings

- We saw taxis dropping off beside the fruit and vegetable stall and this created a bottle neck at the pedestrian crossing that blocked the traffic flow. This became a potential fire safety issue as it restricted fire tender access.
- Taxi drivers told us that patients needed to be dropped off close to the main entrance. Car park attendants told us that they were not on constant patrol in that area to keep it clear.
- Some staff commented to us that there were insufficient car parking spaces for them to use at the hospital. We looked at a designated staff car park on a Friday morning and noted that there were numerous vacant spaces available.
- The hospital visitor's car park was located close to the main entrance and linked by a covered walk way. Wheelchairs were available on car park levels and there was a buggy service to the main door.
- There was no evidence that fridge temperatures in one ward regeneration kitchen were regularly checked and some portable appliance testing was out of date.

## Staffing

- The executive chief nurse told us the trust had conducted a staffing assessment against NICE standards. The nursing dashboard informatics system was used to measure demand levels at any given time and the trust applied the Safe Nursing Care Tool. With the opening of the new Queen Elizabeth Hospital, staffing establishments had been reviewed and agreed.
- Nurse staffing levels were judged using the 'safer nursing' tool. Patient's acuity was assessed daily.
- In general care, nurse staffing levels were expected to be 1:6 on day shifts (i.e. one nurse to every six patients) and 1:9 at night.
- The trust had an internal 'bank staff' agency called Locate which was used in the first instance when staffing levels were expected to be below the expected rate.
- The trust had conducted a review of nurse staffing January 2015 which assessed itself against the National Quality Board 10 expectations regarding staffing. The Trust assessed itself as meeting all expectations. For instance the report detailed all the processes employed to meet staffing establishments on a shift by shift basis.
- There was a policy that encouraged services to over recruit. This ensured staffing levels (or the potential pool of staff) was above that required.

# Summary of findings

## Are services at this trust effective?

### Summary

We saw strong evidence based practice in the trust by many clinical teams.

Staff followed national and local guidance.

We saw strong MDT working in many areas. Staff valued the individual contribution and role of each other in the team.

The trust was breaching its 31 and 62 day cancer target. This seemed to relate to radiotherapy capacity.

The trust IT system was designed to support good outcomes (e.g. restricting actions and reminding staff of interventions due). Also through real-time monitoring out patient outcomes.

The trust monitored medical practice to identify outliers.

### Evidence based care and treatment

- The trust had detailed evidence based guidance for clinical areas.
- Staff followed the national guidance where it was available.
- Where national guidance was not available, staff had worked to develop local evidence based guidance.

### Service planning and delivery

- The trust breached its oncology 31 and 62 day target. A discussion with senior management indicated the breach was largely due to issues with the insufficient theatre time and access to the Linear Accelerator (which is a specialised radiotherapy machine). In addition the trust has seen a significant increase in referrals for radiotherapy from GP's and referring hospitals outside the trust's catchment area.
- The trust has put measures in place to modify the volume of referrals to include working with the private sector and liaising with NHS England to encourage external referrals to follow their own local pathway for treatment thus freeing up more time for the local population.
- The board had reviewed the level of medical cover in specialities and increased the number of staff where there were insufficient to deliver the service effectively. We saw minutes of board meetings in September 2014 where these had been discussed and approved. This included Consultant posts in Immunology and allergy; Haematology; Oncology; Endocrine Services; Gastroenterology and Kidney services.

Good



# Summary of findings

## Patient outcomes

- We saw the trust had an IT interface available on a tablet device for use by the staff whilst interacting with the patient. This allowed staff to see immediately which interventions were due and record observations.
- We saw this device would, for example, restrict prescribing of medication that patients were allergic to, and alert staff of missed medication doses.
- The tool allowed real-time monitoring of patient outcomes and uploaded to the central server.
- We saw a change in practice that had arisen from problems experienced by many patients with delayed medication. During the clerking process, the prescribing medications may be delayed as it can become a task not prioritised at clerking. The trust have now developed their IT system so it defaults to the prescribing page towards the end of the admission process. The junior doctor is unable to leave the patient until prescribing has also been undertaken. This means medication is now started in a timely way.

## Competent staff

- The training uptake rate was good. The trust and staff had a positive attitude to training and prioritised it in their working day. One reason some staff gave for not attending training is they would leave their work area understaffed. To address this some training was offered ward based.
- We spoke to one senior nurse who praised the trusts development programme. She had started at the trust as a domestic assistant and had, with the support of the trust trained in nursing and progressed to be a ward sister.
- University Hospitals Birmingham had been successful at recruiting staff; however, the trust recognised that nationally a lack of trained nurses and doctors would be a challenge for them in the future.
- The trust monitored medical practice to identify outliers. This allowed them to deliver supportive interventions to junior doctors to improve practice.

## Multidisciplinary working

- We saw that the trust encouraged a multidisciplinary working methodology. For example, dieticians were encouraged to be part of mealtimes.
- Doctors reported good working practices in the trust for multidisciplinary working.

# Summary of findings

- We considered the use of theatre technicians to support trauma teams in the Emergency Department as worthy of note. The practice provided support to the duty anaesthetist for more complex patients and allowed learning between disciplines and departments.
- Multidisciplinary team members, such as the pharmacists and speech and language therapists, had a handover every time they visited the critical care unit.
- A length of stay multidisciplinary meeting was held to discuss patients who had a length of stay of 30 days or more in critical care.
- Staff told us how the trust IT system encouraged multidisciplinary working. They explained that single systems encouraged all staff to share and discuss information on patients. They said its use helped them create a single plan of care for each patient.

## **Consent, Mental Capacity Act & Deprivation of Liberty safeguards**

- Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS) has been embraced and embedded in practice with in the trust. There were systems and process in place for sharing information and disseminating lessons learnt from the board to front line staff.
- We noted that the safeguarding procedures for safeguarding adults at risk needed to be more robust as they lacked clarity and needed updating to reflect the most recent on DoLS Supreme Court Ruling in March 2014.
- There were four patients under a DoL safeguard at the time of our visit. The safeguarding lead nurse told us that between April 2014 and end of January 2015, 91 urgent DoLS applications had been made trust wide and 76 applications were withdrawn either due to discharge or a patient regaining mental capacity.
- The trust was not always able to meet the seven day time frame for Urgent DoLS Applications in order to be assessed by a Best Interest Assessor (BIA), and had escalated concerns to the safeguarding adult's board and this was recorded on the Trust at Risk Register. This situation is comparable with other trusts nationally.

## **Are services at this trust caring?**

### **Summary**

We saw a strong ethos of patient centred care

We heard many plaudits from patients praising the staff for their caring role.

**Good**



# Summary of findings

We saw that the trust encouraged this through its culture.

## Compassionate care

- Where we saw staff were very busy; they gave the impression to patients of a calm atmosphere and therefore of 'time to care'.
- We observed positive interactions with both patients and their careers in all areas.
- We received a number of positive comments in praise of individual staff and whole teams on the care they provided.
- Patients told us 'no matter what they are doing, the staff are reassuring'.
- We saw that staff were proud to care for patients on their clinical area.
- Patients in side rooms told us staff would regularly 'pop-in' to make sure they were OK, and to offer a friendly face.

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

- Patients told us they felt involved in their care and the decision making. They told us staff took the time to talk to them.
- Patients told us that they felt able to seek information and support from staff; this included both nursing and medical staff.
- All grades of staff were seen introducing themselves to patients.
- We saw and heard positive examples of patients with learning disabilities and of a patient with epilepsy where staff involved both the patients and carer (as appropriate) in discussions.

## Emotional support

- We saw that staffs interaction with patients was reflective of the situation. Where it was about daily routine care; staff were friendly and light-hearted. Where the situation was more serious, staff portrayed a more respectful and professional attitude.
- The chaplaincy service was available to support patients and their families. This could be accessed through the staff, or through the multi-faith centre in the heart of the trust.
- Patients told us that staff sought to understand each patient; asking them about their home and social life and engaging with them on an individual level.

## Are services at this trust responsive?

### Summary

We saw that the trust was reaching out to its local community to support healthy lifestyle and awareness.

We saw volunteers who supported patients attending the outpatients service and through the trusts main entrance.

Good



# Summary of findings

We saw flow of patients outside the trust (i.e. discharge to community of social care) was a challenge; but internal movements were largely for clinical reasons.

The military defence programme was meeting the needs of injured repatriated military personnel.

We saw bed occupancy over 85%.

We saw a positive culture of learning from complaints; of changing practice and engaging patients in that change.

Staff were encouraged to deal with complaints at source and aim for local resolution. All incidents were captured for greater learning and reflection.

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

- Within the Equality and Delivery report November 2014 we saw that the trust was delivering free talks to the local public regarding subjects such as; heart health, keep fit and healthy eating and osteoporosis.
- The trust had recognised that some of its delivery challenges that related to capacity blocks were caused by offering care to patients whose local hospital also provided this level of care. The trust recognised that some patients chose University Hospitals Birmingham, where closer to home options may exist. In discussion with commissioners, the trust decided to restrict 'routine treatment' referrals to those within the local commissioning areas.
- This decision had been communicated, although anecdotally, we heard that some providers struggled with the short notice and subsequent up-scaling of their capacity. The UHB management saw this as a largely commissioning issue.

## **Meeting people's individual needs**

- The trust was participating in the 'Learning Disability Made Clear' campaign launched across the West Midlands during January 2015. The campaign funded by West Midlands Mental Health Institute and hosted by Black Country Partnership NHS Foundation Trust included a communication tool kit for staff to support people on a hospital visit. It was led by the trust's dignity in care team, launched at an event in the main atrium of the hospital in January 2015 and featured in the trust's News@QEHB monthly new sheet publication and on the trusts web site.
- The needs of people for whom English was not their first language were met either by the use of an interpreter or

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language line. We saw evidence in one of the community sexual health clinics of a Romanian interpreter being used. We noted that patient information leaflets were only available in English and not in other languages.

- A report produced by the trust demonstrated that they were reviewing the services offered to patients regarding translation. Anecdotal feedback from patients and clinicians indicated issues with delays and insufficient languages covered.
- We saw that volunteers were employed as 'greeters' in the main reception. They met people and welcomed them, directed them if they were lost. We spoke to one gentleman who was a volunteer. He was pleased to be able to offer this help to people who were vulnerable. He offered his time one half day per week and found it rewarding.
- Electronic patient records were used extensively within the hospital. All clinical staff had access to up to date information. The ability to update information was made easier by staff being able to use wireless tablets.

## Access and flow

- Staff we spoke to recognised the flow of patients out of the hospital to community or social care was a challenge for the organisation.
- We saw that patient movement across the trust worked well. We rarely saw patients who were outliers (i.e. on a ward which was not they ward they should be on).
- We saw that bed occupancy at the trust was consistently over 85%; this is the value at which it is deemed to have an impact on the efficient running of the hospital. However, we did not see this posed the trust an operational challenge as in many other organisations.

## Learning from complaints and concerns

- Since Q1 2014/15 to Q3 2014/15 the number of complaints the commission received about the Trust averaged 193. The figures have remained mostly static with small fluctuations.
- The top themes for complaints have been outpatient's delays/cancellations of appointments (present in the top three for the three quarters looked at), cancelled surgery, and delayed discharge/appropriateness and communication /information issues.
- Complaints also concerned how the trust responded to and managed complaints about its services. We spoke with a sample of two patients who had protracted contact with the trust because they were dissatisfied with the service. They had

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then become dissatisfied with the way their complaints were handled, including the attitude adopted by the trust. This included a complaint that had been upheld in part by the Parliamentary and Health Service Ombudsman.

- The trust reported that the number of complaints it received had fallen recently. We saw that the number of complaints had fallen each year over the past four years; from 840 in 2010/11 to 664 in 2013/14.
- We saw a number of examples where the trust had taken complaints and comments from patients and changed practice. Two examples of this are:
  - A patient lost their hearing aid and complained to the trust. It was identified that the hearing aid may have not been easily identified. The trust now provides a pink plastic box for each patient wearing hearing aids in which to store their aid. In this way, it is easy to spot and less likely to be lost.
  - One patient complained that they had difficulty sleeping on the wards. This had been a theme of complaints. The trust invited the patient in to discuss this. As a result all patients are now offered complementary eye masks and ear plugs (similar to those used on aeroplanes) to reduce the noise and distraction and night.
- During our inspection we found that the trust had reviewed and reorganised its approach and systems for managing complaints in the months preceding our inspection. This included appointing a new lead manager role for patients experience and complaints.
- All complaints were reviewed by the Chief Nurse or his deputy to determine the response.
- The trust encouraged staff to deal with complaints at source. Staff were encouraged to resolve complains locally and quickly where possible, and if not to be directed as a formal complaint. All complaints were logged with PALs to ensure the learning was retained.
- During focus groups staff confirmed that local resolution was adopted to try and resolve issues promptly for patients.
- A new document from the trust was being circulated to staff sharing learning from complaints. This had just started at the time of our inspection, and it was too early to consider the impact of this.

## Are services at this trust well-led?

### Summary

We saw strong leadership in the trust from all levels. Governance arrangements were strong and effective in most areas of the hospital.

Outstanding



# Summary of findings

We saw a culture of supportive engagement and encouragement for staff who worked for the trust.

Outcomes from the NHS Staff Survey showed the trust was in the top 20% of trusts nationally for staff engagement.

We saw staff understood the trust vision and their role in it. They were proud to work for the trust. This impacted positively on their ability to undertake their role.

Staff told us the trust encouraged a culture of 'patient first'.

There was a culture of improvement and innovation at all levels. All staff were encouraged to bring ideas to improve care and service delivery in the trust.

## **Vision and strategy**

- We saw that the previous strategy which had been planned had been met, resulting in in another five and ten year plans in place.
- The trust had a five year strategy and within this was a focus on individual professional issues and objectives. For example the nursing forum discussed objectives and cross referred with the trust's strategy, there was an allied health professionals forum.
- Individual professions were taken forward through target groups; for example, nursing had three areas of focus, workforce, patient experience and quality & standards.
- We saw and heard from staff who were engaged with this strategy and vision. Staff we spoke with could articulate the trusts future and their part in it.

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

- There were four operational divisions within the trust each with a Divisional Director, Director of Operations and an Associate Director of Nursing. Forums were held each month with matrons.
- The Associate Director of Nursing told us the current risks identified by the trust including leadership issues on two particular wards. During our announced inspection visit we noted that the issues on one of these wards had not been effectively resolved
- The nursing dashboard informatics system was used to measure demand levels and agency staff usage, including the trust's internal bank staff facility Locate at any given time. A performance report went to the Board. The trust identified that it needed clearer performance indicators.

# Summary of findings

- The new hospital was built under the Private Finance Initiative (PFI) and the building's first day of operations was in June 2010 but was fully occupied in 2012.
- We noted that the Post Project Evaluation is due to be undertaken in 2015 as required after at least three years of occupying the building. Our observations identified issues such as the traffic bottleneck and risk to fire tender access developed daily at the main entrance.
- The secretary to the Board who was the trust liaison for the PFI project compliance told us that the Post Project Evaluation was planned to commence during the financial year 2015/16.
- Outcomes of lessons learnt from serious case reviews, incidents and safeguarding investigations were reported and shared with the trust and at the safeguarding committee which met every second month. The committee included a Divisional Associate Director of Nursing, head of risk, HR manager, CCG representation and Trust safeguarding link leads.
- Each directorate had an educational lead who reviewed incidents and actioned training sessions.
- The committee structure feeds into the Board of Directors. The Chairman described how this structure worked well, and whilst the model may be non-standard in many respects (e.g. not having a NED responsible for quality and safety); the trust felt it worked well for them.
- The chief nurse described how divisional directors (usually a senior clinician) cannot be a director of the same division in which their speciality sits. This gave a fresh view and avoided conflict of interests.
- The chief nurse had a weekly clinical day to ensure oversight of clinical delivery and understanding of the issues experienced by staff.
- Senior staff told us how they had developed a tool for junior doctors to give their feedback on the organisation. They explained that traditional exit interviews were reactive; "by the time we get the feedback they've already left". This tool helped respond to issues in advance.
- The trust executive described the key risks they saw for the year coming as increased demand and the tariff structure. Also the trust was sighted on the external environment (social care) as an increasing risk with delays to discharge.
- Whilst the trust was better placed than most in recruitment in many specialities, the trust also viewed recruitment and retention in the context of risk (i.e. not complacent).

# Summary of findings

- Although the governance arrangements were strong, and the trust had identified ward West 2 as an area for improvement, we did see that the quality of service was not comparable to other medical wards for part of our inspection.

## Leadership of the trust

- The leadership of the trust was of a high standard with strong leadership from the CEO. Both the medical and nursing directors were well engaged and respected by staff. We saw a knowledgeable Chairperson and good involvement of both the NED's and Governors.
- We saw that the trust did not have a non-executive director (NED) responsible for quality and safety (as in many other trusts). The trusts view was that safety and quality was the responsibility of every NED, and that appointing a lead may diminish the responsibility of others. We saw this system appeared to be working well.
- We attended the trust board, and saw comprehensive discussion by executive and non-executive directors.
- We heard from many staff that the leadership of the trust valued their input.
- The trust consistently has lower rates of staff sickness than the national average.

## Culture within the trust

- We saw a positive culture within the trust. Senior managers were in positive praise of the executive team. Many of the staff we spoke with told us how proud they were to work for the trust.
- We heard that the trust had a culture of avoiding 'one size fits all' approach to solutions, but rather of adapting solutions to fit each area. We looked at the new electronic key system being adopted in the assessment units. We were told that once the trial was complete, other areas would be encouraged to review and ensure it was adapted for their local use.
- Staff told us that the executive team encouraged a culture of 'patient first'.
- Staff mostly knew the executive team. The board relationship with those delivering and supporting clinical care was strong and helpful.
- We met a student nurse on their last shift in their final year. They were highly complimentary about the educational and clinical support they had received during their placement from all levels of staff.

# Summary of findings

## Fit and Proper Persons

- The board received training and update on the Fit and Proper Persons Requirement in November 2014 as the regulations came into force. All board members had received a presentation and update in the principles and were aware of the requirement.
- During our inspection, the regular Trust Board meeting was being held. A paper was being presented at this meeting to ensure that the trust would be compliant. This confirmed and finalised the existing arrangements.
- No new executive appointments had been made since the regulations came into place in November 2014. However the process that the trust adopted to appoint staff was in line with the new regulations.

## Public and staff engagement

- The trusts engagement with its workforce can be measured through the NHS Staff Survey. Completed by all trusts in the country, this aggregates to an overall engagement score. The trust was in the top 20% of all trusts in the country for staff engagement.
- Public engagement staff were on most of the units and undertook their role with enthusiasm, gaining feedback from the patients.
- Of the 29 Key findings in the staff survey; the trust was better than average in 18 of these, which included nine in the top 20% in the country. Four were below average, with one (% reporting errors, near misses or incidents witnessed in the last month) being in the bottom 20%.
- The trust operates awards systems to engage and motivate its staff. There is a 'best in care award' and a 'best in staff award' and wards receive quality ranking.
- The staff see these awards as encouraging healthy competition and supporting staff to improve.
- In deciding the Trust vision, purpose and values, staff were invited to participate in identifying those that would be adopted (other than the 6 C's). These were approved at board level.

## Innovation, improvement and sustainability

- We saw a strong culture of innovation. Staff were encouraged to bring opportunities to improve and felt engaged in the process of innovation to improve service.
- An example of this was the drug key system on trial on the assessment units. It had been identified that significant nursing time is spent getting access to the drug cupboard key. This can

# Summary of findings

lead to poor practice of control of the key and ineffective use of nurse time. The team had identified a system where an electronic key is released to each member of staff on duty; it is linked to them and an audit trail available. It restricts access to some staff when skills and competencies have not yet been achieved.

- Staff had seen an additional opportunity to link this to patient's bedside medicine locker that allowed prompt access by clinical staff. They were encouraged to discuss this internally and trial the system with a view to wider roll out.
- Staff felt the trust listened to their ideas and was prepared to support those ideas that had merit.
- One person told us "there are 10 reasons that you can do something, rather than not do it" and described a culture of supportive innovation.
- We saw that work from the staff was published on the trusts website and praise given to staff who had achieved work of a high standard.
- Staff praised the IT services for the provision of real-time information. The PICS system provided patient and HR dashboards. Staff said they were both engaged in its development and suggesting new models of working.

# Overview of ratings

## Our ratings for Queen Elizabeth Medical Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Outstanding	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Outstanding	Good	Requires improvement	Good	Good
Critical care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of life care	Good	Good	Good	Outstanding	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients (sexual health services)	Good	Good	Good	Good	Good	Good
<b>Overall</b>	Good	Good	Good	Good	Good	Good

## Our ratings for University Hospitals Birmingham NHS Foundation Trust

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

### Notes

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

# Outstanding practice and areas for improvement

## Outstanding practice

- We considered the use of theatre technicians to support trauma teams in the Emergency Department as an example of outstanding practice. The practice provided support to the duty anaesthetist for more complex patients and allowed learning between disciplines and departments.
- The Emergency Department clinical quality and safety newsletter enabled safety and governance messages to be passed to staff in the department in one concise document which provided a summary of relevant points and hyperlinks to original documents or sources of information. The system reduced the number of emails to staff freeing up time.
- We saw a strong culture of innovation which encouraged staff to take opportunities to enhance the services provided by the trust.
- We saw examples of where the trust had engaged with patients over previous problems and changed practice; such as complementary hearing aid boxes and sleep masks and ear plugs provide to all inpatients.
- We saw strong recruitment practices, where teams were encouraged to over recruit when good candidates presented at interview to secure capable individuals when they were available.

## Areas for improvement

### Action the trust MUST take to improve

Importantly, the trust must:

- Improve infection control and hygiene, particularly in Urgent and Emergency Care services.
- Continue to monitor effectiveness of Urgent and Emergency Care services to continually improve patient outcomes.
- Investigate and resolve the long waiting times in outpatient services.
- Ensure sufficient consultation time is available for patients with complex conditions.
- Review progress on its 31 day cancer target, especially where radiotherapy is part of the pathway.
- Ensure appointment to the Children's safeguarding lead post is made.