University Hospitals Birmingham NHS Foundation Trust

Queen Elizabeth Medical Centre

Quality Report

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

Ratings

Overall rating for this hospital	**Good**
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Good
Critical care	Outstanding
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement
Sexual health services	Good

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, accident and emergency and medical care services.

We inspected all core services provided by the trust (note the hospital does not provide maternity nor children's services). We also inspected sexual health services as an additional core service of Outpatient's.

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.
- Critical Care services provided outstanding effective outcomes focused care and leadership.
- Medical Care and End of Life Care services were outstanding in their responsiveness to patient's needs.
- Urgent and Emergency Care Services had poor infection control practices.
- In surgery, we saw that safety checks of resuscitation equipment were not systematically carried out and some records were not completed appropriately
- 55% of staff waited over 30 minutes for their scheduled appointment in outpatients. During our inspection six patients waited over two hours.
- Staffing levels were good across the trust.

We saw several areas of outstanding practice including:

- We saw examples of excellent care and innovative practice, such as the interaction of trauma team with members from different disciplines.
- Urgent Care services 'clinical quality and safety' newsletter which informed staff of quality and safety issues such as earning from incidents, directed them to learning resources through e-links and shared information. It reduced the burden of emails to staff having this in one single issue.
- Critical Care Services had specialist 'burns shock' rooms (specially designed rooms with self-contained care and treatment facilities) to support best outcomes for these patients.
- Reduction in length of stay and reduction in use of a ventilator through physiotherapy multidisciplinary intervention in critical care.
- The trust used pioneering treatments to achieve positive outcomes for surgical patients with complex trauma cases and transplant needs.

Summary of findings

- Introduction of sleep packs and hearing aid storage boxes to all patients who require them.

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

Importantly, the trust must:

- Improve the infection control issues within Urgent and Emergency Services; both in clinical practice and in cleaning schedules.
- Resolve the poor labelling practices of blood samples in Urgent and Emergency care services.
- Increase focus on delivering the 18 week Referral to Treatment target.
- Improve safety checks of resuscitation equipment and recording in surgery
- Ensure the cleaning and hygiene in the ward based regeneration kitchens is consistently maintained.
- Reduce waiting times in the outpatients department
- Increase consultation time in outpatients particularly for patients with complex conditions
- Improve pain relief response in Urgent and Emergency Care services

In addition the trust should:

- Ensure the responses to the issues on West 2 are sustained, especially with regard to staffing levels.

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	Good 	Overall we found emergency and urgent services to be good. Care was provided in line with national guidelines and accepted care pathways. Staff were well-trained and well-managed which motivated them to provide good care. Our observations showed that staff were caring and compassionate towards patients and their families. The majority of patients we spoke with could not speak highly enough of the staff who had dealt with them. Services were tailored to meet individual patient's needs. Systems were in place to ensure that patients were dealt with as individuals and received assessment, care and treatment targeted to their needs. The service was well-led. We saw examples of excellent care and innovative practice, such as the interaction of trauma team with members from different disciplines, and the department newsletter. Audits were undertaken, but the results from these audits were required to improve outcomes. We did identify a number of issues in relation to infection control and standards of care, which individually would not have caused concern. However, the number of issues and the potential for some of these to affect patient outcomes either singly or in combination caused us to rate the service as 'requires improvement' in the area of safety. Among the issues of concern were: • Poor hand hygiene compliance. • General cleaning processes which left clinical areas unclean, on occasions for a number of consecutive days. • Where areas had not been cleaned because the department was busy, this was not communicated to nursing staff. • Poor practice was observed in labelling blood samples other than at the patient bedside. • Failure to check vital signs where clinical pathways suggested this should be done.

Summary of findings

- There was no compliant, safe mental health assessment room in the department.

Medical care

Good

Medical care services ensured incidents were regularly reported, acted upon and we saw examples of lessons learned. Infection control procedures were upheld by staff and equipment was well-maintained and in good supply.
Risks, concerns and complaints were identified and acted upon swiftly and patients were cared for by compassionate and competent staff.
Medication and staffing levels were well-managed across most medical services. However, concerns were raised on ward west 2 in both areas which prompted an evening visit during the inspection and also an unannounced visit two weeks after the inspection. Concerns were shared with the trust's senior management team and executive board members.
During both additional visits to ward west 2 we found that most of our previous concerns had been satisfactory addressed, except for staffing levels which we were assured was considered by the trust to be an on-going priority.

Surgery

Good

Overall, we found that surgery to be good. Patients told us they were very appreciative of the respect they were shown from the professional, compassionate highly valued staff. Learning from incidents was promoted and seen to be a learning and improvement tool in the trust.
We found that safety checks of resuscitation equipment were not systematically carried out and some records were not completed appropriately. In three areas, records showed that checks had been completed; however, we found medication, and one intravenous fluid bag and resuscitation equipment out of date. These issues were brought to the attention of the manager in charge and rectified promptly. Patients' safety was protected through the completion and review of appropriate risk assessments on the wards and in theatre.
Infection control processes were well-managed and the trust reported cases of infections appropriately.
Staff training completion levels were high and, to maintain these levels, some staff had been coached to deliver the training directly to the staff on their

Summary of findings

ward. There was a multidisciplinary approach which ensured the safe and timely discharge of patients in conjunction with discussions with their carers or family.
The trust used pioneering treatments to achieve positive outcomes for surgical patients with complex trauma cases and transplant needs; they admitted patients from all over the UK and further afield.
Many innovative surgical practices were taking place at the hospital, including the first use of the 'organ assist' device which allowed the transplantation organ to be assessed and prepared prior to the surgery.
Queen Elizabeth Medical Centre was not meeting the 18-week standard referral to treatment time (RTT) performance. This was reflected in the surgery risk register and it was noted that the trust had plans in place to improve performance as agreed with Monitor. Since the inspection the trust has assured us that they are now compliant with RTT, performance in April was 95.5%. 238 operations had been cancelled in the previous three months two reasons being given as lack of theatre time and emergency operations taking priority. The overall staff morale was high; staff felt the open, honest culture at the hospital made it a nice place to work.
The trust excelled in research, including working closely with the University of Birmingham to be one of the world's leading centres for research and treating liver disease.

Critical care

Outstanding ☆

Critical care services were found to be outstanding, providing effective treatment with excellent leadership.
There were sufficient, appropriately skilled and experienced medical and nursing staff available within critical care units.
Critical care services were obtaining excellent results for patients who received treatment that was based on national guidelines. The hospital had seven-day working and outstanding, effective multidisciplinary working which had a positive impact on patient care and recovery. Critical care staff were caring and compassionate.

Summary of findings

Bed capacity of critical care services was not generally a concern, although the unit had experienced delays in discharging patients to other wards. Staff remained with patients if they were moved within the unit to maintain consistency.
The team supported rehabilitation of patients well.
The leadership of critical care was outstanding. Staff reported that nursing and medical leaders were supportive and encouraged innovation. Staff were aware of and committed to the trust's vision and demonstrated commitment to its objectives and values. Staff were proud of the standard of care they provided and said that their achievements were recognised by their senior managers.

End of life care

Good

Overall we rated end of life care services as 'good'. Staff provided compassionate care for patients. Services were very responsive to patients' individual needs and those of their families and next of kin. We saw and heard about many examples where practical, emotional and spiritual needs were considered and met.
Although the trust did not take part in national audits, data from their own survey showed that relatives were positive about the quality of care and their experience of the service. We observed comprehensive and dynamic multidisciplinary working taking place, which covered all aspects of care. The trust's electronic information system ensured that do not attempt cardio-pulmonary resuscitation (DNACPR) records were managed safely. Medicines were prescribed and administered in a safe way and there was guidance available for anticipatory medications.
At the time of our inspection, the service was on the cusp of significant change which the trust believed would enhance and improve the service. It was clear that leaders of end of life care services worked collaboratively across the hospital and their commitment to delivering a good quality service was evident.

Outpatients and diagnostic imaging

Requires improvement

The hospital had recently been built during the past four years so had a new finish, furnishings and equipment. Patients we spoke with felt that the department was always clean. We saw robust infection control audits and cleaning rotas.

Summary of findings

Staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults. Patients told us they felt safe in the hospital and we saw their human rights were respected.

Staffing levels were judged to be safe by the staff and department managers. Staff had received the required mandatory training in order to keep patients safe.

We saw good use of evidence based guidelines and protocols. Staff were proactive in developing their own where none existed. We saw staff audited their work to ensure they were meeting the guideline standards and providing patient's with best practice.

Patients told us treatment was discussed with them and they were involved in the decision making process.

Staff praised the support they received from the trust with continual professional development and training. Staff said they were able to identify their training and experience needs in their regular appraisals and supervisions. We noted several of the senior nurses had links with the universities and some were completing their master's degree in their area of expertise.

We saw most staff were kind, caring and compassionate however we noted some complaints were raised around poor staff attitude.

We saw issues within outpatients around the service planning and access and flow through the department. Some patients waited as long as two-three hours for an appointment. We asked senior staff about waiting times, they told us patients only waited up to 45 minutes.

We noted that delays were due to staff overbooking clinics; seeing patients with complex conditions; delayed start to the clinic and emergency patients. We saw there was no action plan for planning the service accordingly to reduce the amount of delays and there were no targets set. There was a lack of clinic space for medical staff. We observed some medical staff had 10 minute slots to see each patient. Some medical staff told us this was not enough time especially for people who had complex conditions. However the average appointment time booked was 20 minutes.

Summary of findings

We saw within outpatient's gaps where the department was not developing action plans for areas of poor performance such as delays and overbooking. We noted there were infection control audits, cleaning and refurbishment audits, a governor walk round to gain patient's perspectives and that clinical audits were well established to ensure quality. Although monitoring took place we did not see actions associated to effect change. We saw there were plans at a strategic steering group to review areas for improvement. We noted local leadership for the service required further development. Some of the management team confirmed this and said they felt the recent development of the strategic steering group meeting would be essential in filling the current gap for the direction of the department and would provide clear vision which could be cascaded to staff.

Outpatients (sexual health services)

Good

Staff received mandatory and specialist training to meet patients' needs. Staff were knowledgeable about incident reporting and received feedback on lessons learned Infection control procedures were being followed. Medicines were being stored appropriately.

Evidence-based care was provided by competent staff and in accordance with national guidelines. An annual schedule of national and local audits took place to monitor the effectiveness of treatment. The results were regularly monitored within governance meetings and reported back to staff to implement changes to practice where required.

We found the sexual health services to be caring. Patients spoke highly of the staff and the service they had received. Patients were treated with dignity and respect. Patients felt supported and were given clear explanations about their care and treatment.

There was flexible access to clinics with booked and walk-in appointments. Early morning and evening appointments were available to accommodate people who worked during the day. Clinics were situated across Birmingham to provide more local services.

Some nursing staff who had previously worked in sexual and reproductive health service felt unsupported, undermined and not valued by management. However, there was a disparity

Summary of findings

between staff groups as medical staff and nursing staff who had previously worked in genitourinary medicine did feel well-supported. Medical staff who previously worked in sexual and reproductive health service felt the same. We acknowledged that this was a newly integrated service but improvements were needed to ensure that all staff felt supported.

Queen Elizabeth Medical Centre

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients and diagnostic imaging; Outpatients (sexual health services)

Detailed findings

Contents

Background to Queen Elizabeth Medical Centre

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

University Hospitals Birmingham has Foundation Trust status.

The trust is part of the Shelford group which comprises ten NHS multi-specialty academic healthcare organisations. They seek to benchmark to each other and demonstrate system-wide leadership.

The Queen Elizabeth Medical Centre opened as a new building in 2010 and most services moved from the Queen Elizabeth and Selly Oak Hospitals 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 sizable Pakistani (13.5%) and Indian (6.0%) communities. Birmingham District ranked nine out of 326 local authorities in the Indices of Multiple Deprivation.

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

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

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 Radiographer who manages an acute hospitals radiology service; a Junior Doctor in Genitourinary and HIV Medicine; 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 who took part in the inspection and who were a part 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.

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; 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.

Facts and data about Queen Elizabeth Medical Centre

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

- 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);

Detailed findings

- 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 28 are questions and the other two indicators relate to response rate and overall engagement scores: 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).

Our ratings for this hospital

Our ratings for this hospital are:

	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
Overall	Good	Good	Good	Good	Good	Good

Notes

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

Urgent and emergency services

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

Information about the service

University Hospitals Birmingham NHS Foundation Trust consists of two sites, the old Queen Elizabeth Hospital and the new Queen Elizabeth Medical Centre. Emergency services for the trust were provided at the new hospital site.

The hospital provided an emergency department fully staffed 24 hours per day, seven day a week.

Figures compiled by NHS England show that, in the 12 months from January to December 2014, a total of 101,671 patients attended the emergency department. On average through that period, 95% of patients were seen within four hours despite the difficulties of the winter months.

The trust was a major trauma centre and the hospital dealt with more than 250 critically injured patients per year. It offered a consultant-led resuscitative trauma team, dedicated trauma theatres and operating lists and the presence of all major surgical specialties on a single site.

The new hospital was opened to patients in 2010, but the planning and design dated back many years before that. The emergency services department was designed based on estimates of forecast demand. Over recent years, numbers of patients visiting emergency departments have increased, far in excess of expected numbers.

Due to proximity of the Birmingham Children's Hospital the Queen Elizabeth Medical Centre emergency department dealt primarily with adult patients, although around 5% or approximately 5,100 patients were children or young people who were either brought to the hospital to reduce travel times in life-threatening situations, or those who have been brought in by relatives for convenience.

Our inspection was completed over a three-day period. We visited the resuscitation unit, Major injuries (Majors) and minor injuries (Minors) units which formed the main accident and emergency (A&E) area, the diagnostic screening services, and clinical decisions unit. In addition, we followed the admission process of patients from A&E on to the wards.

We spoke with a total of 55 patients or their family members, and 45 staff, including nurses, healthcare assistants, housekeeping, porters, managers and doctors of various grades and support staff, including security and ambulance services.

We checked both electronic and paper patient records and other records and audits which demonstrated how the department was managed and assessed.

We consulted with patient groups and referred to national audits and statistical information to enable us to reach a judgement on the services provided.

Urgent and emergency services

Summary of findings

Overall we found emergency and urgent services to be good.

Care was provided in line with national guidelines and accepted care pathways. Staff were well-trained and well-managed which motivated them to provide good care. Our observations showed that staff were caring and compassionate towards patients and their families. The majority of patients we spoke with could not speak highly enough of the staff who had dealt with them. Services were tailored to meet individual patient's needs. Systems were in place to ensure that patients were dealt with as individuals and received assessment, care and treatment targeted to their needs.

Where children had attended the department and had been stabilised they were transferred by ambulance to the Birmingham Children's Hospital. Service level agreements existed between the two hospitals and the ambulance trust.

The service was well-led.

We saw examples of excellent care and innovative practice, such as the interaction of trauma team members from different disciplines, and the department newsletter.

An innovative clinical quality and safety newsletter had been introduced to the department which promoted good work and reduced administrative burden.

Audits were undertaken, but the results from these audits were required to improve outcomes.

We did identify a number of issues in relation to infection control and standards of care, which individually would not have caused concern. However, the number of issues and the potential for some of these to affect patient outcomes either singly or in combination caused us to rate the service as 'requires improvement' in the area of safety.

Among the issues of concern were:

- Poor hand hygiene compliance.
- General cleaning processes which left clinical areas unclean, on occasions for a number of consecutive days.
- Where areas had not been cleaned because the department was busy, this was not communicated to nursing staff.
- Poor practice was observed in labelling blood samples other than at the patient bedside.
- Failure to check vital signs where clinical pathways suggested this should be done.

There was no compliant, safe mental health assessment room in the department.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Summary

We found that improvements were needed in relation to infection control measures, some practices relating to records, timely assessment and re-assessment of patients, facilities for dealing with patients with mental health needs and in relation to consultant handover to junior doctors.

Incident reporting was supported by learning opportunities. We saw that a newsletter was produced by a consultant for staff who found it useful.

During the inspection we saw a number of issues which compromised infection control, these included; blood-stained sharps bins; blood-stained privacy curtains; we saw one incident of a syringe containing blood left on top of a sharps bin; and poor cleaning of blood gas machines. The plaster room had accumulations of large, dirty grey particles behind trolleys and bins and in the corners of the room.

Cleaning staff completed daily cleaning schedules which identified areas to the next shift of housekeepers. However, if the area remained busy, it would not be cleaned. The cleaning staff we spoke with told us they did not report any missed areas to the nursing team.

Formal handover of patients from consultants to junior doctors did not always take place when consultants needed to leave the department.

Where children had attended the department and had been stabilised they were transferred by ambulance to the Birmingham Children's Hospital. Service level agreements existed between the two hospitals and the ambulance trust.

Many aspects of the service which were measured in this area were good, such as: staffing levels of nurses and doctors; assessment and learning from incidents; the management of drugs; and safeguarding of patients.

Records were accurately maintained. Timely reassessment of patients' vital signs were not always completed.

Facilities for accommodating and assessing patients with mental health issues were not fit for purpose.

Incidents

- Urgent and Emergency Care services had reported no Never Events during the preceding twelve months. Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The trust used electronic incident reporting; all the staff we spoke with understood the system. We saw how incidents formed part of structured team meetings and were also discussed at handover. Learning from incidents was shared between teams.
- Senior managers told us they were confident that the system captured all reportable incidents in the department; however, some staff told us that minor incidents did not always get reported as staff, "didn't always have time". All staff were confident that incidents which affected safety were properly reported.
- Staff were able to describe instances where incidents had led to improvements or better understanding. Examples included where a junior doctor reported an incident where a patient was suffering from severe sepsis. The nurse coordinator, whose tasks included ensuring patient flow through the department to make room for new arrivals, tried to insist on the patient being moved despite three doctors stating that the patient should be catheterised prior to being moved. As a result, nursing staff now had a better understanding of the needs of sepsis patients.
- The emergency department 'clinical quality and safety' newsletter highlighted an incident where an investigation into a death had identified that, while in A&E, the patient's standardised early warning score (SEWS) had been incorrectly calculated as zero when it should have been one. The SEWS score of one would have prompted more tests. The importance of correctly calculating the SEWS score was emphasised.
- A department 'clinical quality and safety' newsletter had recently been introduced by one of the senior consultants. Doctors we spoke with told us they had found the newsletter really useful. We viewed a copy and saw that it contained summaries of senior

management meetings, with performance indicators, updates or outcomes from local audits, medical alerts and reviews of serious incidents and how to avoid similar incidents.
- The newsletter was designed as an electronic document and contained hyperlinks which enabled interested parties to access original documents or further advice about topics. We spoke with the author of the newsletter who told us that they had compiled it to create a simple overview of important news and issues, which could be emailed to all staff in the department reducing the number of messages which staff had to read. They told us they hoped to develop the newsletter to include photographs and more interactive elements.
- We found the newsletter to be an innovative and useful tool to keep clinical staff informed, promote good work and reduce administrative burden for its recipients.
- Mortality meetings took place monthly, where multidisciplinary staff discussed patient deaths within the department. The meetings identified the circumstances of the patient attending, the initial and follow-up care and treatment they had received and the circumstances of the death. We saw evidence of how learning from such situations was shared with the team.

Cleanliness, infection control and hygiene

- During the first day of our inspection, we found a number of infection control issues. In the resuscitation department, we saw that a full syringe of blood with uncapped needle had been left on top of a sharps bin. From our observation this was left for over 20 minutes and only placed into the bin when we pointed it out to a member of staff. Staff told us that this was a common practice and occurred when blood samples had been taken and blood gas analysis was being done. The syringes were kept in case further tests were needed.
- We saw that three sharps bins were contaminated with blood which had dried on the containers.
- On the second day we observed two emergency trauma cases admitted directly to the resuscitation unit by ambulance. In one incident, it was noted that, when staff removed the patients' boots, they were placed on top of a clean operating trolley. During the second case, we saw that the privacy curtains around the bay were contaminated with dry blood. This was pointed out to staff and the curtains were eventually changed.
- We noted that areas of work-surface adjacent to the blood gas machine and under the controlled drugs cabinet were worn, which could make it difficult to clean and also pose an infection risk.
- We spoke with two of the cleaning staff in the emergency department. They confirmed that cleaning the resuscitation area was part of their responsibility. We were told that because of how busy the resuscitation unit was, they found it difficult to find an opportunity to clean it. The area was designated for cleaning during the night shift when it was less busy.
- We looked at the cleaning schedule which housekeeping staff complete to indicate which cubicles and areas they had cleaned during their shift. According to the records, on some occasions, individual cubicles had not been cleaned for two and three days in a row. On some nights, the resuscitation area had not been recorded as cleaned. Records for 27 to 29 January 2015 had not been completed at all, so it was not possible to say if any cleaning had taken place on those dates.
- Cleaning staff told us that, when the department was very busy, they did not always manage to clean every area. They made a note of the areas which had not been cleaned and updated their schedule so that the next shift of cleaners would be aware. However, they told us that they did not routinely alert senior nursing staff about areas which had not been cleaned. This meant unclean areas could be in constant use, adding to the risk of cross-contamination. Alerting senior staff might have allowed staff to take the area out of use long enough for cleaning to take place.
- While there had been no reported incidents of hospital-acquired infections in the emergency department, the consequences of poor infection control practice would only become apparent some days later when patients had returned home or been admitted to wards.
- We saw that hand-cleansing gels were available in each cubicle of the department and also at various points around the department. We saw that staff used the gel; but we saw very few patients and visitors using hand gel.
- The service compliance with hand hygiene was 57% during the period 01/07/2014 to 31/10/2014 as shown by the trust's audit. As part of the hand hygiene audit additional improvement work was undertaken such as the supportive challenge of colleagues.
- We spoke with one doctor about hand hygiene procedures. The doctor had just completed a procedure

which involved four required stages where hand washing should take place. The doctor told us that hand washing had only taken place once throughout the whole procedure, explaining that, when they originally trained, (outside of this trust) the procedure only required hands to be washed on one occasion. The doctor agreed that induction training had been provided but had no recollection of infection control training being a part of it. Other doctors confirmed that infection control had formed part of the induction process.

- In another incident, a doctor was observed giving morphine to a patient via a cannula. The cannula was not capped and the exposed ends of the lines were not protected during the procedure; however, they did wear gloves and an apron and followed other aspects of the aseptic procedure correctly.
- We saw that personal protective equipment, which included disposable aprons and gloves, were used by healthcare workers and nurses during most of their interactions with patients. Most patients we spoke with told us they had seen doctors wash their hands or use disposable gloves when examining them.
- When dealing with emergency trauma cases, we saw that infection control procedures were followed. However, the efforts of staff were diminished by the fact that the resuscitation area hadn't been cleaned and the privacy curtains and sharps bins were blood-stained. We saw that the trauma team used wipe-clean tabards which acted as infection control barriers and also identified their role.
- The trust did have a number of systems in place to help monitor, control and prevent infection, these included, monthly technical and environmental audits. Which included curtain change procedures and close liaison between the infection control lead the department matrons and the Associate Director of Nursing. Additional training, monitoring and challenge regarding hand hygiene.
- The trust had an assessment of infection room (AIR) to isolate very high risk patients prior to entry to the emergency department.

Environment and equipment

- The hospital ambulance liaison officer's role was to ensure ambulance patients are received into the emergency department as quickly and efficiently as possible and to monitor the performance of the ambulance staff – They told us they had witnessed the department during very busy periods and said they had been impressed because the department allocated a dedicated nurse to continually monitor, assess and liaise with patients who were waiting in corridors to be seen or waiting to be admitted.
- The emergency department did not have a clinically safe room to accommodate and assess mentally ill patients in accordance with the Mental Health Act 1983 and the College of Emergency Medicine guidance. A room was available which nursing staff and the Rapid, Assessment, Interface and Discharge (RAID) mental health team members referred to as the 'mental health assessment room'. However, while the room met some of the requirements – it had two entrance/exit doors, panic alarms, and the furniture was secured to the floor – it failed to meet the requirements as it had a number of ligature points, and did not have an observation panel in the doors. The external windows of the room did not have obscured glass and there was a clear view into the room from administration offices a few metres away across a courtyard. This could cause increased anxiety for patients. When we asked a senior member of staff about this room, they agreed that the trust did not have a Mental Health Act-compliant room and the room in question was an interview room; they said the trust was looking to identify a more suitable room. We were assured that vulnerable patients were not left alone in this room which mitigated the risk.
- Resuscitation equipment was well-maintained, and we saw that regular checks were made to ensure equipment was present and ready for use from records. A log of these checks was kept. We saw that some checks had been missed, however, these were infrequent and subsequent checks showed that the equipment was in order. We saw documents to corroborate this that audit and checks of resuscitation equipment took place.
- We saw that the plaster room in the emergency department was dirty. It was clear that the main floor area was being mopped; we had seen how white plaster dust had been cleaned from the floor. However, plaster dust had been allowed to accumulate in the corners of the room and behind trolleys and bins. The dust had formed small grey balls which gave the impression that the dust had been brushed repeatedly into the corners by mopping. This was pointed out to cleaning staff on duty and the area was then cleaned properly.

- We examined trolleys and mattresses which were found to be clean and well-maintained. We observed staff checking trolleys and changing the medical gas cylinders on them, exchanging those which were low so that the trolleys were ready for use.
- Following bereavements, the department had a viewing room where relatives could be with their loved ones. The room was slightly less clinical than the treatment areas and shrouds were available to help make the deceased more presentable. Comprehensive bereavement packs were available which provided advice and guidance for relatives.
- We also saw the family or quiet room. This was a private room within the main waiting room where family members could meet with clinicians or nurses. People were able to spend time coming to terms with bad news and composing themselves before going back into public areas.
- We noted that, when patients were being treated in the resuscitation unit, their relatives waited directly outside the unit in the Major's area. The area was very close to the nurse station and ambulance booking-in terminal. This meant that relatives might overhear information being passed by the ambulance crew to nursing staff during the booking-in procedure, which could include personal information and clinical information regarding not only their own relative but also other patients. This posed a risk to the trust's information governance.
- We saw that there was sufficient equipment available to staff in the ED to enable them to provide appropriate care and treatment, such as ECG monitors.
- When we checked equipment, we found that devices such as commodes were generally kept clean and ready for use, although we saw one which required cleaning and another on which the frame was rusting.

Medicines

- We saw that there were systems, processes and policies to ensure medicines were received, stored administered and, where appropriate, destroyed safely. We saw that medicines were properly stored in secure cabinets. We checked stocks of medicine against registers and administration charts and found them to be in order.
- We saw that supplies of blood were stored in locked refrigerators and temperatures were monitored.
- Blank hospital prescription pads were left unattended on the doctor's station. We noted that five pads were out. The doctor and nurse stations consisted of large desks which had pedestal shelves along the outer edge. On one occasion, a prescription pad was left on the top of the shelf in full view and easily accessible to patients or visitors. We pointed this out to the nurse in charge who stated that this was normal practice, that it was not possible to secure the booklets as they were in constant use. They believed the risk of abuse was low because the prescriptions could only be used in the hospital pharmacy and not in community pharmacies.

Records

- The trust used an electronic patient records system. We saw that records were updated by staff as soon as they had dealt with a patient. This helped to prevent errors or omissions. We saw that records contained health and risk assessments appropriate to the individual patients.
- Some areas in the trust used integrated monitoring systems which meant patients' vital signs could be input directly into the system and staff would receive alarms if vital signs were outside expected ranges or if the checks were overdue. While the electronic records were available in the emergency department, the integrated system was not.
- Patient vital signs and the interpretation of them were recorded manually. We saw a number of instances where vital signs had not been recorded at appropriate times.
- A whiteboard was used to monitor patient flow through the department. A member of the nursing team was allocated the task of updating the board and allocating cubicles as they became free. We saw that most information was updated correctly and this allowed staff to quickly recognise where particular patients were within the department. The information on the whiteboards included due times for patients' vital signs to be repeated. We saw that, despite the board, vital signs were often left uncompleted. In one patients case, recording of vital signs was over two hours late.
- Clinicians did not always follow best practice. On one occasion, a doctor was observed labelling blood bottles at the doctor's station rather than at the patient's bedside. Best practice dictates that samples be labelled at the patient's bedside so that there are no distractions which could lead to incorrect information being recorded.

Urgent and emergency services

Safeguarding

- The trust had a safeguarding group which met at two-monthly intervals. We saw minutes of meetings in the emergency department which showed how trust-wide learning was shared with staff.
- We saw that adult safeguarding training was recorded, with 99% complete, and children's safeguarding training at 94% at the time of our inspection.
- Adult and children's safeguarding training was provided at two levels for nursing and clinical staff depending on their role. All the nursing staff and doctors we spoke with told us they had completed safeguarding training.
- We noted that safeguarding flowcharts were posted on the walls of the department with easy-to-follow action plans for staff.
- Staff we spoke with all had a good understanding of safeguarding procedures. They were able to name safeguarding leads. Although the trust had not had a children's safeguarding lead since October 2014, we were told that a new lead was due to start in April 2015. The trust adult safeguarding lead had been available to staff in the absence of a children's lead.
- We saw how chaperones were used to protect patients and staff. We saw that the chaperone system was used when a doctor approached a member of the nursing team and asked them to perform this role during an examination.

Mandatory training

- Nursing Staff told us that they had all completed mandatory training. Information provided by the trust confirmed that all nursing staff in the emergency department had completed their training.
- Hospital Life Support was mandatory for nursing staff achieving 87% against the hospital target of 90%. Manual handling target was 90% with the hospital nursing staff achieving 87% (hospital wide).

Assessing and responding to patient risk

- Patients arriving in the emergency department were assessed **in the Assist Area (high dependency area)** in accordance with national guidance; the Safer Nursing Care Tool was used.
- The emergency department used a streaming system to assess patients who attended other than by ambulance. Streaming took place between 8am and 8pm and during this time a senior nurse (usually a sister) would speak with each patient as they entered the department. Patients were categorised based on their condition and were given a coloured card. The cards dictated the patients flow through the department. Green cards indicated a patient who could be dealt with in Minors; an amber card meant patients progressed direct to Majors without needing further triage. Red cards elicited an immediate transfer to the resuscitation area. We observed this system in action as patients presented themselves to the streaming desk. Patients were assessed on the basis of their own presentation and the observation of the nurse. We saw that the system was effective in identifying the acuity or seriousness of patients' condition on arrival. We saw how a patient with chest pain was provided with a wheelchair and taken directly to the resuscitation area.
- The matron explained that streaming had been introduced on 5 January 2015. While a formal audit of the system had yet to be undertaken, the system had greatly improved patient flow, particularly for more serious cases which were being seen more quickly than in the past.
- Patients with minor conditions were seen by the Minors department and used the 'See and Treat' care pathway which was designed to improve waiting times and patient experience. Patients we spoke with who were waiting for, or had been seen under this process, all told us they were satisfied with how they had been treated and with the advice they had received.
- Some staff felt that they did not have sufficient time to spend with patients and described the department as a "production line", although they believed that patients received the care and treatment they required.
- Doctors told us of good interaction between specialities which enabled them to provide a holistic service to patients and to increase their knowledge and skills.
- An area of concern was in the checking and recording of patients' vital signs, which were not done in a timely manner. Re-checking vital signs was reliant on staff noticing the time themselves or marking up the patient whiteboard and being reminded by the coordinator, who was busy trying to manage flow of patients to and from cubicles.
- The trust did not routinely provide emergency services to children; these were dealt with by the neighbouring Birmingham Children's Hospital. However, staff were trained and well-prepared to deal with patients of any age. Staff explained that, in dire emergencies, ambulances brought sick children to the unit if it meant the child might receive earlier treatment. In addition,

staff explained that parents often brought children to the hospital, either because it was closer or some parents had stated they found it too difficult to find parking at the children's hospital. The trust had an agreement with the Birmingham Children's Hospital to enable children and young people to be transferred once they were stable and able to be moved. We did not see any young children using the department during the inspection. The trust had a paediatric resuscitation procedure which contained clear guidance regarding when and how to transfer a child to Birmingham Childrens' Hospital.

- All nursing staff were trained in basic paediatric life support and some had received advanced paediatric life support training. This meant that 100% of nursing staff were suitably trained.
- Rapid assessment and treatment had been recommended in emergency departments by NHS England as a potential method of improving standards and patient experience. While this unit did not have a formal rapid assessment and treatment team, we saw that many of the principles of the scheme were used, however because assessments were completed by staff in Majors there was no impact on patient flow. Rapid assessment teams can influence patient flow because they are an additional resource. Serious cases were assessed by a senior doctor on arrival and, in line with the scheme, this enabled:
- Early identification of cases which required admission.
- Time critical treatments and investigations to be initiated early.
- Patient outcomes and experience to be greatly improved.
- Junior doctors to learn by example.

The scheme was not used throughout the department but was complemented by the patient streaming system.

Nursing staffing

- Staff used the Safer Nursing Care Tool adult acuity and dependency measurement tool to assess and prioritise patients.
- We observed staff handovers in different areas including the 'hospital at night' handover. Bed management and anticipated demand were discussed based on historic information and trends in order to assess current and anticipated workloads. Key personnel from the different divisions were represented which enabled the 'hospital at night' team to understand where capacity was available and what issues might arise. Minutes of the meetings were recorded.
- Nurse staffing levels in the emergency department were safe. The department's forecast establishment and actual establishment are reproduced in the table below. The 'required establishment' refers to the number of staff which conventional calculations dictate are required for a department of this size. 'Planned future' refers to how the department will be staffed following planned recruitment. 'Actual' was the establishment on the day of inspection. All numbers represent whole time equivalent (WTE) of nursing staff.

Band/skill Level	B7	B6	B5	B3	B2
Required establishment	8	14	50	10.7	10.9
Planned profile	9	16.7	54	10.8	16.8
Actual establishment on inspection	10	15.4	51	10	16.8

- Agency staff were used in the emergency department to ensure safe levels of nursing and healthcare staff. We were told that, wherever possible, vacancies were covered by staff from within the department or by bank (overtime) staff who were employed by the trust and were familiar with the systems and processes.
- During one visit to the department, we were able to speak with night staff. Two qualified nurses who were on duty were agency nurses, one of whom told us that they had not received any local induction to the department.
- The trust worked in cooperation with the military and many of the staff were full-time members of the armed services. Military doctors and nurses worked alongside civilian staff, the military staff told us that working in the hospital enabled them to maintain and develop their clinical skills which helped equip them if they were deployed in their military capacity.

Medical staffing

- Medical staffing levels in the department were safe. Rotas were created to take account of skills mix and experience. Recognised tools were used to identify establishment.

Urgent and emergency services

- At the time of our inspection, the mix of experienced and trainee doctors within urgent and emergency services identified that there were no middle career doctors (those with at least three years' experience senior house officer or higher grade within their chosen speciality) in the department. However, the department had far more registrar and consultant-level doctors than would be usual for a department of this size. This compensated for the lack of middle grades.
- Junior doctors and registrars told us that the trust was an excellent and sought-after location to undergo initial training. They believed the trust was an excellent place to work and had a reputation in the medical community for clinical excellence. However, the trust tended to offer lower pay scales to middle career doctors than other hospitals, which may have contributed to staff moving on when they had completed their training.
- The higher number of consultant-level doctors resulted from the foreign doctor programme which was coordinated by the emergency department. We spoke with the administrator of the programme. They explained how doctors were recruited from many countries around the world to work at the hospital. The doctors had completed training in their own countries and had attained the level of consultant. They were recruited to the department for a two-year period and, in addition to the general A&E work, they were able to study and train in specific specialities. The result was that the department had greater numbers of higher grade doctors.

Percentage of doctors in each grade compared to the average of all trusts.

	Trust	England average
Junior	16%	25%
Registrar	54%	39%
Middle career	0%	13%
Consultant	30%	23%

- Consultants were available in the department between 8am and midnight each day; cover outside these hours was on a call-out basis. Senior managers explained that this was due to the lack of suitably qualified staff in the recruitment market. The trust was trying to recruit suitable consultants which would enable full cover 24 hours a day, seven days a week. During the core hours of 8am to 5pm the department had a minimum of four consultants on duty; at the time of our visit, there were five. Between 5pm and midnight the department had two consultants on duty.
- Some junior doctors reported that, on occasions, all the consultants would leave the clinical area to attend meetings or other duties and did not hand over responsibility to one of the senior registrars. This is acceptable practice for short periods; however, these absences often extended for several hours and on occasions consultants did not return after their meetings. The trust may wish to explore how to formalise the process to ensure handovers take place in case consultants are unable to return as quickly as they had anticipated.

Major incident awareness and training

- The trust had major incident plans which were accessible to staff on the intranet. Periodic reviews were completed of policies and procedures to ensure they were current and meet changing circumstances. We were advised that the trust was undertaking a scheduled review of the major incident policy at the time of our inspection.
- Nursing and clinical staff were aware of emergency planning procedures, including the trust business continuity plans. They understood and were able to describe their role and the command structures which were in place. Action cards were held in all areas with specific guidance to staff. The major incident plans and business continuity plans and action cards were all available on the trust intranet.
- We saw that major incident equipment was stored securely, labelled and ready to be taken into use. This included tabards for specific staff corresponding to action card roles, making identification of roles easier for other staff and other agencies who may be involved.
- Staff had received training in relation to chemical, biological, radiological and nuclear incidents. Decontamination facilities were available for these incidents.
- We asked staff to walk us through the care pathway if a patient presented with symptoms of Ebola. We saw that plans were in place to deal with such emergencies and staff understood how to follow them.
- Because the hospital was a centre for the repatriation of injured armed service personnel, security staff were alert to the possibility of extremist protests or attacks.

Urgent and emergency services

Uniformed security staff patrolled the hospital and grounds and monitored CCTV systems. They were not employed directly by the trust but, when we spoke with them, they told us that they had an excellent working relationship with staff at all levels and they were treated like part of the team. They understood their role in reducing conflict and protecting staff and patients.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Summary

Emergency and urgent services were effective but some improvement was required.

Within the last two years the trust confirmed that at least 30 audits have been completed in the department, of which 22 were local audits and eight were national audits. The National Audits included Severe Sepsis & Septic Shock, Paracetamol Overdose 2013/14 national audit report, Neck of Femur, Renal Colic, Mental Health, Assessing for cognitive impairment in older people. However when results had not demonstrated the level of compliance and improvement was needed the associated plans were not robust enough.

Staff were well-trained, and supported in their practice and training, with regular supervision and appraisals. Staff were motivated and enthusiastic about their work.

Patients were booked in to the service efficiently regardless of how they had arrived at the hospital. Initial assessments were completed in line with national guidelines. Streaming of patients occurred between 8am and 8pm which reduced waiting times for more serious patients.

Multidisciplinary teams worked to provide the most effective care pathway for the individual patient, whether in preparation for admission to a ward or in order to treat and discharge.

Evidence-based care and treatment

- Recognised care pathways were followed which ensured patients were dealt with and, where required, admitted or referred on to specialist wards or departments.
- A number of local audits were completed to assess compliance with local and national guidance. Other audits were completed by junior doctors as part of their training and were shared with the department.

Pain relief

- Recognised tools were used to assess people's level of pain. Most patients we spoke with told us that staff regularly discussed pain levels and medication had been provided when required or requested.
- We noted that one patient arrived by ambulance at 5.40pm with abdominal pain. The patient was seen by a doctor at 5.55pm but they did not receive pain relief until 7.50pm -- a delay of over two hours.
- The trust engaged in a College or Emergency Medicine's Fractured Neck of Femur Audit (2012-2013).The audit showed that the trust were comparatively slow to provide pain relief and also slow to arrange diagnostic x-ray services. Our observations indicated that prompt pain relief was still an issue, however, we did not evidence any delay in obtaining diagnostic screening services. We observed two incidents of serious trauma where patients received screening within 20 minutes of arrival.
- A recent local audit on shoulder dislocation was reported in the departments' January safety newsletter and stated: "In summary we are slow to give pain relief". The newsletter also advised that an audit of pain management had been completed in the department just prior to publication, but the results were awaited.

Equipment

- We saw that equipment was maintained ready for use, and that testing was completed and equipment date-marked to show when the next checks were required.
- We witnessed staff checking equipment labels and dates prior to using items.

Nutrition and hydration

- Most patients who attended A&E were seen and discharged before the need to consider food or drink arose. Patients attending the Minors unit had the option of using vending machines in the waiting room for drinks and snacks.

- Patients in Majors who were detained for longer periods were offered snacks and drinks if their condition allowed. Those whose health or condition appeared to be affected by, or could be compromised by, lack of fluid or nutrition were risk-assessed using recognised tools.
- We witnessed staff offering food and drink to a patient and their family member, when we spoke with the patient they confirmed that staff had been attentive to their needs. They had not needed to ask for food or drinks as these had been offered.

Patient outcomes

- Comprehensive statistical information was gathered and analysed within the department. The clinical A&E performance dashboard collected information which was used by NHS England to compare performance between trusts.
- We looked at the data for the nine weeks prior to our inspection between 7 December 2014 and 5 February 2015. Over this period the department met the 4 hour A&E target of 95% five times, narrowly missed the target (less than 1%) three times and significantly missed the target once (91.5%). The emergency department had participated in six of a possible 11 national College of Emergency Medicine (CEM) audits since 2010. The remaining CEM audits related to children's services which meant UHB were exempt.
- Doctors we spoke with were not aware if a more recent Vital Signs Audit had been completed.
- We did review the 'Saving lives audit' for Jan – April 2015, it demonstrated that cannula insertion and on-going care averaged 78%.
- Audits were completed locally. Junior medical staff told us they were given responsibility for certain audits or projects, and they then researched and presented the completed audit to the department as part of their training and development. Outcomes from these audits were used to provide evidence of effectiveness or identify areas for improvement. We saw how the audits were summarised in the departments' clinical newsletter. An example of how the audits were used to improve patient care would be the audit of pain relief in cases of shoulder dislocation. Following the audit guidance was circulated on pain relief and best practice, emphasising the need for timely interaction and prescribing of Entonox.
- Consultant sign-off was completed in accordance with the College of Emergency Medicine guidance (requiring a senior consultant or an experienced registrar to sign their agreement to discharge of patients with serious conditions). The conditions are listed as.

1. Adults over 17 who attended with non-traumatic chest pain.
2. Febrile children less than one year old.
3. Unscheduled return to emergency department within 72 hours of discharge.

- We reviewed the results of the Sepsis management audit, of the five measurements two were not met and the rest were nearly met. The initial audit was undertaken in 2014, it was re-audited in 2014 with some improvement. An associated action plan was produced, however no timescales were identified.
- Overall the trust had participated organised and collected data from a number of local audits. Of note patient outcomes on audit data collected in the pregnancy testing in advanced trauma, Paracetamol overdose, urinary retention and severe sepsis audits were poor. Only 8% of women of child bearing age admitted with acute trauma were tested for pregnancy, in line with best practice guidelines.
- The trust did not submit to the College of Emergency Medicine audit on Paracetamol overdose. They performed a local audit on this instead which found "significant non-compliance" with national standards. Post the findings of this audit, new guidance has been issued within the trust in January 2105, the implementation of which awaits a re-audit.
- During the initial College of Emergency Medicine sepsis audit in 2014, the A+E department performed very poorly on time to first administration of antibiotics. A re-audit was performed post local education and there was significant improvement, with 70% of patients admitted with sepsis given antibiotics in timely manner (an increase from 24% in the previous audit). In both audits however, initial treatment with a bolus of intravenous fluid was found to be poor. This fluid resuscitation finding was also supported by the monthly delayed ITU admission analysis. The trust found a recurrent theme of low volume fluid resuscitation in septic patients.
- Patients admitted with urinary retention had delays in receiving a urinary catheter to relieve the retention. 19% of patients audited had a catheter within an hour, with

60% patients having blood tests to assess their kidney function. Since the findings of this audit, further training has been planned for nurses to ensure more staff are able to catheterise a patient.

- There was good initial assessment of patients who came to hospital with an ankle injury with 95% of patients reviewed in accordance with the Ottawa ankle rules. Patients admitted with a head injury were rapidly assessed (83% in 5 minutes) and had timely access to CT scans and advice on discharge.
- Our observations during the inspection suggest that vital signs were taken and recorded but not always in a timely manner or followed up in the prescribed time. Underlying issues could be missed if vital signs were not checked, and early checks enable patients with deteriorating conditions to be identified more quickly and interventions put in place.
- We saw that many of the local audits which were completed were based on College of Emergency Medicine standards and complied with their guidance. However, the trust did not engage with the national audits which meant that it was not possible to compare performance at the hospital with similar hospitals.
- The full benefits of streaming patients on arrival in the department had still to be formally evaluated as it had only been introduced on 5 January 2015, however, anecdotal evidence suggested that it had not only reduced waiting times (particularly for more serious patients), but had improved patient outcomes and the number of admissions.

Competent staff

- We saw that nursing staff had all undergone appraisals with their line managers. Staff we spoke with told us they found the appraisal system a useful tool, enabling them to receive feedback on their work and to highlight areas of interest or specialities which they wished to pursue. Junior doctors described having been given projects or topics to research as part of their training. Projects had to be presented to their peers and senior staff.
- Doctors were supported in their revalidation process and reported that they had sufficient time to study in preparation for revalidation.
- Junior doctors explained how they were supported and monitored by senior clinicians. We were told how consultants who had observed practice would take junior doctors aside if they were not happy with their performance and, after a critical appraisal of the incident, would provide advice on how the procedure or examination should be conducted and, if required, assist the junior doctor through it. This meant that learning could take place in an open atmosphere and patient and staff confidentiality were respected.
- Consultant and junior doctor skills mix was monitored to ensure a combination of specialities was available. Where specialist advice was required outside the field of those present, specialists could be contacted on the wards. This was demonstrated by the attendance of an ear, nose and throat specialist when a family were not happy that a patient who had been waiting to see a specialist as an outpatient deteriorated and had needed to attend A&E.

Multidisciplinary working

- Doctors reported good working practices in relation to multidisciplinary working. This was evidenced during treatment of patients in resuscitation. Trauma surgeons worked alongside the A&E teams.
- Multidisciplinary team meetings were held each day to discuss patients in the department and ensure they were placed on the most appropriate clinical care pathway. Where patients fell within different disciplines, emphasis was placed on the most critical area when considering admission to wards.
- The clinical lead for A&E described how treatment of patients was dictated by the patient's individual needs, with cross-speciality working to ensure that clinically appropriate pathways were implemented for each patient. They gave examples of how patients were assessed against recognised care pathways which then dictated their progress through the department to admission or discharge. During our observations of practice in the department, we saw how doctors with different specialist skills assisted with initial examination and treatment of the more serious patients. This meant that patients received a more holistic review of their needs.
- Theatre practitioners worked alongside the duty anaesthetist in the resuscitation unit, bringing additional skills to the team, and providing skilled assistance to the anaesthetist.
- Patients in Minors tended to have less urgent issues. These patients were seen by specialist nurses or doctors

who were able either to treat and discharge or treat and refer back to the patient's GP with advice or guidance. If required, patients could progress on to Majors for more intensive treatment.

- Children under 16 years old were only admitted to the hospital where it was deemed clinically necessary and any such admission had to be authorised by the medical director or director of nursing. Where children had attended the department and had been stabilised they were transferred by ambulance to the Birmingham Children's Hospital. Service level agreements existed between the two hospitals and the ambulance trust. The hospital ambulance liaison officer confirmed that the ambulance trust worked with the two hospitals to coordinate transfers. They told us that they were confident that only patients who were well enough to travel were transferred and they had never had to challenge a transfer decision.
- Mental health assessments and support were provided by the RAID team – a specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham, for people aged over 16. In addition to teams being based in the acute trust, the service worked closely with other hospital psychologists and alcohol treatment practitioners.
- Diagnostic screening services were adjacent to the Majors department and we saw that there was very little delay in transferring emergency patients for scans and x-rays. We observed two trauma patients, both of whom received diagnostic screening within 20 minutes of arrival. Other patients in Majors or Minors had longer waiting times as they waited for doctors to refer them to the service. We spoke with staff in the diagnostic services during an evening visit; we saw that the department was quiet. Staff confirmed that A&E patients were all dealt with virtually as they arrived in the department during evenings and weekends.
- Ambulatory care services were provided in three locations within the trust. The services include day units and care for patients who had surgery and may require an overnight stay in hospital. The service complements the emergency department by providing a first point of contact for patients who have undergone procedures and returned home who felt unwell or needed additional advice or guidance. This helped to prevent unnecessary attendance at A&E.
- The department was part of the West Midlands Major Trauma Centre Collaborative which includes all trauma centres in the region. Quarterly meetings were held where best practice, training and common issues were shared.

Seven-day services

- The emergency department was open seven days per week and 24 hours a day. However, patient streaming, which routed patients to the most appropriate area of the department, was only conducted during busy periods. This meant that patients with more serious conditions had to wait to be triaged for long periods alongside patients with very minor injuries or issues.
- Diagnostic services were available on a seven-day, 24-hour basis.

Access to information

- The trust used electronic patient records, which meant that information was accessible. Ward areas also had integrated patient monitoring systems which alerted staff to medication or vital signs recording. We were told that the system was going to be rolled-out to the emergency department, but no timetable had been set.
- Trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides to policies and procedures to assist in their own role.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act 2005. We saw a number of examples of staff seeking consent and ensuring that patients understood what was being said.
- There were patients subject to or requiring deprivation of liberty safeguards assessment during our inspection. These assessments were required in circumstances where restrictions needed to be placed on a patient in order to ensure their or other people's safety.
- The assessment required external agencies to be involved in assessing the risk before a decision was made. Staff were able to restrict people's liberty while the process was being applied for, but needed to record the decision-making process and who had been involved to show that any decision was made in the

patient's best interest. Staff explained that while the assessments were applied for in relevant cases, the patient had often left the department before the formal process was completed.

Are urgent and emergency services caring?

Good

Summary

Services were caring.

We observed many instances of good practice during interactions between staff and patients. This included not only nursing and clinical staff but also porters, housekeeping staff and receptionists. Patients referred to staff who had treated them as "brilliant", "absolutely marvellous" and other similar tributes. Staff told us how they involve patients and, where appropriate, family members in discussions about their care and proposed treatment.

Consent was always sought and, where informed consent could not be given, reference was made to the Mental Capacity Act 2005. Patients confirmed that doctors and nurses had discussed their condition with them and that they had felt engaged in the process.

We saw that staff were friendly and courteous; they had a quiet, calm and relaxed manner.

Compassionate care

- We found that, throughout our inspection of the emergency department, there was a calm atmosphere. Staff were busy but did not give the impression of being rushed. Nursing staff in particular greeted people with a smile and put patients and worried relatives at ease.
- We saw how patients were spoken to by staff of all disciplines. They were asked about their condition, given explanations of treatment and asked if they consented before any treatment was given. The exception to the process being where patients were unconscious, or unable to communicate because of their condition, when treatment took priority over consent. Even then we were told that, in most cases, ambulance staff had spoken with or brought with them family members who had confirmed that, to the best of their knowledge, the patient would not object to any aspect of treatment.
- We observed staff interactions with patients and their families, offering drinks or taking time to explain. All staff were seen to display caring and compassionate attitude towards patients, sympathising with them and passing encouraging remarks. We saw a porter chatting with a patient in a wheelchair as he helped them put their slippers on. The porter explained where they would be going and what the patient might expect to see when they arrived.
- Some medical staff told us they felt they were too busy to dedicate the amount of time they would like to patients. They reported a "production line" approach to care which enabled them to address people's health needs but not always their emotional needs. Patients we spoke with did not feel this was the case; the majority of patients and their families told us they had found staff at all levels to be caring and compassionate.
- We followed a patient on their journey through the emergency department. They had attended the department with a relative who had driven them to the hospital. Because of their condition, they were streamed to the resuscitation area. The patient told us the staff had been amazing and efficient, they had looked after them and their partner.
- The trust was engaged in the NHS Friends and Family Test and patient satisfaction surveys were conducted in the emergency department. The department scored 8.8 out of a maximum 10 marks in relation to people's satisfaction with the amount of information provided to them about their condition or treatment. They scored 9 out of 10 in relation to being provided with sufficient privacy while being examined or treated in the A&E. These outcomes were largely in line with other trusts (NHS In-patient survey 2013 Emergency Department).
- Within the CQC accident and emergency patient survey 2014 the hospital scored similar results to other trusts, specifically within the care related questions.

Understanding and involvement of patients and those close to them

- Patients and their relatives all told us that they had felt involved in the assessment and treatment process. When we asked if patients had been given a choice of

treatments or options about their care, many patients said that there hadn't really been options. However, they knew themselves why they had attended and had an expectation of what the service could do for them and the staff had confirmed everything about treatment provided.

- Patients with more complex needs who were able to talk with us said that they had been told about treatment options and the benefits of one course of action over another. They said that they had been able to ask questions and consider what they wanted and felt fully involved.

Emotional support

- We saw how staff dealt with patients when providing feedback or guidance on their medical condition. Very often these exchanges were light-hearted and friendly because the information was not distressing. Where staff discussed more serious conditions with the patient or with relatives, we saw that nursing staff and doctors were very professional.
- Staff told us how the trust chaplaincy service was available to help support patients and their families, and in addition to the family room within the department staff patients and visitors could all use the trusts multi faith centre.

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

(for example, to feedback?)

Outstanding ☆

Summary

Services were tailored to meet the needs of individuals and delivered flexibly, with choice and continuity of care. The services in the emergency department were responsive to people's needs.

On 5 January 2015, the trust had introduced a new system for how people were assessed on arrival in the department. Anecdotal evidence suggested that this had improved waiting times for more serious cases, although a formal audit of the system had yet to take place.

There was an active review of complaints and how they were managed and responded to. The department was appropriately organised to meet the needs of patients. We saw evidence of how learning from complaints had resulted in changes to the service. There were policies and procedures in place to help patients move through the department and to receive treatment appropriate to their needs.

It was identified that the department was now too small for the number of patients who used the service. As a result, some patients in Majors were assessed in corridor areas due to all the cubicles being occupied. However, we saw that these patients received appropriate care and support. In such busy periods, the lead emergency department nurse on duty allocated a nurse to assess and observe those patients in the corridor area.

Service planning and delivery to meet the needs of local people

- Capacity issues did arise on occasions when demand outstripped the facilities. In order to cope with the demand during these periods, the department had a system in place to meet the needs of patients unable to remain in a bay or treatment room. A nurse was removed from the normal workload and had responsibility for monitoring and assessing patients who were having to wait in the corridors around the Majors area due to lack of assessment bays or treatment rooms. This meant that any patients whose condition started to deteriorate or required additional interventions could be referred back to the nurse in charge and they could be prioritised.
- Traditional triage still operated in the department after 8pm at night, where all patients who arrived at reception were booked in and waited to be seen and assessed by the triage nurse. However, the department had recently introduced a streaming system where a senior nurse met new patients as they arrived at the reception desk. The patients were streamed immediately using a colour-coded system: a red card meant they went straight to resuscitation, amber card to Majors, and green card to Minors.
- The clinical A&E performance dashboard collected statistical information and compared department performance against trust performance. Live information was recorded in relation to numbers of attendees in the department and the number of admissions by hour during the previous twelve hours,

compared to the same hourly periods during the previous three months. Staff could identify how many patients were waiting to be seen, how many were waiting for a decision on discharge or admission. Numbers of patients ready for discharge but still in the department and the numbers of patients who had been admitted but were waiting bed space on the wards.

- The system also provided comprehensive information to enable managers to analyse and respond to performance targets. The following areas were monitored:
  - patient attendances – Averaged 8,746 per month (May to October 2014)
  - re-attendances with seven days – Averaged 7%, over the period.
  - waiting times – to treatment – On average over the period 95% of patients were seen within 2 hours and 22 minutes
  - waiting times – to admission from decision to admit – 95% of patients were admitted within 3 hours and 15 minutes of the decision being made.
  - the number of emergency ambulance patients who did not receive an initial assessment (including brief history, pain and early warning scores) within 15 minutes of arrival – All ambulance patients were recorded as having had an initial assessment within 15 minutes of arrival

Data was also collected and analysed in respect of

- total time in A&E
- number of inconclusive diagnosis
- number of deep vein thrombosis and Cellulitis cases.

Meeting people's individual needs

- The emergency department dealt with patients according to their individual needs. There were three routes into treatment, which were reflected in the patient streaming process.
- Urgent patients who check in either via ambulance or helicopter or through the steaming system went directly to the resuscitation area. Emergency phone calls preceded the admission of these patients to allow the most appropriate team to gather in readiness.
- Serious illness or injuries were dealt with in the Majors department.
- Less-serious illness or injuries were dealt with in Minors.
- Translation services were available through a call-out system via the trust switchboard during office hours. Outside these hours a telephone service was used.
- Staff told us that it was rare that a translator was needed as the department had a very diverse workforce and there was usually someone available within the team who could translate. They also said that many people whose first language was not English brought a relative or friend with them who they were happy to have present during consultations. Whilst this is not considered best practice staff told us that it allowed patients to be seen in a timely manner and if required translation services could be called upon.
- Nursing staff had received training in dementia awareness. We observed how a nurse interacted with an elderly patient who was also living with dementia. We saw that both the patient and relative were fully involved in the conversation, and the patient was given time to consider what was being said and provide an answer. Where the patient appeared unable to answer, the relative was asked and the response was repeated to the patient.
- We were told that some patients who needed to attend on a regular basis carried hospital passports. This document gave reception and nursing staff details of their particular needs and contact details for assistance. The system was used to assist patients with a learning disability or those with a physical disability to help staff to communicate effectively with the patient without assistance.
- The hospital ambulance liaison officer told us that there was an excellent relationship between the emergency department staff and the ambulance crews. Each service was acutely aware of the targets and needs of the other's needs and both worked to ensure that patients received the best experience available. They described how, on occasions during busy periods, there could be delays in processing patients due to the availability of computer terminals and staff to book people in. The hospital ambulance liaison officer commented, "They will always take patients here; some hospitals will refuse patients when the details were phoned through even though the paramedics might think they were suitable, this place will take everything, they are brilliant".
- We saw how the department had introduced innovative working with the introduction of a theatre practitioner. A theatre technician worked alongside the A&E staff in the

resuscitation unit. This was improving patient outcomes by assisting the anaesthetist with more complex patient needs and increasing understanding between disciplines.

- One patient told us they had wanted to have a cigarette but, because they were unable to leave the hospital, they had been provided with nicotine patches.
- The matron described how a review had identified that a large number of asthma patients from the city's student population attended A&E as a result of poor management of their condition. Because of this the department were setting up a nurse-led asthma clinic to respond to the issues.
- The majority of patients in Minors said that, at no time during their visit had anyone told them how long they might have to wait, nor were there any notices to show estimated waiting times or reasons for delays. Patients in Majors were slightly better informed as staff would give them very rough estimates of waiting times to see doctors or receive test results.
- The trust had a multi-faith prayer room available for patients, visitors and staff.

Access and flow

- The emergency department dealt, on average, with 260 patients per day. The department was originally designed to deal with an average flow of 200 patients per day. Because of the constraints of the building when the department was busy, patients in Majors could find themselves waiting for considerable periods in corridors for cubicles to become free. We were told that, very occasionally, patients may receive assessments and be discharged without ever reaching a cubicle. Despite the lack of space, we saw that patients were treated with care and dignity regardless of where they waited.
- Figures produced by the Health and Social Care Information Centre indicated that, through May and October 2014, the number of patients who attended A&E each month averaged 8,746 and, of these, 7% or 609 patients had re-attended within seven days. Figures for November 2014 indicated a reduction in attendances to 8,328 and only 6.1% or 504 patients had re-attended. During the same six-month period, re-attendance figures for all England trusts averaged 7.5%. The re-attendance figure for the emergency department for November remained at 7.5%. This showed that the department performed better than the average. The matron, who took up the post in November 2014, advised us that a review of re-attendances was in the process of being completed.
- The ambulance staff and the hospital ambulance liaison officer said there were very few problems regarding breaches of transfer at the trust. They told us that most breaches occurred during very busy periods and were caused as a result of how long it took to input patient details into the system. They told us they had just observed an ambulance transfer which was recorded as having taken nine minutes – the target being 15minutes.

Learning from complaints and concerns

- The trust had a formal complaints system and advice was available in written form to help people make complaints. The trust Patient Advice and Liaison Service supported people who wanted to make a complaint and also provided advice and guidance on general matters.
- We saw that there were leaflets in various languages in the main waiting room explaining to people how to make a complaint if they wished to do so. We also saw that there was extensive information and advice to help people lodge a complaint on the trust's website.
- Staff told us that they tried to address people's concerns before they felt the need to complain. Staff told us that a regular source of concern for people was having to wait long periods to be seen after booking into the department. Staff were confident that the streaming system was having an impact on waiting times. We saw evidence that learning from complaints was shared during team meetings.
- We were given an example of how a complaint had been investigated and resulted in improvements in the department. Following a complaint from a psychiatric patient, the medical director had visited the department and discussed issues of chaperoning. As a result, an additional six healthcare workers were employed to provide sufficient staff to act as chaperones where required.
- The emergency department had received 101 complaints since 1 November 2013. We saw how these had been assessed. For statistical purposes, complaints were closed off in one of three categories. 'Upheld'

refers to complaints which had been found to be substantially correct. 'Partially upheld' was when part of the complaint had been proved. 'Not upheld' was where evidence did not support the allegation.

- Many complaints contained a number of elements, however, from our analysis we found that 43 complaints related primarily to treatment issues; 41 to how people were cared for; and 17 related to staff attitude.

Complaint outcomes November 2013 to November 2014

	Treatment	Care	Attitude
Upheld	6	7	0
Partially upheld	10	8	10
Not upheld	22	18	6
Awaiting classification	5	8	1
Total	**43**	**41**	**17**

- Staff told us that complaints were discussed during team and departmental meetings. We saw that complaints were included in the minutes of meetings when we checked these documents.

Are urgent and emergency services well-led?

Good

Summary

The department was well-led.

Staff were aware of the vision and values of the organisation. There were positive relationships between all members of the team.

Arrangements were in place for the governance, risk management and quality measurement of the department.

The matron had only been in post for two months and had instigated changes to systems and processes which had already impacted on the department. The matron had also identified a number of the issues which we found in our investigation. The mental health assessment room had been partially refurbished to make it less clinical, while negotiations to identify and equip a more suitable room had commenced.

Vision and strategy for this service

- Nursing staff and doctors we spoke with were proud of the hospital; they were enthusiastic about their role and believed they contributed to the vision and values of the trust.
- We saw that the trust's values were reflected in the way staff approached and dealt with the patients and their families.

Governance, risk management and quality measurement

- Local and national audits were completed which enabled managers to review different aspects of the service. Waiting time breaches were investigated on a daily basis to assess where improvements could be made and what barriers had caused the lapses. Breaches were reviewed independently of the department and once validated details were returned for the attention of the matron and department manager.
- Senior leadership within the department when asked were not able to tell us which national audits the department had not taken part in and why. Following the inspection the trust confirmed the only national audits they did not take part in were related to children and were not relevant to the hospital.
- We saw that the department risk register was monitored by senior managers and we were given assurances about the reviews and updates which had occurred, and we saw how these had been actioned. However, the register itself only provided the current stage of any improvement plan. It did not contain the date the risk was first identified or any chronology of events or projected completion dates. It did have an action plan column which had a short summary of the actions required to mitigate risks.

Leadership of service

- The department was led by a senior team of staff consisting of a matron, general manager and clinical director. Senior staff we spoke with described positive relationships with members of the Trust Board who they

said had visited the department and listened to their concerns. Junior staff were also aware of who senior staff and Trust Board members were and said they visited the department.
- The matron for emergency services had only been in post for a short period of time but had a clear understanding of the department and staff.
- Nursing staff at all levels told us they felt respected and had confidence in their managers. Staff had all received appraisals and they felt supported in their respective roles.
- Senior nursing staff band 7 and above met on a monthly basis to discuss issues and performance. Band 6 nurses met the following week where information was disseminated.
- The A&E clinical lead oversaw weekly departmental meetings.
- Senior nurse leadership within A&E was excellent. The senior sister/nurse in charge acted as a role model for the team, challenging issues such as patient confidentiality. They always remained calm when the area was busy and under pressure.

Culture within the service
- Staff told us they felt they were an important part of the trust.
- Staff at all levels in the department set themselves high standards in how they dealt with patients and used the latest techniques and clinical guidance to achieve good outcomes for their patients. However, it appeared that the less-dynamic and more mundane aspects of the work were given least attention which led to minor breakdowns in infection control standards and procedures.
- The department used a number of methods to collect and analyse information to assist in understanding their performance. Internal audits, with the same criteria as national audits, were used with good effect.

Public and staff engagement
- The trust used a combination of email, intranet messages and newsletters to engage with staff. Managers, including executive level, were visible in the department. The A&E clinical performance dashboard recorded executive visits to the department.
- Staff told us that they had confidence in their managers and believed they were genuinely interested in improving services and conditions. We were told that a member of the board had visited the department when following up a complaint from a patient and, as a result, an additional six healthcare assistants were employed to ensure sufficient staff were available to act as chaperones to protect patients and staff.
- The emergency department's 'clinical quality and safety' newsletter was emailed to all staff in the department and summarised issues, meetings and good news in one place.
- The trust newsletter was available to the public through the trust's website. We were told that hard copies of the newsletter were also available for members of the public; however, we did not see any of these in the public areas of the emergency department.
- The trust newsletter included a 'You said, we did' section where the trust demonstrated how it had responded to issues or problems identified and reported by the public.

Innovation, improvement and sustainability
- Membership of the West Midlands Major Trauma Centre Collaborative provided an opportunity to share and learn from similar departments.
- Membership of the Shelford Group meant that cross-site learning between group members could take place for staff at all levels of the service, including in A&E.
- The theatre technicians' resuscitation project increased understanding between departments and provided skilled assistance to the duty anaesthetist and training opportunities for A&E nurses as well as the theatre technicians.
- Individual junior doctors were given audits and projects to complete as part of their training. This increased their skills and managerial understanding. It also provided additional audited material for department managers to help assess performance.
- The emergency department's 'clinical quality and safety' newsletter reduced the number of staff emails and provided an instant guide to issues, with hyperlinks to more detailed information or guidance for those who required it.
- A nurse led Asthma clinic was being introduced following a review which identified poor self-management of the condition within the local student population.

Medical care (including older people's care)

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

Information about the service

From a medical services perspective, the trust is a regional centre for cancer with a specialised cancer service and renal dialysis service. The trust has the largest kidney programme in the UK and is a major specialist for neurosciences.

It provides a series of specialist medical services, including cardiac and liver care to patients across the UK. The hospital's liver and hepato-pancreato-biliary **(**HPB**)** unit is one of the largest in the UK, providing a comprehensive range of hepatology (liver medicine) services to patients globally.

The trust leads on diabetic renal disease at national centres for renal replacement. It is the Royal Centre for Defence Medicine's (RCDM) The primary function of the Royal Centre for Defense Medicine (RCDM) is to provide medical support to military operational deployments. It also provides secondary and specialist care for members of the armed forces. It is a dedicated training center for defense personnel and a focus for medical research.

We visited 19 medical wards, including: coronary care, acute medicine, cardiology, respiratory medicine, stroke medicine, older adult, oncology, haematology and ambulatory care. Some of the wards were located on the old Queen Elizabeth site.

We talked to 112 patients and relatives, 136 staff (including healthcare assistants, therapists, nurses and doctors). We held planned focus groups, one for consultants with attendees and one for nurses with attendees some of which worked within the medical directorate

We attended nursing and medical handovers and multidisciplinary team meetings.

Medical care (including older people's care)

Summary of findings

Medical care services ensured incidents were regularly reported, acted upon and we saw examples of lessons learned. Infection control procedures were upheld by staff and equipment was well-maintained and in good supply.

Risks, concerns and complaints were identified and acted upon swiftly and patients were cared for by compassionate and competent staff.

Medication and staffing levels were well-managed across most medical services. However, concerns were raised on ward West 2 in both areas which prompted an evening visit during the inspection and also an unannounced visit two weeks after the inspection. Concerns were shared with the trust's senior management team and executive board members. The use of agency staff on ward West 2 was increasing over a three month period Nov 2014- Jan 12015.

During both additional visits to ward West 2 we found that most of our previous concerns had been satisfactory addressed, except for staffing levels which we were assured was considered by the trust to be an ongoing priority.

Are medical care services safe?

Good

Summary

Almost all the medical wards we visited were good with the exception of West 2; however at the unannounced visit it had significantly improved. Most medical services protected people from avoidable harm therefore we rated services as good. The Trust picked up on concerns and addressed them. The initial significant concerns rose with ward West 2 gave cause for concern. Initial concerns related to basic nursing care of older adults, medication administration and staffing levels.

Patients who required help to reposition in bed for comfort and safety were not assisted until we pointed it out. Staff told us that not all personnel used appropriate equipment to move patients in bed, with some using bed sheets instead.

On West 2 medication was not administered to patients as per their prescription: 50% of patients had 'missed doses' over a 24-hour period, with reasons given as "out of stock" or "patient refused". Despite the fact that on two occasion's medication was available when we asked the nurse to double check the stock cupboard.

High ward vacancy levels resulted in substantial agency usage which permanent staff found difficult as this lead to a lack of continuity for patients and a reduction in quality of care.

During our inspection period, we conducted an evening visit to ward West 2, night-time staffing levels had increased, the ward environment was calm and well-organised and patients appeared comfortable and had their needs attended to.

Two weeks post inspection, we conducted a further unannounced visit. Initial areas of concern relating to basic nursing care and medication had been addressed by the trust and staff reported an overall improvement. Patient's needs had been met in all areas of comfort, safety and medication administration, appropriate equipment was being used for all patients.

Vacancies were starting to be filled and agency staff were kept to a minimum of two per shift.

Medical care (including older people's care)

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were zero Never Events registered for Medical Care services from 1 April 2014 to 31 December 2014.
- In the same period, there were 91 serious incidents which required investigation, including 23 grade 4 pressure ulcers, 31 grade 3 pressure ulcers, 23 slips and falls and 11 hospital-acquired infections.
- Staff across all medical wards were encouraged to report incidents and were able to access the trust's electronic incident-reporting system. They understood that a 'no blame' culture was promoted.
- Staff were made aware of incidents from other services within the trust in various forms – for example, through weekly team meetings, monthly governance meetings and emails disseminated from line managers to share lessons learned.
- 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.. The SHMI is the ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
- Information was gathered from each hospital division and submitted to the medical director. Any death requiring an investigation was reviewed by the medical director quality group and the quality committee made up of members of the executive board.
- Staff were invited to attend a root cause analysis executive meeting to discuss serious untoward incidents such as medication missed doses, or poor performance. Although many staff told us they found this a daunting experience, the majority of staff agreed that it improved patient care and provided a strong link between staff and the executive team. During staff focus groups we were told the frequency of these meetings had decreased which indicated practice was improving.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. Results of the monthly safety thermometer audit were captured per ward by the informatics software system accessible to staff, however, this information was not displayed on wards for patients, relatives or visitors to see.
- The information included prevalence of pressure ulcers, falls, venous thromboembolism (VTE or blood clots) and catheter-acquired urinary tract infections (CAUTI). The results related to the individual ward or area and showed results compared with the previous month.
- Across the period July to December 2014, a total of 285 pressure ulcers were reported across medical services. The number per month ranged from 46 to 55, with the exception of October, when only 32 were reported. In the same period, 907 falls were reported in medical services. Between July and September, the monthly number of falls was in the range 159 to 165 – it subsequently dropped to 126 in October, and 133 in November. In December, the number of falls rose to 165. Across the six months to December 2014, there were 14 catheter-acquired infections – of which five occurred in July. Between one and three were reported each month between August and December.

Cleanliness, infection control and hygiene

- All the staff we spoke with were aware of current infection prevention and control guidelines.
- There was sufficient hand-washing facilities at the entrance to and inside most medical wards. Ward West 2, situated on the old Queen Elizabeth site, had visible dirt and staining to the patients' bathroom floor and the resuscitation trolley was dusty.
- All other clinical and communal wards were visibly clean and in a good state of repair.
- We observed staff consistently following hand hygiene practice and 'bare below the elbow' guidance. Aprons and gloves were readily available in all areas. The hand washing audit showed that generally staff used every opportunity to wash their hands in between providing care to patients.
- Side rooms were used where possible as isolation rooms for patients identified as an increased infection control risk (for example, patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.

- We noted in a ward kitchen where food was re-heated that it required cleaning. This was shared with the management when we observed it. However the following day it had not been addressed.

Environment and equipment

- Resuscitation equipment on wards had been recorded as checked regularly; equipment was in date, appropriately packaged and ready for use.
- Pressure-relieving mattresses and cushions for people at risk of pressure damage were in place. The trust had a central equipment bank for pressure-relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- All medical wards had good supply of manual handling equipment such as hoists, slings, sliding sheets and condition-specific equipment such as nebulisers, syringe drivers and monitors, which were well maintained. In most cases, staff used equipment appropriately, however staff from ward West 2 told us that slide sheets were not always used to reposition patients in bed and that patients were sometimes moved using their hospital sheets. This put patients at increased risk of skin damage. This information was escalated to the trust's senior management team.

Medicines

- All medical wards had appropriate storage facilities for medicines and safe systems for the handling and disposal of medicines. All ward-based staff reported a good to excellent service from the pharmacy team.
- The trust had a pharmacist acting as controlled drugs Accountable Officer.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient and regular checks of controlled drugs balances were recorded.
- Fridge temperatures were regularly recorded and checked, recorded and adjusted as appropriate.
- Patients across most medical wards were prescribed and administered medication as per their prescription charts. The medication informatics system alerted staff when a patient was prescribed a medication they were allergic to. However, isolated incidents of poor medicine management occurred on ward 513, for example, a patient was dispensed antibiotics despite the red alert bracelet stating that they were allergic. The same patient was prescribed insulin at tea time and had to request several times for this dose to be changed to their usual time of 11pm.
- Several issues were identified on ward West 2: one patient had left their full medication dose on their bed without taking it. The trust's informatics system showed live data as to how many patients on a ward have 'missed doses' At the time of the inspection there were 49 non-antibiotic doses omitted, just over 7% and only 1 antibiotic omitted, around 0.1%. The trust pharmacist stated that the ward regularly ran out of medication and rarely stocked up in advance to prevent this recurring.

Records

- Patient records were held on two systems: an electronic information software system and also two sets of paper-based records for patients' nursing and medical needs. Risk assessments were completed weekly to include electronic updates for: manual handling, falls, nutrition and pressure ulcer damage. This included electronic fluid balanced charts and repositioning charts.
- Electronic repositioning charts on ward 515 and ward West 2 were not always completed appropriately. According to records, one patient on each ward who required four-hourly repositioning to avoid pressure damage had not been repositioned for 12 hours and seven hours respectively.
- Nursing records in most medical wards were updated regularly and included care plans.
- The skin inspection and assessment tool and pressure ulcer prevention plan contained a body map, initial wound assessment and daily inspection record. The pressure ulcer prevention plan was initiated for patients who had a Waterlow risk assessment score of more than 10 for pressure sores and provided information about seating/reposition regime, pressure-relieving equipment, continence and nutritional risk factors.
- We saw comprehensive and well-documented wound management plans. These showed that wounds were assessed; treatment records were in place and evaluated to show progress of healing.
- Care plans in ward West 2 and Bournville wards were in place, however, in many instances the care plans were not individualised to meet each patient's needs. The care needs page was left blank and only the evaluation page was completed.

Medical care (including older people's care)

Safeguarding

- Staff demonstrated through interviews a good knowledge of the trust's safeguarding policy and the processes involved for raising an alert.
- Staff received safeguarding training at induction and at regular intervals and this was well-attended. The hospital target is 90%, documents supplied demonstrated that nursing staff had achieved 73% compliance with safeguarding adults' level 2. Medics were not required by the hospital to undertake this level having completed level 1 of which 100% compliance had been achieved (hospital wide).
- Staff knew the name of the trust safeguarding lead. They told us they were well-supported and would seek advice if they had safeguarding concerns.
- We saw that safeguarding alerts were completed within the recommended 24-hour timeframe and were relayed verbally during staff handover times to ensure that all staff were aware of patients' safeguarding issues.

Mandatory training

- Mandatory training was well-attended by staff of all grades and disciplines across the medical directorate. Hospital Life Support was mandatory for nursing staff achieving 87% against the hospital target of 90%. Manual handling target was 90% with the hospital nursing staff achieving 87% (hospital wide).
- Staff told us they received appraisals from their line managers. Generally staff from all disciplines attended mandatory training, such as fire, infection control, resuscitation and major incident training.

Assessing and responding to patient risk

- Patients' individual risk assessments were completed weekly or sooner if their condition deteriorated.
- Staff used a standardised early warning system as a tool to alert if a patient's health deteriorated; this was entered on to the informatics system and monitored at regular intervals throughout the day.
- Patients were seen by their consultant within the first 24 hours of their admission and either by the consultant or a member of ward 622, oncology patients were given contact cards and encouraged to contact the ward if they felt unwell at home. They had open access to the ward 24 hours a day, seven days a week if they required a medical assessment.
- Nursing staff told us that, should a medical assessment be required for a deteriorating patient, attendance to the ward was swift and assessments were thorough.
- Handovers took place at the beginning of every shift change. Patient information sheets were given to each member of staff.
- Nurses routinely attended ward rounds, making communication of nursing and medical information efficient and enabling nursing and medical staff to respond to patients' needs in a timely manner.

Nursing staffing

- Nursing staffing levels across most medical wards were well-organised. Rotas were planned in advance and the staff skills mix was appropriate to adequately meet patients' needs.
- The only exception at ward West 2. Staff told us and we looked at the off duty and saw not all agency requests had been filled. Documents supplied by the trust demonstrated that agency use was increasing on West 2. November 2014 the ward had required 266 hours increasing in December and in January 2015 they had used 855 hours. The trust representative told us this was due to patients needing one to one care.
- Nursing handovers occurred every morning, afternoon and night time. Each ward manager was counted in the daily staffing rota and were not supernumerary.
- Wards were encouraged to over-recruit to minimise the need to use agency staff. The trust stated that no more than two agency staff were booked on each shift across all medical wards. This was achieved across most medical wards.
- However, ward West 2 used a high number of agency staff on a daily basis due to a significant amount of nursing vacancies. Staff told us that nine nursing staff left ward West 2 some months ago to work on another ward within the trust and that the vacancies were difficult to fill. The robust recruitment process was in place by the Human Resources department but vacancies remained.

Medical staffing

- There were adequate staffing levels of doctors and consultants across all medical wards, ensuring that patient assessments, care and treatment were conducted in a timely manner.
- The oncology service provided seven-day consultant cover, with 24-hour access to consultants for inpatients and outpatients with acute needs.

Medical care (including older people's care)

- There were two medical teams at night covering all medical wards, one clinical decision unit (CDU) team and an acute medical team.
- Nursing staff reported excellent medical cover across all wards, with minimal delays when requested to assess patients whose condition had deteriorated.
- Junior doctors covered weekends and had access to medical registrars as required.
- There were minimal requirements for medical locum use.
- Analysis of the 2014 quarter 3 trust board minutes revealed several business cases for an increase in establishments across medical service. This included a proposed establishment of two consultant posts in haematology relating to the haemostasis and thrombosis in March 2014, which was approved and posts filled.
- In the same month, the trust board approved the proposal to recruit additional staff to develop the service for the long-term management of cancer survivors.
- Three new oncology consultants' posts were submitted to the trust board. The decision to approve was still under consideration at the time of our inspection.
- The trust saw growth in dobutamine stress echocardiography of 70%. This is a specialised diagnostic procedure that assesses the heart muscle under stress and is useful in the investigation of ischemic heart disease. Approval was given by the board in July 2014 for the appointment of a consultant cardiologist which was recruited to.

Major incident awareness and training

- Major incident training levels were recorded as 100% attendance.
- The major incident response plan was in place and written with reference to the NHS Emergency Planning Guidance 2005.
- The plan provided detailed information for how the trust would respond to a major incident, including primary and secondary command centres and local action cards specific to each division and department.
- Staff were aware of the plan and confident that their respective area managers understood their roles.

Are medical care services effective?

Good

Summary

Care was provided in line with national best practice guidelines and the trust participated in all national clinical audits they were eligible to take part in. Results of national audits were varied.

Patients were well-supported with nutrition, hydration and pain relief by well-trained, competent staff.

Multidisciplinary working was well-embedded in the trust and patients had access to nursing, and medics seven days per week and therapists Monday to Friday.

Evidence-based care and treatment

- All medical services delivered evidence-based practice and followed recognised and approved national guidance across the medical directorate.
- Staff understood their roles and clinicians worked within their scope of practice in accordance with their professional governing bodies.
- Medical teams made timely internal and external referrals to other healthcare professionals to ensure that patients were seen by the right person at the right time.
- Staff told us they had access to and frequently used the trust's policies and procedures which were stored electronically.

Pain relief

- A dedicated pain team provided specialist support and advice for patients with complex conditions and unresolved pain.
- Patients were administered pain relief according to their individual prescriptions and nursing staff were vigilant when monitoring patients' pain levels.
- However, there was ad hoc recording of patients' pain levels from ward to ward and pain care plans were not always used.

Nutrition and hydration

- A Malnutrition Universal Screening Tool (MUST) was completed on admission and at regular intervals to monitor patients' nutritional status.
- Referrals to the dietician were carried out promptly when required and patients' weight was recorded weekly.

- Patients who were identified as being nutritionally compromised were placed on the 'red system' which included a red food tray and red water jug lid. This identified to staff patients who required assistance or encouragement to eat and/or drink.
- In addition, all staff were told in handovers who was on the 'red system' and a list was displayed on each ward as a reminder.
- The majority of patients told us that the food was tasty and enjoyable and portion sizes were adequate.
- Hot and cold drinks were offered to patients at regular intervals and fluid balance charts were recorded appropriately.

Patient outcomes

- Individual wards held performance data to measure the quality of care and the documentation for each patient via the clinical dashboard.
- Within the hospital Haemodialysis accounted for just under 5% of the national dialysis activity Haemodialysis Survival was better than the England average. For other indicators (adequacy, haemoglobin and phosphate targets) were also better than the national average.
- The heart failure audit conducted by the trust for 2012/13 showed that medical services performed worse than the national average in all 11 reported areas.
- Myocardial Ischaemia National Audit Project (MINAP) audit for 2012/13 showed that the trust performed better than the national average in all three areas reported.
- Data for 2012/13 demonstrated that the trust performed better than the national average for people with ST segment elevation myocardial infarction (STEMI – a form of heart attack) being seen by a cardiologist, with a record of 100%.
- The trust saw a mixed performance in the National Diabetes Inpatient Audit (NaDIA) recording 12 out of 22 areas as better and worse on 9 than the national average.
- There was a steady and significant improvement overall score E to D which is average across all 10 areas with the National Sentinel stroke Audit from quarter 3 (October to December 2013) to quarter 1 (April to June 2014).
- During the past 12 months the medical services completed 36 local audits to measure quality and performance across a range of clinical conditions to include diabetes, dermatology, heart failure, respiratory and stroke. We saw outcomes of an audit within dermatology and Chronic obstructive pulmonary disorders, which had recommendations to improve patient outcomes.

Competent staff

- We observed clinical practice, attended staff handovers and MDT meetings and saw that staff across all medical services were competent and knowledgeable within their chosen wards. However, on occasions staff were asked to move wards during times of staff shortage which meant they worked outside their area of clinical confidence. This did not compromise on patient safety, as staff would seek advice from their peers or nurse in charge.
- We observed nursing and medical staff handovers where staff demonstrated a high level of specialist knowledge, particularly on the CDU, oncology and renal services.
- We also saw high levels of clinical competence, through observing practice with staff on the CDU, ambulatory care and oncology services. .
- Competencies were in place to show that staff had been assessed and were competent within their respective specialist wards, training records supported this.
- In the annual staff survey 2013, the trust scored better than the national average in terms of personal development, access to appropriate training for jobs and for line management support to enable staff to fulfil their potential.
- Respiratory, cardiac and renal specialist nurses were situated on their designated wards and provided specialist support and advice to staff and patients.

Multidisciplinary working

- Staff demonstrated good internal multidisciplinary working across medical services, particularly at stroke, the CDU, renal and oncology services.
- Staff demonstrated a wider team knowledge, which enabled them to refer patients in a timely manner to other specialist areas.
- There was an obvious professional respect between doctors, consultant, nurses and therapists which made communication of patient information at handovers, ward rounds and multidisciplinary team meetings effective and efficient.

Medical care (including older people's care)

- Clinical nurse specialists such as tissue viability nurse, speech and language therapist, dementia lead, falls lead and dieticians provided an in-reach service to wards on request. ('In-reach' staff help to move patients to wards and discharge.)

Seven-day services

- Renal service, stroke and cardiology provided seven-day consultant cover.
- The oncology service provided seven-day consultant cover, with 24-hour access to consultants for inpatients and outpatients with acute needs.
- There were two medical teams at night covering all medical wards, one CDU team and acute medical team. This was considered safe and appropriate to meet patients' needs.
- Junior doctors covered weekends, with access to medical registrars as required.
- Renal service, stroke and cardiology provided seven-day consultant cover.

Access to information

- Nursing notes were kept at the foot of the patient's bed and were accessible at all times. However, patients rarely reviewed their notes.
- The trust used the electronic informatics system which enabled staff instant access to patient information including times when patients were transferred between wards or departments.
- We did not receive patient feedback on this trial during our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated through interviews they had good knowledge of the Mental Capacity Act 2005 and understood issues relating to deprivation of liberty safeguards and when to raise the alert.
- Patient advice leaflets about the Act were displayed at each ward.

Are medical care services caring?

Good

Summary

Staff were caring, kind and respected patients' wishes. We saw compassionate nursing care at the oncology and renal wards where staff interacted with patients regularly, explaining options, treatments and side effects.

All patients had only positive comments about medical services and told us staff were kind and caring and when providing care and treatment. We saw staff treating people with dignity and respect across all medical services and 'going the extra mile' to ensure patient's individual needs were met and patients were looked after.

Compassionate care

- Patients were asked to complete the trust's patient experience survey prior to discharge. The results indicated that patients were very satisfied with the care and treatment provided.
- Patients across all medical wards were satisfied with the quality of service they received and all 112 patients we talked to told us they had no complaints.

Understanding and involvement of patients and those close to them

- Patients told us they felt generally involved in aspects of their care and treatment.
- Staff were happy to answer questions when patients asked.
- Excellent patient involvement was seen at ambulatory care, the CDU, ward 622 (oncology) and ward 301(renal dialysis) as staff on these wards took extra time to explain treatment options, therapeutic use of medicines and side effects and made time to answer questions from patients and relatives.
- In December 2014, Harbourne, Bournville, wards 303, 516 and 517 scored 100% in the NHS Friends and Family test and the lowest recorded ward was West 2 with 92%.

Emotional support

- Ambulatory care, the CDU and ward 301(renal dialysis) provided emotional support to patients and people close to them.

Medical care (including older people's care)

- Ward 622 (oncology), including teenage cancer services, provided emotional support, making ample time to reassure inpatients and particularly outpatients who called for telephone advice about symptom management such as pain, nausea and constipation.
- The trust provided a chaplaincy team to support the diverse needs of the hospital population to include a range of religions.

Are medical care services responsive?

Good

Summary

Many medical services proposals for service development had been realised. However, due to external social service issues, the medical services continued to experience delays in discharging older adults who required long-term placements or packages of care.

Ambulatory care demonstrated a responsive admission and discharge planning.

Patients' individual needs were generally met, despite the absence of individualised care plans. Patients living with dementia or a learning disability were well-supported.

The trust's complaints system was robust and staff took complaints seriously and followed the complaints policy.

Service planning and delivery to meet the needs of local people

- National standards state that 90% of referred patients should start consultant-led treatment within 18 weeks of referral. Between June 2013 and September 2014, general medicine, geriatric medicine and rheumatology services achieved 100%. All other services such as cardiology, gastroenterology, dermatology and neurology achieved the target of between 95% and 99%.
- All medical wards were proactively planning patient's discharges, however due to delays experienced with external social services packages of care, this slowed down the process. Senior management told us, the trust continually strives to work with external agencies to find a solution to this problem.
- The trust saw significant growth in activity over the past 15 years in chronic kidney disease service. The trust's renal unit is one of the largest providers of secondary and tertiary renal care in Europe and offers investigational nephrology and dialysis.
- The CDU provided renal replacement therapy services to 1,077 patients with end-stage renal failure. Care was delivered through the provision of an on-site chronic dialysis unit and nine satellite haemodialysis units, peritoneal dialysis service supporting 165 patients and a large home haemodialysis service. We were told the trust had plans to open its own satellite unit in Smethwick under NHS subsidiary.
- An implementation phase had begun where inpatients were given a diary of the events planned during their stay, including the expected date and time of discharge, meal times, ward rounds and visiting times.
- The diary will act as a central point to coordinate booked events from multiple services, while focusing on the needs of the patient. Nursing staff will use the diary as a starting point to engage with the patient and their carers daily.

Access and flow

- External delays relating to social service packages of care existed across most medical services, which made discharges for older adult patients slow and impacted significantly against patient access and flow.
- Between July 2013 and June 2014 the trust reported average length of stay to be longer than the national average in areas of cardiology, haematology, nephrology, general and geriatric medicine. This was to be expected due to UHB being an acute tertiary centre and therefore treating more complex patients than in some other trusts.
- Senior nurses told us there was good strategic management of bed capacity at the CDU, and ambulatory care and effective liaison with the emergency departments to monitor patient flow and bed capacity.
- Ambulatory care services were proactive in assessing, transferring and discharging patients to meet their needs. There were minimal delays in prescribing and dispensing of medication which led to more effective discharge planning and better patient outcomes.

Meeting people's individual needs

- Care plans across many medical wards were not individualised to patients' needs. This was particularly

evident in West 2 and Bournville wards. Patients with condition-specific diseases, such as motor neurone or multiple sclerosis, did not have care plans which identified their unique needs and preferences.

- Patients living with dementia or learning disabilities had a booklet called 'All about me'. This provided information to staff about the patient's life history likes and dislikes and how the patient preferred to be cared for. Across most medical services we saw the booklet was completed well. However, at ward West 2, three booklets were left blank in the back of the patients' nursing notes.
- Staff alerted the lead nurse for dementia when a patient with specific needs was admitted. They also did the same for patients living with a learning disability.
- Dementia screening and assessment was undertaken for patients aged over 65 years and the dementia lead provided dementia boxes for patients to use during their stay to provide stimulation and aid memory skills.
- Patients living with a learning disability or dementia had 24-hour visiting access and staff openly encouraged discussions with relatives to learn about the patients they cared for.
- The trust provided a translation service. Staff told us this was used frequently.
- Clinical ethics group were quick to respond to complex and serious ethical patient issues. They were fully supported by the executive team and met every six weeks.

Learning from complaints and concerns

- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally such as complaints about food menu or lost items of clothing and how to escalate more serious concerns when required.
- Patient Advice and Liaison Service leaflets were not readily available for patients at their bedside but were displayed on each ward, either at the nursing station or at the ward entrance.
- Around 225 complaints were registered by the trust relating to medical services between November 2013 and October 2014, of which about 50% were upheld or partially upheld.

Are medical care services well-led?

Good

Summary

There was a clear vision and strategy for the future development of medical services shared equally between executive level and front line staff.

Clinical governance and risks, together with quality measurements, were priorities across all medical services.

Culturally, all services were compassionate and individuals were self-driven to provide excellent care.

Staff were supported with career progression to take up internal secondment opportunities leading to individual job satisfaction and long term retention of permanent staff.

Vision and strategy for this service

- Staff shared in the trust's future vision and strategy which focused on providing excellent clinical quality, patient experience, workforce, research and innovation.
  - Staff from all disciplines considered themselves as working for the best NHS trust in the country.
  - Staff were enthusiastic and encouraged and supported by ward managers, matrons, divisional directors to provide high standards of care.
- This was displayed by all staff we met and in the focus groups.
- In May 2014, the chief operating officer proposed the substantive appointment of three renal medicine consultants in the place of existing locum consultants.

Governance, risk management and quality measurement

- The quality of care was measured using clinical performance dashboards, and ward performance was ranked within their division and against the rest of the trust.
- Under-performing wards were monitored closely by ward managers and matrons and plans put in place for remedial action.
- Medicine's risk register identified the risk with timescales for completion of actions. Once the actions were completed, the item was removed from the register.
- Each directorate had an educational lead who reviewed incidents and actioned training sessions.
- Individual ward performance was measured by 'back to the floor' trust governors and the senior nursing team.

This involved governors and members of the senior team who visited individual wards to observe clinical practice and talking to patients about the quality of their care and treatment.
- The governors introduced the 'comfort packs' initiative and secured funding for it.

Leadership of service

- Staff told us their immediate line managers and executive team were visible, accessible and approachable, and described them as outstanding leaders with excellent support systems in place.
- Executive members of the board were described by staff as "inspirational" and "nurturing" and, during focus group meetings, staff were eager to applaud the executive team for strength in leadership and for addressing issues such as incidents and complaints swiftly and sensitively.
- Excellent local leadership was evident in oncology, the CDU and ambulatory care services. These services were exceptionally well-organised and strong team working was encouraged, resulting in excellent patient outcomes.
- Ward managers met regularly with matrons and divisional directors to discuss performance and quality.
- Staff were supported to attend mandatory training and actively encouraged to attend specialist training specific to their role.
- Staff were supported by local and senior managers with internal professional progression by taking up secondment opportunities for career enhancement and job satisfaction.

Culture within the service

- In general, we found the culture of care delivered by staff across all medical services was dedicated and compassionate and strongly supported at executive, divisional and ward level.
- Staff were hard-working and committed to providing the best care possible to their patients on a daily basis.
- Staff from all disciplines spoke with passion about their work and conveyed how happy they were to be working at the trust.
- Many staff told us they felt job security at the trust due to the excellent reputation and wealth of job opportunities.
- Staff were proud to be part of what they considered to be a winning team.

Public and staff engagement

- Results were better than the national average for the NHS Friends and Family test which asks patients and their families if they would recommend the hospital to others. Overall, response scores were higher for this trust than the national picture for 14 of 16 months. The test's individual ward scores were audited on a monthly basis.
- The annual staff survey 2013 indicated that the trust had the highest response rate in the country, and that it scored in the top 20% or above average in 19 of 28 areas in the survey.
- We talked with 112 patients and relatives across medical services who were extremely happy about the care and treatment provided by nursing medical and therapy staff and many patients told us it's the best care they have ever received. One patient told us they could have used their private healthcare but they knew they would receive excellent care and treatment at this hospital as they had been before and its reputation is "still wonderful".
- Regular patient experience feedback was reported to the care quality group which reported to the board of directors.
- The trust had four patients and carer councils – one for wards (inpatients), one for outpatients, a mystery patient council and a young person's council. The purpose of the councils was for patients, foundation trust members and the public to work in partnership with staff to improve the services provided to patients.

Innovation, improvement and sustainability

- Senior managers encouraged innovation and improvements in practice across medical services.
- During the senior nursing focus group we were told about the quality and outcome research unit which was clinically led by specialist nurses. The aim was to provide a forum for both medics and nurses to discuss quality issues affecting patient care and how to resolve them.
- The falls and fracture lead identified 363 care homes within the local area and contacted more than 150 of these to raise awareness of falls and how to avoid them. Audit results were not available to view during the inspection.
- The VTE (venous thromboembolism) initiative for junior doctors identified that performance for VTE risk assessments was 99% or over since June 2012 and

assessments and treatment of VTE was above 88.5%. This was largely due to the success of the outlier policy which aimed to identify those clinicians with a higher need for further educational support. The team also look to identify high performing clinicians to ensure shared learning and contribute positive outcome data to their portfolio's.

Surgery

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

Information about the service

University Hospitals Birmingham NHS Foundation Trust provides a series of highly specialist cardiac, liver, oncology and neurosurgery services. It is world-renowned for its trauma care and has developed pioneering surgical techniques in the management of ballistic and blast injuries. Queen Elizabeth Medical Centre is a designated level 1 trauma centre and is host of the UK's only £20m National Institute for Health Research (NIHR) Surgical Reconstruction and Microbiology Research Centre. The hospital is host to the Royal Centre for Defence Medicine and treats all seriously injured British military personnel evacuated from overseas. It also treats military casualties from other countries, such as Denmark. In addition, it also provides colorectal, ENT, and urology services. In total the hospital undertook 45,276 surgical spells between July 13-June14.

It is a regional centre for cancer, burns and plastic surgery, and has the largest solid organ transplantation programme in Europe. The hospital's ambulatory care centre offers treatments, interventions or procedures on an outpatient basis, avoiding hospital admission. The surgical division has above-average activity level with 42% day-case, 29% elective, 29% emergency patients.

The adult wards were divided into single-sex areas of bedded bays or single side rooms. We visited 12 wards, six theatre suites, the recovery area and ambulatory ward. We met and spoke with 51 patients, 132 nursing staff, 59 doctors, and 27 members of the public. We spoke with 26 other staff working at the trust, including physiotherapists, occupational therapists, domestics, porter staff and volunteers. We observed patient handovers, ward rounds and multidisciplinary team meetings.

Surgery

Summary of findings

Overall, we found that surgery was good. Patients told us they were very appreciative of the respect they were shown from the professional, compassionate highly valued staff. Learning from incidents was promoted and seen to be a learning and improvement tool in the trust.

We found that safety checks of resuscitation equipment were not systematically carried out and some records were not completed appropriately. In three wards, records showed that checks had been completed; however, we found medication, intravenous fluids and resuscitation equipment out of date. These issues were brought to the attention of the manager in charge and rectified promptly. Patients' safety was protected through the completion and review of appropriate risk assessments on the wards and in theatre.

The hospital was not meeting the 18-week standard referral to treatment time performance and this was reflected in the surgery risk register. Also, 238 (2%) operations were cancelled in the previous three months due to lack of theatre time and emergency operations taking priority.

Infection control processes were well-managed and the trust reported cases of infections appropriately. Staff training completion levels were high and, to maintain these levels, some staff had been coached to deliver the training directly to the staff on their ward. There was a multidisciplinary approach which ensured the safe and timely discharge of patients in conjunction with discussions with their carers or family.

The trust used pioneering treatments to achieve positive outcomes for surgical patients with complex trauma cases and transplant needs; they admitted patients from all over the UK and further afield.

Many innovative surgical practices were taking place at the hospital, including the first use of the 'organ assist' device which allowed the transplantation organ to be assessed and prepared prior to the surgery.

The overall staff morale was high; staff felt the open, honest culture at the hospital made it a nice place to work. The trust excelled in research, including working closely with the University of Birmingham to be one of the world's leading centres for research and treating liver disease.

Surgery

Are surgery services safe?

Good

Summary

We found that the safety in surgery to be good. Three Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) had been reported, with full root cause analysis completed by the Trust Board. Minor incident reporting had increased in the previous four months which highlighted the higher dependency of the patients admitted and the vigilance of the staff in being proactive in patient safety.

On three wards we found resuscitation records incomplete and equipment and intravenous fluids out of date. In a theatre we found an emergency drug box out of date; all issues were highlighted to the staff and the equipment was replaced immediately.

We heard examples of how staff learned lessons from discussing incidents and changing practices to avoid harm to other patients. Each directorate was well-managed, promoting patient safety and good practice. However, we identified that there was minimal networking between the directorates.

The wards we visited were exceptionally clean and tidy. Results from the NHS Safety Thermometer (a tool used for measuring, monitoring patient harm and harm-free care) were easily accessible by the ward staff but not displayed for the patients and public to see.

Incidents

- Three Never Events were reported since April 2014. Classed as surgical errors – two occurred during outpatient day procedures – and one was classified as 'other' – a retained foreign object. Root cause analysis investigations took place at the monthly safety escalation meetings. Closer management of the world health organization (WHO) checklist had been carried out to ensure patient safety was protected.
- We heard of lessons learned being discussed at ward meetings in each directorate. Senior staff took an active role in delivering and promoting safety, learning and improvement in their areas. We heard that one directorate was not always aware of an issue in another directorate. Further cross-directorate networking would ensure learning from incidents and complaints was fully embedded across the entire organisation. We saw good examples of learning from incidents on the surgical assessment unit, with feedback provided on a daily basis from the ward sister to staff on clinical incidents in the area.
- Mortality and morbidity meetings were held for each directorate. Again, further cross-directorate networking would ensure that staff were fully aware of the trust-wide issues.
- During 2013/14, there were 63 serious incidents reported, of which 50 were grade 1 and 2 pressure ulcers. Staff told us that, because of the increase in reporting, the tissue viability team had promoted the use of pressure-relieving cushions and mattresses. We saw one patient who was in need of, but not using, a pressure-relieving cushion. We alerted the nurse in charge and a suitable cushion was put in place.
- From July to the end of October 2014, 311 incidents were reported for surgery. 308 were classed as 'minor', two classed as insignificant and one classed as 'moderate'.. Ward 305 (upper gastrointestinal surgery) saw an increase of over 150% in the number of incidents reported (September to October 2014, compared to July to August 2014). The explanation for this was related to the higher dependency of the patients admitted, the vigilance of the staff and the improvement in reporting minor incidents in a timely way.

Safety thermometer

- Safety thermometer results were not displayed on the wards. Ward managers and the staff accessed the data on the trust informatics software. Each directorate was monitored trust-wide for their compliance. Staff told us they discussed the data at ward meetings.
- Risk assessments supported the safety thermometer data. For example, in December 2014 ward 624 exceeded the trust's target compliance score of 80%. The Malnutrition Universal Screening Tool (MUST) scored 97%, Waterlow records completion was 97% and management of venous thromboembolism (VTE or blood clot prevention) scored 98% which was compliant with the trusts' VTE target percentage. One complaint had been received and was being investigated. This meant that patients were being monitored for their safety while on the ward.
- Five falls resulting in the person sustaining harm were recorded and the trust performance was better than the

national average for 2013/14. We were told that, following a patient fall, the staff reviewed the care to identify possible contributory factors and prevent further occurrences.

Cleanliness, infection control and hygiene

- All areas we visited were exceptionally clean, including compliance with the sterile field in theatres. Wards areas were tidy and free from trip hazards. Patients told us the standard of cleanliness was high at all times.
- There were no cases of MRSA or Clostridium difficile (C. difficile) infection within the surgical directorate (2013/14). The trust monitored the numbers of surgical site infections and the Trust Board received a monthly update on rates of infection. During 2014/15 two cases of MRSA and one case of C. difficile were reported elsewhere in the trust. Root cause analyses were completed at board level, with participation from ward staff and managers and clinical pathways were instigated. For example, division D part of the surgical specialities data showed 100% compliance in the C. difficile care bundle pathway between July and October 2014. This meant that patients were being appropriately cared for in the prevention and treatment of C.difficile.
- Patients were screened for infectious diseases at the earliest opportunity. They were isolated within a side room until found to be clear of infection, thereby offering protection for themselves and for other patients and staff.
- The trust's hand hygiene data reports showed 96.2% compliance for division B and 91.3% compliance for division D. Areas for improvement were noted to be hand hygiene after touching a patient in division B and before touching a patient in division D.
- We saw staff wearing protective clothing and observed hand washing and the use of hand gel. We identified that the importance of hand hygiene for visitors was not clear. Hand-washing facilities were sited at the entrance of the wards and hand gel was available, however, there was no clear signage to instruct visitors to use this. This was discussed with the infection prevention nurse consultant.
- The trust maintained theatre discipline practice such as using appropriate theatre wear and minimising movement of people in and out of the operating area. Effective hand hygiene and decontamination was followed to reduce the risk during a procedure.
- We observed all but four medical staff conforming with 'bare below the elbows' best hygiene practice as per trust's policy on the wards. The staff that were not in compliance told us they were aware of the policy and apologised.
- We observed a medical specimen taken in theatre, logged and stored safely in line with accepted practice.

Environment and equipment

- Environment audit results showed compliance rates were consistently at or above 95%. This meant that the surgical wards were clean, hygienic and well maintained when checked in the audit process. The fabric of the new building was conducive to high standards of cleanliness and a dust-free environment.
- Resuscitation trolleys were checked on each ward. We found gaps on daily checks in most areas. We found out-of-date equipment and intravenous fluids on two trolleys which had been checked as correct; both occurrences were highlighted to the staff and replaced immediately. In ambulatory care we found unsigned check records on three trolleys and patient records unsecure in part of the unit.
- We looked at ward equipment available to support patients' needs and these were labelled with safety-checked and review dates. We found two stored air mattress pumps out of date; one dated 'due to be checked March 2014' and the second dated 'due to be checked September 2014'. These were brought to the attention of the staff on the ward.
- We observed safe processes of waste management in theatre and on the wards.

Medicines

- We found the emergency drug box in the anaesthetic room of Theatre 24 one month out of date. This was highlighted to the theatre suite manager.
- Between November 2013 and October 2014, 86% of high-risk patients were prescribed anti-sickness medication at the time of surgery so medication could be given promptly after the operation to avoid nausea and vomiting.
- Each ward and department had a designated pharmacist and pharmacy technician who visited the ward on a daily basis. The trust's electronic information system was used to manage medicines on the wards and was proving to be safe and effective, reducing errors and omissions.

Surgery

- We observed the correct storage of controlled medication. Clinical rooms were clean and tidy with cupboards locked appropriately. Room and refrigerator temperatures were recorded.

Records

- We reviewed patient notes during the inspection. We looked at 10 sets of notes, including nursing risk assessments and care records. We found that the standard of record-keeping followed professional standards, except for the initial 'nursing assessment sheet'. A nursing assessment sheet was completed for each patient on admission as per trust policy. We identified that these were frequently not completed correctly, with missing signatures, dates, and actions. These were highlighted to the nurse in charge.
- Every patient was assessed on admission for a range of potential risks, including malnutrition, moving and handling, risk of developing pressure ulcers, and falls. Risk assessments were completed when necessary to avoid patient harm. This data was monitored on a daily basis to check for increasing or decreasing risk.
- Preoperative assessments were carried out in pre-assessment clinic as an outpatient, in emergency department or on the ward. Standardised records were completed and patients told us that preoperative advice and relevant guidance had been given. Patients also told us they were given time to ask questions and discuss the surgery and postoperative expectations.
- We looked at five current anaesthetic records which were documented accurately.

Safeguarding

- Safeguard training was mandatory. Staff we spoke with were fully aware of their responsibilities in observing for and reporting safeguarding situations. Local records seen on wards showed the most nursing staff were up to date with their mandatory training.
- The hospital target is 90%; documents supplied demonstrated that nursing staff had achieved 71% compliance with safeguarding adults' level 2. Medics were not required by the hospital to undertake this level having completed level 1 of which 100% compliance had been achieved (hospital wide).
- A designated safeguarding intranet with an electronic multiagency safeguarding referral form enabled managers to directly email safeguarding alerts to social services.
- The trust had a zero tolerance to violence and aggression.

Mandatory training

- Mandatory training levels were compliant across the surgical directorate. Specific modules, like the Hospital Life Support were very popular and, therefore, difficult to get on, nursing staff achieving 87% against the hospital target of 90%. Manual handling target was 90% with the hospital nursing staff achieving 87% (hospital wide).
- It was difficult to get on the courses in in a proactive approach practice – for example, ward nurses being sent on 'train the trainer' courses to run further sessions locally for other ward staff.

Assessing and responding to patient risk

- To recognise the deteriorating patient, staff recorded data on to a standardised early warning system (SEWS). By recording patient observations on to the information system, a patient's condition was monitored and alerts were raised when necessary. Abnormal patient observations which were recorded electronically in 'real-time' raised immediate alerts for staff to escalate care for potentially deteriorating patients. Doctors also accessed this information and reviewed patient observations remotely. We heard examples from the staff when they had been advised and supported by the outreach team who were also alerted by the system to any deteriorating patient, seven days a week.
- Within theatre we observed the use of 'five steps to safer surgery' along with the WHO surgical safety checklist. We recognised compliance in all areas, apart from one occasion out of eight when a briefing took place without introduction of the staff. Results of the audits demonstrated that for Q3 2013/13 the theatres achieved their 99% completion target rate.
- Medical input in all areas was visible. Nursing staff told us they were well-supported by all grades of the medical team 24 hours a day, seven days a week.

Nursing staffing

- We observed there were enough staff to meet the needs of patients**.** There was a high ratio of registered nurses to healthcare assistants on duty and listed on ward staffing rotas. We saw that, on most wards, each trained staff was responsible for six patients during the daytime

and between eight and nine patients at night which was in line with safer staffing. There was one registered nurse for four to six patients with support from healthcare assistants.

- An automated acuity tool delivered 'planned' and 'actual' staffing levels based on the dependency of the inpatients. These staffing numbers were displayed on each ward we visited. We saw evidence of collaborative working between various departments in the hospital. The neurosurgical services (shared between two wards) worked in cohesion to ensure safe staffing on both wards. On the surgical assessment unit, staff used a booking system called 'It's my turn so that, if possible, staff took turns to help in other areas. We saw evidence of this, with a healthcare support worker from the unit assisting on another surgical ward on the day of the inspection. Staff told us that, in the majority of cases, gaps were filled by their own bank (overtime) staff and, very occasionally, outside agency staff.
- We observed a staged ward handover, with the senior nurses in the office and then at the bedside with patient involvement. We also saw 'ward board' handover meetings between multidisciplinary team members. Handovers took place at the beginning of every shift change. Patient information sheets were given to each member of staff to update them on the inpatients. Staff were organised in to teams with a set amount of patients that they were responsible for.

Medical staffing

- 24-hour consultant-led care was arranged within the surgical division. However, we were told that, in some cases, junior doctors could perform surgical procedures at night without consultant presence if deemed competent to do so. One junior doctor told us that they had performed surgery out of hours, which was assessed as appropriate by their senior at the time. An assessment of the appropriateness for a surgical trainee to undertake a case at night without the direct supervision from a consultant was undertaken by the consultant surgeon on call. This included a conversation with the surgical trainee who had assessed the patient, discussing the patient's condition, presenting symptoms, imaging and laboratory results. The assessment included the complexity of the operation required and the skills of the surgical trainee. The consultant anaesthetist, supported by the theatre staff also considered the appropriateness of the case being undertaken by a surgical trainee.
- Out-of-hours cover arrangements were effective and sufficient. We heard of staff being responsive and supportive.
- Junior doctors were given weekly questionnaires which included patient safety issues, consultant ward rounds and any bullying and harassment issues. Each junior doctor told us they had clinical supervision and regular reviews.
- During 2013/14 the Defence Postgraduate Medical Deanery reviewed defence doctors in training at the Queen Elizabeth Hospital Birmingham. They found that the pilot of a smartphone 'Feedback app' for foundation programme trainees at the hospital represented good practice in the reporting of patient safety and education quality concerns. The defence doctors explained that the feedback app resulted in serious issues being addressed quickly, with timely feedback to the individual who raised the issue.
- Medical staff handovers took place in a formal way, with full debrief of the acute inpatients and a review of the emergency department and surgical assessment unit status.
- Surgical locum use was minimal. We were told that a formal induction was not always carried out for locums and nursing staff provided support in orientation and around protocols. We were shown locum medical booking procedure document number 473. This document was in place to ensure that locum medical and dental staff from agency organisations met the trust's requirements to enable them to work effectively. The document written in January 2012 was due to be reviewed in January 2015.
- Medical staffing skills mix was similar to the England average for consultants and juniors. Middle grades were recorded as 2% when the England average was 11% and there was a larger group of registrars 48% to the England average of 37% this was trust wide. Although there were less middle grade doctors than the England average because the trust had more registrars it was not a detrimental situation.

Surgery

Major incident awareness and training

- The major incident response plan provided a clear action plan to be followed in the event of a major incident. Action cards, detailing the process, were available for specific areas of the hospital.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were in place.
- Major incident training levels were recorded as 100% attendance.

Are surgery services effective?

Outstanding ☆

Summary

We rated this domain as outstanding. We found evidence of audit leading to improvement of care outcomes and we saw care and treatment delivered that was based on published guidance.

The trust used pioneering treatments to achieve positive outcomes for surgical patients with complex problems. We saw examples of the staff delivering care provided in line with National Institute for Health and Care Excellence (NICE) guidelines and patients were suitably risk-assessed to promote their safety and experience.

We visited the designated trauma and orthopaedic ward for military patients that was staffed by a team of military and civilian nurses and therapists. Working in partnership with UHB the service provided care to military casualties. The hospital offered clinical expertise to treat highly complex injuries.

The trust performed better than average for most audits. Readmission rates showed a worse than average risk of readmission, particularly for elective patients. This was explained as being related to the complexity of the patients and care pathways whereby patients who were readmitted for investigations had been wrongly coded, this could result in the wrong conclusions drawn from data. We were told that patients who were discharged from the surgical assessment unit to return for on-going investigations had been coded as a readmission rather than continuing care.

Patients received appropriate preadmission assessment prior to theatre which protected and promoted their safety.

Evidence-based care and treatment

- Trust policies and procedures were available on the trust's intranet and staff reported they could access them easily. We saw that the trust's policies were reviewed and updated at regular intervals and were based on NICE and Royal College guidelines.
- We saw examples of the staff delivering care provided in line with NICE guidelines – for example, preoperative tests ensuring patients were safe for theatre and the processes carried out in theatre.
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations from the review of the perioperative care of surgical patients were being adhered to. Patients scheduled for elective surgery were seen and fully investigated in a pre-assessment clinic. We saw one of the nine pre-assessment documentation we looked at was incomplete and the theatre procedure was delayed because of this.
- The Confidential Enquiry into Perioperative Deaths (CEPOD) data for operating out of hours and the grades of surgeons and anaesthetist performing operations was logged. We looked at data from 1 November 2014 to 31 January 2015: 473 anaesthetists had performed anaesthetics outside of core hours and 475 surgeons performed the surgery, of which 19 were junior doctors.
- VTE risk was monitored and audited through the trust's information software. Results of prophylaxis showed better than average compliance for each surgical directorate.
- Care plans and assessments were reviewed daily and the ward managers reviewed compliance of record-keeping through 'back-to-the-floor' audits.

Pain relief

- We saw that patients were given a preoperative assessment for postoperative pain relief. The information software was programmed to ensure that this was highlighted and adhered to by prescribing staff. Patients told us they had been kept pain-free and staff appeared to be prompt in delivering pain relief when requested.
- Staff told us how they requested anticipatory pain relief for some procedures as their experience had shown this would be required.
- A dedicated pain team were available to discuss cases of ineffective pain relief or offer advice on other methods of achieving patient comfort.

- We were told that staff responded in a timely way to requests for pain relief and we observed a patient being asked about the effectiveness of their pain relieving medication.

Nutrition and hydration

- A MUST score was recorded to monitor and observe each patient's nutritional state. We saw that patients' nutritional intake and fluid balance was recorded throughout the day. Staff told us how they referred patients to the dietician through the information software system.
- Patients told us that the food provided had been edible and enjoyable. They told us they had been offered hot and cold drinks at frequent intervals. One patient told us that the staff had discussed the need to be prescribed supplements and went on to explain their benefits.

Patient outcomes

- The trust participated in national audits such as the Patient Reported Outcome Measures (PROMs) – for example, the trust performed better than the England average for the care of varicose veins. The proportion of patients who reported that their health had worsened for groin hernia was in line with the national picture, with a higher proportion of patients reporting an improvement when compared to national numbers.
- National Bowel Cancer Audit (2013) results showed better than the national average for case ascertainment rate and cases seen by the clinical nurse specialist.
- National Bowel Cancer Audit results also showed 80% data completeness overall, with 100% of cases being discussed at multidisciplinary team meetings.
- National Lung Cancer Audit (2012) results showed better than the national average, with patients receiving a computerised tomography (CT) scan before bronchoscopy, and for 97% of cases being discussed at multidisciplinary team meetings.
- The National Hip Fracture Audit (2013) showed mixed results. The trust scored better than the national average for patients receiving surgery within 48 hours but worse than the national average in relation to their length of stay. Documents supplied demonstrated that geriatrician input was also above the England average.
- The National Emergency Laparotomy Audit (2014) showed mixed results. A discrepancy caused by the fact that the hospital had entered less than 50% of estimated cases in the first year of the audit had been discussed with the team reporting on the audit. The audit confirmed that the numbers were determined by using a six-year average and should not be of any concern. The trust was confident that applicable cases were included in the audit and theatre access to the audit's website was being arranged to allow immediate data entry.
- Between April and October 2014, 42% of cases (30,466 cases) were registered as day surgery. 3,131 bed days resulted from failed day cases where a patient stayed in hospital overnight. This showed a conversion rate of 3.88% which was just above the national average benchmark.
- Average length of stay was recorded as worse than the national average for some elective cardiac surgery, non-elective trauma and orthopaedics. This was explained as being due to the complexity of the cases being treated. The trust, a tertiary centre, performed a higher proportion of more complex surgery than other trusts.
- Readmission rates showed a worse than average risk of readmission, particularly for elective patients. This was also described as being related to the complexity of the patients.
- Between November 2013 and October 2014, 7.4% of patients were readmitted as emergencies within 28 days following first-time; isolated coronary artery bypass graft and this remained within the range of expected variation.
- Between November 2013 and October 2014, there were 1.3% of unplanned returns to theatre for all non-emergency surgical patients.
- The hospital cared for military personnel injured whilst on duty. The trust repatriates them and within trauma and orthopaedics treats their injuries. Published research conducted within the hospital demonstrated that there were improvements in the survival rates of this type of patient.
- Documents supplied by the trust demonstrated that patients undergoing renal transplants had better than England average survival rates at 5 years post-operative (90% vs 87%) and 10 years post-operative (80% vs 75%).

Competent staff

- Staff received annual appraisals and benefitted from attendance at comprehensive mandatory training sessions. Staff told us that appraisals were linked to the

trust's vision and values and they thought the process was effective. They confirmed that the process included professional development, the enhancement of clinical skills and encouragement to attend courses.
- We were told that weekly teaching sessions took place on the wards in conjunction with the link nurses and practice development team.
- We were told that, through effective ward supervision, incidents of staff poor performance were very rare but, when they did occur, they were well-managed and proactive in raising care standards. Staff told us they could raise issues and discuss them individually or as a team. They told us they felt listened to.
- Junior medical staff felt they were well-supported by their clinical and educational supervisors. They attended audit presentation meetings, clinical updates and morbidity and mortality meetings in their protected time.
- Revalidation of doctors was monitored and completed as required.
- We were provided with examples of academic articles and papers presented at conferences about patient outcomes following surgery at the trust. The trust's website displayed the work carried out by the surgical team consultant surgeons. For example in January 2015 the QEHB Healing Foundation Centre for Burns Research, hosted the first European Burns Research Network which brought together authorities in a range of fields, from wound repair to reconstructive surgery in order to plan for new collaborative opportunities.

Multidisciplinary working

- We saw very good examples of multidisciplinary team (MDT) working across the services. Patient notes demonstrated multidisciplinary input and there were records of regular meetings including dieticians, physiotherapists and occupational therapists. We saw that ward handovers took place with all the MDT involved. We spoke with physiotherapists who told us they were integrated in to the teams along with those mentioned.
- We spoke with physiotherapist and occupational therapists who felt very much part of the nursing/ medical team and valued members of the multidisciplinary team.

Seven-day services

- We were told that daily wards rounds took place for all patients, except in urology. The urology consultant saw each patient postoperatively on a daily basis, not on a formal ward round. When necessary, consultant presence out of hours was available in all areas.
- The ward staff were aware of medical availability and of out-of-hours imaging and pharmacy services. Occupational therapy had a five-day service and physiotherapy was available five days with acute and on-call cover in the hospital at weekends.

Access to information

- Care plans, risk assessments and relevant information was in place to support the staff to deliver effective care and treatment. The trust used a systematic approach to ensuring test results were available when required.
- We heard that when patients moved between services a robust handover process was in place which ensured their on-going care continued in a timely way and in line with relevant protocols.
- Electronic and paper based record systems were accessible to those staff who required them giving them access to the necessary records.
- We were told by a patient on ward 726 that they had been given a print-out of their year's appointments to ensure that they were fully informed and able to attend.
- We heard an example of the records audit on ward 727 scoring below the trust average. The audit checked ward data such as patient charts, handover sheets and patient records. With training and improved management, subsequent audit results had greatly improved.
- Staff told us they access to the intranet to complete eLearning and keep update with trust policies and procedures. Newly implemented documents were highlighted on the home page.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that verbal and written consents were gained appropriately. Verbal consents were observed for medication administration, wound care and general observations. Written consent was gained for operations, interventions and procedures. Patients told us they felt the staff were very respectful and informative.

Surgery

- Staff we spoke with had a good knowledge of the Mental Capacity Act (2005) and the need to report issues relating to the Act's deprivation of liberty safeguards. Patient advice leaflets about the Act were seen to be available on the wards.

Are surgery services caring?

Good

Summary

Evidence provided by the trust, and from talking to patients, provided us with assurance that surgery was delivering a caring service overall.

The professional, calm ward atmosphere was a credit to the staff and greatly appreciated by the patients we spoke with. During the inspection we observed and heard from patients and relatives many examples of compassionate, caring and friendly staff.

Compassionate care

- The 51 patients we spoke with were extremely positive about their experiences of care and treatment with one relative who had logged a complaint with the Patient Advice and Liaison Service.
- We observed positive interactions between staff on duty and patients and their relatives and visitors to the wards.
- The professional, calm ward atmosphere was a credit to the staff and greatly appreciated by the patients we spoke with. They told us they had been treated respectfully and their dignity maintained. Relatives told us they felt there was good communication with the staff: they felt involved and that they had been given time to talk about the care.
- There was a higher response rate than the England average for the NHS Friends and Family Test. Overall; response scores were higher for this trust than the national picture for 14 of 16 months. The test's individual ward scores were available for each ward manager to review on a monthly basis; however, the results were not displayed for the patients and public to see. Satisfaction scores for December 2014 ranged between 86.5% for ward 727 and 100% for ward 407 and ward 728.

Patient understanding and involvement

- 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. During that time they were able to discuss any issues.
- All grades of staff were seen introducing themselves and talking to patients to put them at ease.

Emotional support

- Clinical nurse specialists supported patients within their surgical speciality.
- We were told that patients were supported by the mental health team when required.
- Patients and relatives told us that they had been dealt with compassionately and in a thoughtful way; they were offered time to talk and discuss their worries and concerns.
- We heard examples of staff being supported by their managers when stressful situations had occurred on the wards.

Are surgery services responsive?

Requires improvement

Summary

Queen Elizabeth Medical Centre was not meeting the 18-week standard referral to treatment time performance and this was reflected in the surgery risk register. We heard that the ambulatory care model had relieved the pressure on the surgical wards and reduced the levels of overnight admissions. The directorate managed, as far as practicable, the availability of beds to ensure that patients were admitted as expected. There had been a significant number of cancellations throughout the year. In the last three months of 2014, 238 (2%) operations were cancelled due to lack of theatre time and because emergency operations took priority.

Patients with complex needs had been well-supported by the ward staff and teams of multidisciplinary staff. Specific pathways had been developed for conditions such as abdominal pain, whereby a patient could be discharged and brought back the following morning for investigations.

The discharge lounge provided patients with a safe and comfortable environment to await collection by family or

ambulance services. The trust had a policy for dealing with patients with complex needs, including surgical needs, learning disabilities and dementia. Translation services were also available.

Service planning and delivery to meet the needs of local people

- Operational standards overall picture was consistently below 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. The hospital was not meeting the standard performance and was recorded as below the standard for six of the 10 specialties (June 2013 to September 2014). This was reflected in the surgery risk register. Five of these targets were included in Monitor's risk assessment framework (RAF) whilst the 62 day upgrade target was set contractually. Performance for the 62 day GP target remained below target at 79% against the 85% target. For 62 day referral from screening the trust achieved 75% however this related to a single patient breach of the target. 31 day first treatment performance was below target at 90.6% against the target of 96%. Performance for 31 day subsequent surgery target was 71.3% against the 94% target.
- In 2013/14, the trusts performance was 96.2%, exceeding the national target of 95% for the 31-day cancer wait for second or subsequent treatment in surgery.

Access and flow

- Between October and December 2014, 238 (2%) operations were cancelled for non-clinical reasons on the day of, or after admission. The two main reasons were lack of theatre time and emergency cases taking priority. Quarterly England average for percentage of patients whose operation was cancelled and were not treated within 28 days has been in the range 3% to 7% from Apr/11 to Sep/14.
- Two patients were recorded to have stayed in recovery overnight between October and December 2014. This was due to lack of suitable bed availability following their theatre procedures.
- The introduction of the ambulatory care model had relieved the pressure on the surgical wards and reduced the levels of overnight admissions. The surgical assessment unit also held patients for up to 36 hours before discharging or admitting to the appropriate wards. Some surgical beds were being used for medical patients which did impact on the workload for the ward staff when dealing with medical staff and organising investigations.
- Once they had left the ward, the discharge lounge provided patients with a safe and comfortable environment to await collection by family or the ambulance service. Staff told us, and patients confirmed that patients were notified of their expected discharge date. The lounge was open Monday to Friday.
- Of patients who sustained a fractured neck of femur, 88.1% were operated on within 48 hours -- better than the England average which is 86%. All of these of patients had a falls risk assessment completed.

Meeting people's individual needs

- The trust had a policy for dealing with patients with complex needs. We were told that multidisciplinary meetings, planned input and regular review maximised the patients' experience and reduced their hospital stay.
- The trust had access to translation services. Staff told us that interpreting services were easily accessible and added great value to patient care. We saw signs promoting to patients the availability of interpreters when needed.
- We observed call bells being answered in a timely manner and patients told us they had been attended to when they had called for assistance.
- Several relatives we spoke with told us they felt the time taken to park was unacceptable. They told us that the walk from the car park to the lifts and the subsequent walk from the lift to the ward was exhausting. We saw that seating areas and wheelchairs were available; however, one relative told us the wheelchairs were, at times, all in use.
- We saw patient information leaflets on all the wards relating to the speciality. One patient told us they had read the leaflet on the hospital website. Staff alerted the nurse practitioner for learning disabilities when a patient with special needs was admitted. We saw an example of discreet support being offered to a patient with a learning disability by staff who had acted in a thoughtful and reassuring way; the staff ensured that a small group cared for this patient to provide reassurance and familiarity. The learning disabilities link nurses contacted the community learning disability team to support transition from hospital to the community.

Surgery

- We were told that a patient with special needs, such as a learning disability or those living with dementia, could be escorted to theatre by their carers or family to alleviate fears and anxiety.
- Dementia screening assessment was undertaken for patients over 65 years and there was clinical advice and input available from consultant orthogeriatricians who attended weekly multidisciplinary meetings.
- Patients living with dementia were supported on the wards. A dignity and care team promoted resources on the ward to assist staff and offer in-house training. 'All about me' documentation was completed with the involvement of family or friends to ensure that staff got to know the patients' preferences. One-to-one support was provided when necessary and some healthcare workers were trained in diversional therapies (those that use leisure and recreational experiences).
- We heard from a young mother who was due to have elective surgery. She said that the hospital had enabled her to attend to her family issues while being reassured that her bed would be still available.

Learning from complaints and concerns

- During 2013/14, there were 222 complaints received for surgery, with 36 upheld. A number of complaints about the provider were mainly about delayed or cancelled operations or poor patient care.
- Senior staff told us that, although they did not like receiving complaints, the feedback provided did help to improve the service. Specific complaints and how they could have been avoided were discussed at ward meetings. We were told how, by comparing the complaint details alongside the satisfaction survey results, the trust was able to see how the wards were performing overall.

Are surgery services well-led?

Good

Summary

We found that wards and theatres were well-led, with motivated managers leading teams of professional and enthusiastic staff. The majority of staff told us they often saw members of the senior management team. Surgery directorate consistently performed higher than the national average in the NHS Friends and Family test.

Overall staff morale was high; staff felt the open, honest culture at the hospital made it a nice place to work. Incidents were followed up, with action plans to address the issue and reduce the risks of recurrence. Due to the layout of the hospital, we heard examples of cases where some areas didn't always know what was happening in other parts of the hospital. At the same time, we were also told that information sharing had improved with the distribution of the trust's newsletter.

Vision and strategy for this service

- The vision and strategy for the trust was very well understood by staff and was easily discussed by staff we spoke with. They understood that the appraisal system related to the vision and values and their responsibility to promote them.

Governance, risk management and quality measurement

- Clinical performance dashboards were being used to monitor quality and patient outcomes. Centrally logged, these were visible to all directorates for use as comparison benchmarks.
- The trust's risk register identified the risk, with timescales for completion of actions. Once the actions were completed, the item was removed from the register. Trust representatives told us there were action plans in place to address the Referral to Treatment times and the 31 and 62 day cancer waits.
- The surgery directorate had an educational lead who reviewed incidents and actioned training sessions.

Leadership of service

- Staff told us they felt they were well-managed and supported. They told us of the clear leadership and approachable management team that listened to them.
- We heard of divisional directors and matrons being very visible, holding regular meetings and discussions over escalated issues.

Culture within the service

- We saw a strong culture of reporting, with learning via trust emails and newsletters. Incidents were immediately escalated to senior staff.
- All levels of staff told us they felt valued and enjoyed their work. On ward 624, we were told that some patients could be on the ward for several weeks and the staff were trying to add normality to their stay for example a Valentine's Day event was planned, with funding arranged and extra staff on.

- We heard examples of how lessons were learned 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 there was an open, honest explanation and they had described lessons learned. This was subsequently discussed in a ward meeting and practice had changed.

Public and staff engagement

- Patients were asked to complete the trust's patient experience survey prior to being discharged. The results demonstrated that patients were very satisfied with the care and treatment provided.
- Many support groups were advertised around the hospital and on the website. The hospital gained the views of patients and carers through their patient and carer councils. They were committed to working in partnership with patients, their carers and the public. They aimed to gain a better understanding of the priorities and concerns of those who used the services by involving them in their work, including policy and planning.
- Patients were encouraged to become members of the Queen Elizabeth Hospital Birmingham. Patients were encouraged to become members for a variety of reasons. To share their thoughts and ideas, to help in and around your hospitals, electing governors or becoming a governor themselves. The trust felt that the more involved members were, the more closely it reflected the different communities they treated and would give everyone involved a better understanding.
- Patients and visitors were encouraged to express their views on the NHS Choices website or leave feedback cards.
- The Patient Advice and Liaison Service advertised their availability on the wards. Contact could be made via the local office, telephone calls, emails or their online form.
- Staff told us they attended ward meetings, were able to give suggestions and felt listened to.

Innovation, improvement and sustainability

- We saw innovative practice for mandatory training; ward staff had become trainers to complete ward-based training and some domestic staff had been trained to carry out staff hand hygiene audits.
- We saw certificates were awarded to recognise and celebrate achievements, for example a 'Best Team' award.
- We heard of good multidisciplinary working with the added support for patients of access to of QEHB@Home (supported recovery at home) and Recovery@Home whereby a multidisciplinary team of nurses, physiotherapists and occupational therapist were able to support patients within the community for up to 10 days while awaiting social services to take over the care of the patient.
- Volunteers offered five hours support every day on ward 517 (vascular) to speak with patients and support the ward staff.
- We saw that bed spaces were labelled in recovery to assist theatre staff in easily transferring the patient to the correct bed.
- We heard of many innovative surgical practices taking place at the hospital, including the first use of the 'organ assist' device which allowed the transplantation organ to be assessed and prepared prior to the surgery taking place.
- World class research by the hospital's doctors into a lethal and increasingly common form of liver disease was to be the subject of a BBC Radio 4 programme.
- The trust worked closely with the University of Birmingham to be one of the world's leading centres for researching and treating liver disease. We were told of the improved patient recovery benefits of auxiliary liver graft transplantation.
- Among the ground breaking work underway at the hospital is the world's largest randomised trial of stem cell treatment in patients with liver cirrhosis.

Critical care

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

Information about the service

University Hospitals Birmingham NHS Foundation Trust had up to 100 intensive care/high dependency beds within four critical care units identified as A, B, C and D. Each unit primarily provided care for a specialist patient group: Unit A provided care and treatment for liver and general surgery patients; Unit B provided care and treatment for trauma, burns and plastics patients; Unit C provided care and treatment for neurology and neurological surgery patients; and Unit D provided care and treatment for cardiac surgery and cardiology patients. The units provided a mix of level 3 and level 2 beds. Level 3 are beds for critically ill patients, who are ventilated and have other complex care requirements. Level 2 patients are also critically ill and have complex care needs, but do not require ventilation. The critical care units at the time of our inspection were funded to accommodate up to 65 level 3 patients. The critical care units had admitted 4,396 patients between January and December 2014.

There were 32 intensive care consultants. Two consultants were available each day for each unit (so, eight consultants in total) and were supported by middle grade and junior doctors. There were 403 qualified nurses working within critical care. A minimum of 66 nurses were on duty for each shift, supported by healthcare assistants.

Evening and overnight medical cover was provided by a registrar on site for each unit, with two consultants on call from home for all four critical care units.

There was a critical care outreach team 24 hours a day, seven days a week for the management of critically ill patients in the hospital. There were seven to eight nurses available during the day and six nurses available at night

We visited each of the four critical care units during our announced inspection and also visited again unannounced on 13 February 2015. We spoke with eight patients, 23 relatives and 64 staff – nurses, doctors, domestic staff and managers. We observed care and treatment, and looked at the records of 16 patients on the units. Before the inspection we reviewed performance information about the hospital.

Critical care

Summary of findings

Critical care services were found to be outstanding, providing effective treatment with excellent leadership.

There were sufficient, appropriately skilled and experienced medical and nursing staff available within critical care units.

Critical care services were obtaining excellent results for patients who received treatment that was based on national guidelines. The hospital had seven-day working and outstanding, effective multidisciplinary working which had a positive impact on patient care and recovery. Critical care staff were caring and compassionate.

Bed capacity of critical care services was not generally a concern, although the unit had experienced delays in discharging patients to other wards. Staff remained with patients if they were moved within the unit to maintain consistency.

The team supported rehabilitation of patients well.

The leadership of critical care was outstanding. Staff reported that nursing and medical leaders were supportive and encouraged innovation. Staff were aware of and committed to the trust's vision and demonstrated commitment to its objectives and values. Staff were proud of the standard of care they provided and said that their achievements were recognised by their senior managers.

Are critical care services safe?

Good

Summary

Critical care services were rated good. There were appropriate systems in place to highlight and respond to risks, incidents and near misses. The units had sufficient and appropriate medical and nursing staff. The critical care units frequently needed to use agency nurses but there were appropriate systems in place to minimise this additional need.

Critical care services provided treatment for patients with complex injuries or conditions which were life-threatening and which district hospitals were unable to treat. This had resulted in a higher death rate compared to other hospitals. Critical care had a proactive reporting system which enabled them to put actions in place to provide patients with increased protection from harm.

Staff had received mandatory training, including in safeguarding, but their understanding about the use of restraint in safeguarding situations needed to be improved.

The critical care units were clean and there were appropriate systems in place to minimise the risk of cross-infection.

There were appropriate arrangements for the administration and storage of medicines. Improvements were needed to ensure that intravenous fluids were securely stored and were appropriately and safely administered. Resuscitation trolleys were accessible on each unit and had been checked and signed as 'in order' on a daily basis, as per trust policy.

Incidents

- There were 40 serious incidents reported to the trust's strategic executive information system (2013/14) for critical care services within the University Hospitals Birmingham NHS Foundation Trust – 24 incidents related to patients with grade 3 pressure ulcers, 12 grade 4 pressure ulcers, three breaches of confidential information, one fall with harm and one communicable infection. All of these incidents had been investigated and, when required, appropriate action taken.
- When things had gone wrong, robust reviews and investigations were carried out which included the

involvement of staff, patients and their relatives. The matron confirmed that, whenever possible, a meeting was arranged to provide an apology and patients and their relatives were told of actions that would be undertaken as a result.

- The trust investigated every serious incident through a root cause analysis investigation process and, when needed, an action plan for improvement was identified. We looked at a selection of root cause analysis investigations which included pressure ulcers, falls and incidence of infections. They were comprehensively investigated and identified actions that would be undertaken to reduce the risk of similar incidents in the future. We also saw that required actions had or were being addressed.
- The hospital had a computer-based system for reporting incidents and near misses. All staff, including bank (overtime) staff, were able to report incidents and were aware of those that needed to be reported. Agency staff required a permanent staff member to complete the form for them online. Medical and nursing staff we spoke with said that they had reported incidents, such as pressure ulcers or general concerns about care. Staff told us that they received feedback about incidents, and were confident that actions were taken in response.
- Mortality and morbidity meetings were held monthly and were attended by representatives from critical care staff groups and teams. During those meetings, attendees reviewed the notes for patients whose death was not expected and who had died within critical care or following a recent critical care stay. Minutes of meetings we reviewed showed that, when needed, actions were taken to improve practice.
- Medical staff on Unit D spoke positively about the mortality review meeting and the benefits of the learning when caring for other patients. However, medical staff told us that they sometimes had difficulties attending the monthly meeting as they were needed in theatre. Medical staff felt that there could be better communication and planning to enable them to attend these meetings.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The hospital's safety information was updated monthly. It showed that, in the critical care units between July and December 2014, there had been nine patient falls, and 194 pressure ulcers. Critical care Unit A had the highest number of pressure ulcers of any department in the hospital (82) of the total number of 632.
- We discussed information about pressure ulcers with senior critical care nurses and the tissue viability nurse specialist. We were told that the hospital and critical care unit reported any pressure damage as 'patient harm' including from medical devices such as breathing tubes, urinary catheters and tapes used to secure them, anti-embolism stockings and rectal drainage tubes. All incidents of pressure damage were investigated by a tissue viability nurse specialist and any grade 3 or 4 pressure ulcers were reviewed by the executive team.
- As part of the root cause analysis, the pressure ulcer was assessed as avoidable or non-avoidable. Missing information such as a failure to record a change of position or movement of the tube or tape would mean that the harm was judged to be avoidable. Staff told us that this approach had led to a substantial reduction in the number of patients with pressure damage.
- The ward performance dashboards included information on MRSA infection rates, venous thromboembolism (VTE or blood clot) assessments, patient harm incidents, pain assessment, completion of falls risk assessment and missed insulin doses. The performance dashboard also made a comparison between the unit's and trust's performance. The critical care units were mostly performing well compared to the rest of the trust. Senior nurses told us they had identified a need for the critical care dashboard to more closely consider critical care risks. We were told that the critical care matron was looking at what critical care risks should be reviewed within the dashboard.
- The safety thermometer was not displayed on the wards. Information was shared with ward managers about the performance of their ward and, when required, actions needed to improve performance. This information was disseminated to the teams during team meetings.
- Risk assessments for patient pressure ulcers and VTEs were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean and well-maintained.

Critical care

- There were up-to-date signed cleaning schedules and labels on equipment showing when cleaning had last taken place.
- The cleanliness of the critical care unit areas were audited daily, with an overall score reported monthly. The units had scored highly when audited by an independent manager. Figures seen during the inspection was 100% compliant and weekly cleanliness audits compliance seen over 92% all required actions undertaken and then checked. Overall compliance over 92%
- Staff compliance with hand hygiene was checked daily in each area by a senior nurse. A report of overall staff compliance for each critical care unit between 1 July and 31 October 2014 identified overall staff compliance with hand hygiene as: Unit A – 97.4%; Unit B – 97.2%; Unit C – 98.7%; Unit D – 99.2%.
- Hand gel was available at the entrance to every critical care area, and at bed spaces and throughout each unit. Signs to remind staff and visitors to wash their hands and the importance of hand washing were inconsistently used and visible. We noted that hand-washing signs were not available in the majority of staff and visitors toilets we inspected.
- In the last 12 months, the units reported acceptable MRSA infection rates which were better than other comparable hospitals. There had been one case of Clostridium difficile (C. difficile) in critical care between April 2014 and February 2015. Information provided by the trust showed that incidents were reported and a root cause analysis undertaken and, when needed, actions were completed
- Side rooms were used where possible as isolation rooms for patients identified as an increased infection control risk (for example, patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.
- We observed that used syringes were left on top of the contaminated sharps bins alongside the blood gas machine. We highlighted this to a band 6 nurse who agreed it was poor practice and that they should have been appropriately disposed of. We found on our unannounced visit that syringes were being appropriately disposed of, following our feedback to the trust.
- Critical care had a bed-cleaning team available from 10am to 8pm Monday to Friday. The purpose of the bed-cleaning team was to ensure the timely and effective cleaning of the bed space to minimise vacant bed time. The matron told us that this team had been invaluable to ensuring effective and systematic cleaning

Environment and equipment

- We saw that patient areas were free from trip hazards. Units appeared tidy and organised.
- To ensure patient safety, appropriate checks on equipment were undertaken. For example, we observed checks to portable capnograph monitors. Capnographs are used to check the location of breathing or feeding tubes.
- All critical care units used the same equipment which enabled continuity in staff training and staff use.
- We saw that the resuscitation equipment was regularly checked and, when needed, restocked. There was a record of when and who had undertaken this check.
- An intercom and buzzer system was used to gain entry to the critical care unit, to identify visitors and staff, and ensure that patients were kept safe.

Medicines

- We observed medicines rooms and cupboards at patients' bed spaces were locked.
- All controlled medication, high-risk medication and associated paperwork were appropriately and safely stored.
- We observed that intravenous catheter flush bag fluid (0.9% sodium chloride intravenous fluid) was not prescribed by a suitably qualified person. We also observed that the bedside safety checks undertaken did not specifically ask the nurse to check the flush bag fluid to reduce further patient risk.
- Intravenous fluids were not securely stored. We found that the intravenous fluid storage room used by units A and B was unlocked. We found it was normal practice for intravenous fluids to be stored on trolleys on each unit. We made senior staff in critical care and at trust level aware of our findings.
- The medicines fridge minimum and maximum temperatures were recorded daily. The temperature of the room/area where medicines were stored was not recorded in the units we visited. A regular check on temperature provides assurance that medicines are stored safely, and their effectiveness is not adversely affected.

Critical care

- The critical care units used an electronic prescribing and medication administration record system for patients which facilitated the safe administration of medicines. Nursing staff used a computer-based system to confirm when medicines had been administered or the reason the medicine had not been given. Doctors and nursing staff were positive about the system and told us of its many advantages in improving patient safety. Doctors told us that the system alerted them if medicines were considered unsuitable, or if the patient was allergic to the medicine. Doctors also told us they were only able to prescribe from an agreed list of medicines and only more experienced doctors or consultants could prescribe specialist medicines.
- Emergency medicines were available for use and there was evidence that these were regularly checked.
- There was a senior pharmacist available for each unit to advise doctors on medicines. There was a top-up service for ward 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

- The critical care units used a combination of computerised and paper records. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient, and their treatment and care needs.
- Within the critical care units, paper-based nursing documentation 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 was 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 had policies and procedures in place for safeguarding children and vulnerable adults. Over 90% of all staff had received safeguarding training.
- Staff we spoke with knew how to access safeguarding policies and procedures on the trust's intranet.
- Staff confirmed that they had received safeguarding awareness training, and confirmed actions that would be undertaken to keep people safe. Staff told us that they had a phone number to call if they had any safeguarding concerns. Two staff members told us that they had rung the safeguarding number and received advice on how to ensure that the patient was protected. Staff were aware of their safeguarding responsibilities.
- We found that, although staff generally understood safeguarding procedures, there was a lack of understanding about the use of restraint, such as the use of sedative medicines or equipment used to stop patients pulling out life intravenous lines. Staff did not always understand that any form of restraint needed to be fully considered and recorded as in the patient's best interest.

Mandatory training

- Nursing and medical staff confirmed that they received annual mandatory training in areas such as infection control, moving and handling, medicines management and information governance. Data showed over 95% compliance with mandatory training.
- Senior medical and nursing managers told us that mandatory training was reviewed as part of each staff member's appraisal. The medical critical care lead told us that annual reviews and appraisals were only signed off when all mandatory training had been completed.
- Mandatory training attendance for nursing staff was monitored by the ward manager and professional development nursing team.
- Medical staff training was monitored by each doctor's mentor and by the clinical medical education lead. The clinical lead was committed to ensuring compliance, but the critical care board meeting minutes suggests this remains a challenge for the team.

Assessing and responding to patient risk

- The hospital used the severity early warning score (SEWS) to identify deteriorating adult patients. At the time of the inspection, the process was for the nurse in charge to phone medical staff about an acutely unwell adult patient. The computerised patient observation records were being extended by autumn 2015 to include the SEWS score which will then be electronically escalated to the patient's consultant and nurse in charge of the ward to ensure that timely and appropriate treatment is provided.

- Risk assessments for patients for pressure ulcers, falls and VTEs were being completed appropriately and reviewed at the required frequency. Risks assessments identified required actions for staff to follow to minimise risks to patients.
- The unit had an identified clinical audit programme to monitor adherence to guidance, and staff were delegated responsibility to carry out audits. For example, hand hygiene, record keeping, anti-microbial prescribing in intensive care units, burns in intensive care units, initial management and general cleanliness audits, in which they identified appropriate compliance. Weekly cleanliness audits compliance seen showed over 92% all required actions undertaken

Nursing staffing

- The critical care units used a number of nursing staff based on the anticipated number of level 3 patients (additional nursing staff provision was available if level 4 care was required).
- The required number of nursing staff on duty for each shift, and the actual number of qualified and unqualified staff, was identified and displayed within each critical care area.
- We found that nurse staffing numbers met core standards for intensive care units. Nurses on the critical care unit were allocated to one-to-one care for level 3 patients, one nurse provided care for up to two level 2 patients. In addition, the critical care units at the trust provided level 4 care when two nurses provided care to one patient. Healthcare assistants were also on duty to provide assistance with personal care.
- If staffing levels were not met from their own staff working their contracted hours, the critical care staff were able to work overtime hours for the hospital's bank team. Bank staff were employed by the hospital and had received all required mandatory training.
- The critical care units also used agency nurses, who covered around 9% of nursing shifts in the last six months. The hospital had preferred agencies whose staff had received all the trust's mandatory training and competency assessments, including training to use the electronic patient medication system. We spoke with one agency nurse who said that they would only work at University Hospital Birmingham, they told us, "The systems here are safe". Only if a shift could not be filled by one of the preferred agencies would the shift go out to be filled by other agencies. Staff told us that using alternative agency staff was problematic as personnel were unable to use the electronic systems which meant that a permanent member of staff needed to assist them with most tasks, including drug administration. We found that, on occasions, there were up to 10% of agency nurses from a non-preferred agency working in the units.
- All shifts within each critical care unit had at least two supernumerary senior nurses (band 6 or 7). Units A and D had three supernumerary nurses on duty. 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 handovers occurred at least twice a day, during which staff communicated any changes to a patient's condition to ensure that actions were undertaken to minimise any risks.

Medical staffing

- Medical care in the critical care units was led by a team of 32 consultants (20.7 whole time equivalents) who were qualified in intensive care. Two critical care consultants were present on each of the four units from 8am to 5pm. The ratio of consultants to patients was between 1:10 and 1:13, dependent on the unit size. This meets national recommendations of not more than 15 patients to each consultant.
- Consultants were supported by two registrars and junior doctors for each unit during the day, seven days a week.
- The consultants each worked seven-day blocks. Consultants told us that they felt that this aided continuity of care. The trust may wish to consider that core standards for intensive care 2013 identify five-day blocks of day shifts on intensive care units have been shown to reduce burn-out in intensivists and maintain the same patient outcomes as seven-day blocks.
- There were two medical handovers each day. Consultants worked their seven days either Thursday to Thursday or Friday to Friday. Consultants told us that this ensured there was at least one consultant on duty for each unit who was fully aware of the patients and this ensured continuity of care.
- The critical care consultants undertake ward rounds twice daily. This meant that patients' health and recovery was regularly assessed to ensure they received appropriate and timely treatment.

Critical care

- All potential admissions to critical care were discussed with a consultant and all new admissions were reviewed by a consultant within 12 hours of admission.
- There were appropriate arrangements for medical cover for all units overnight. A registrar or middle grade doctor with intensive care experience was on duty for each unit between 5pm and 8am. In addition, two consultants (one for units A and B and another for units C and D) were on call from home for critical care.

Major incident awareness and training

- The trust had a major incident plan and business continuity plan. The major incident plan identified different types and levels of incidents and responses required by the hospital's staff. As a major trauma centre, hospital staff had to be prepared for the likelihood of a major incident.
- Staff told us that a printed copy of the major incident procedure had recently been enclosed with their pay slips and there were major incident drills at least annually. For these practise sessions, staff told us that they received a text message identifying that there was an incident drill, asking them if they were free to come in to work. Staff we spoke with were familiar with their roles in the event of a major incident.

Are critical care services effective?

Outstanding ☆

Summary

We judged this domain to be outstanding. Nursing and medical staff had excellent training and development opportunities. There was excellent multidisciplinary working that provided effective patient care. Staff believed that the critical care unit provided effective care because of strong "team working".

Seven-day working was in place for all medical and nursing staff and for most other staff disciplines. There were also appropriate arrangements in place for weekends, evening and overnight cover.

Innovations had resulted in effective facilities for the management of burns patients, early rehabilitation of ventilated patients and treatment for patients requiring renal dialysis.

The unit had a clinical audit programme to monitor adherence to guidance. All staff were involved in quality improvement projects and audits. Patients underwent an assessment of their rehabilitation needs within 24 hours of admission to the unit, and the subsequent plan for their rehabilitation needs was clearly documented in the notes.

Evidence-based care and treatment

- Critical care used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society, and Faculty of Intensive Care Medicine guidelines, to determine the treatment it provided. Local policies were written in line with this.
- The hospital was meeting the requirements of NICE (guidance 83) which identified a need for an individualised, structured rehabilitation programme. We saw from patients records that this guidance was being met. In addition, all patients had their physiotherapy plan on the wall behind their bed on white plastic to enable any changes to their plan to be recorded, and it to be clearly visible.
- The UHB had a proactive physiotherapy lead who had developed the rehabilitation programme, had won an award for this work and had spoken internationally on the benefits of the programme.
- There were care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated, had a tracheostomy or another type of breathing tube.

Pain relief

- A pain assessment score for patients, who were unconscious, or conscious but unable to express pain, was used by staff. The 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 told us that staff ensured they had pain relief when needed and that they were kept comfortable.

Equipment

- Staff told us that the use of portable ventilators had supported patients to be able to sit out of bed and move around the unit and the hospital. Staff told us that the use of the portable ventilators had reduced the risk

of further complications, improved patient morale and was decreasing length of stay in critical care. Staff gave us examples of how this had helped to mobilise and rehabilitate patients.

- The critical care units had an equipment team who ensured that equipment was appropriately maintained and available. We observed that the cost of equipment and dressings was displayed where the items were stored to remind staff of the cost and need for effective use. The matron told us that the equipment team had a key role to ensure the effective use of equipment and to negotiate and secure competitive prices and cost savings.
- The hospital had introduced a new pure water filter to improve renal replacement therapy in critical care. The critical care unit has been modified so that on-tap purified water was provided at each of the 100 bed spaces. Benefits included:
- The renal replacement therapy was prepared at the bedside to meet patients' needs.
- The service enabled large volume exchanges to cater for the very sick and achieve stability more rapidly.
- The system's flexibility had enabled patients to receive treatment overnight which had increased opportunities for full mobilisation and rehabilitation during daylight hours.
- Staff were no longer required to lift up to two 5-litre bags from floor to head height every hour which had been a risk.
- There was no spillage as the waste water was plumbed into the drains as opposed to the previous 5-litre disposable plastic bags.

Environment

- Critical care Unit B had two specialist 'burns shock' rooms. The critical care service influenced the design of these specialist rooms which had showering and plumbing facilities.
- These facilities enabled the burns patient to remain inside the side rooms while still being able to shower, scrub and redress their burns. This prevented patients being exposed to temperature swings and needing to use theatre time for dressings with the aim of promoting faster recovery. It also reduced the risk of cross-infection and unnecessary patient moves.
- These rooms provided excellent facilities for effective management of burns patients.

Nutrition and hydration

- Staff had reviewed records to ensure that there were appropriate arrangements to highlight the risk of dehydration.
- The trust used national guidance for parenteral and enteral nutrition. Policies were in place to enable patients who were unable to take oral diet or fluid to be given specialist feeds until they could be seen by a dietician. This meant that patients were protected against the risk of malnourishment.
- Patients we spoke with said that the food was tasty and appropriate for their needs. We observed that drinks were accessible for patients and, when needed, nursing staff provided appropriate assistance.
- The critical care units had three dieticians providing individualised dietetic advice using their expertise in food, nutrient, drug interactions, and enteral feeding. Referral to dieticians was made electronically. Nursing staff told us that the electronic system worked well and they could also request advice in person when the dieticians were on the unit.

Patient outcomes

- The unit contributed to the Intensive Care National Audit & Research Centre (ICNARC) database. The data demonstrated that the trust's critical care units performed better in most outcomes assessed.
- The ICNARC data showed that non-clinical transfers from critical care and unplanned readmissions to critical care were better than the national average.
- Data given to the ICNARC identified that the critical care unit's mortality rate was slightly worse at University Hospitals Birmingham NHS Foundation Trust than other trusts. However, this was explained by the trust as because they received referrals for highly complex patients (patients who have major trauma, burns or require organ transplant) with potentially life-threatening and life-limiting conditions that could not be managed in a district general hospital.
- Data from ICNARC shows that the trust has the largest (by number of admissions) critical care unit in the country. Data analysis shows that the difference in their mortality rate is not statistically significant when compared to other critical care units.
- The physiotherapy rehabilitation service in critical care had been developed to include an individual patient exercise plan for patients while they were in critical care (using a portable ventilator) and additional weekly

exercise classes for up to eight weeks following discharge to a ward. The rehabilitation programme had demonstrated improved outcomes for patients who had been ventilated for five days or more, which included:
  - reduced length of stay from 16.9 days to 14.2 day within critical care
  - reduction in patient ventilated days from 11.7 to 9.3 days
  - reduced hospital length of stay from 35.3 days to 30.1 days
  - improved mobility – from hoisting patients leaving critical care to being able to transfer to a chair
  - reduction in time to mobilise from 9.3 days to 6.2 days.
- The reduction in critical care length of stay translated into significant financial benefits and represented significant cost savings to the hospital and the availability of beds for new admissions (McWilliams et al, Journal of Critical Care, 2014). We found that this was an area of outstanding evidence-based, effective practice which improved patient outcomes and identified cost savings.
- A length of stay multidisciplinary meeting was held to discuss patients who had a length of stay of 30 days or more. The meeting was attended by the multidisciplinary team responsible for that particular patient's care. The success of this approach was demonstrated by a trust report published in June 2014, which showed that the total number of patients who had a length of stay of more than 30 days was 10, who experienced an average stay of around 95 days. Individual patients' length of stay had reduced and, in December 2014, there were two patients with a length of stay of over 30 days, experiencing an average stay of around 43 days.
- The electronic system has demonstrated improved patient outcomes, enabling routine blood to be ordered based on previous results and clinical history. The trust identified that this has led to a significant reduction in blood tests and laboratory costs.

Competent staff

- All band 6 and above nurses (137 nurses) had a post-registration qualification in critical care. In addition, 79 of the band 5s also held the qualification. The critical care units met the required standard of at least 50% of nursing staff with a post-registration award in critical care nursing.
- The General Medical Council National Training Survey 2013 reported positively on the training, support and supervision provided by the critical care department at the hospital.
- Nursing staff had an induction period during which they were supernumerary for at least four weeks, although this could be extended for nurses who had not previously worked in critical care. The supernumerary period was then followed by a three-week supervisory programme where they were closely monitored by their mentor or supervisor. All nursing staff had to successfully complete this supervisory period.
- All nurse competencies were checked against standards identified by the National Competency Framework for Adult Critical Care Nurses. Nursing staff we spoke with told us that there were basic band 5 competencies, followed by senior band 5 competencies and then band 6 and above competencies. This meant that there were assurances in place to ensure staff practice and competency.
- The critical care units had a clinical care practice development team of eight nurses who provided teaching to enhance clinical skills, supervision and support to all unit staff. There was approximately one whole time equivalent practice development nurse to 50 nurses. The availability of the practice development nurses was significantly better than core standards which required one whole time equivalent practice nurse for every 75 nurses.
- The lead nurse for nurse and doctor professional development had put together an extensive teaching and development programme. Both the medical and nursing practice development leads told us that they were proud of their training programme which included speakers who were nationally recognised clinical experts.
- Nursing and medical staff had an allocated mentor. The mentor provided support and acted as a role model. Doctors and nurses we spoke with said they felt supported by their mentor and other staff.
- All staff we spoke with confirmed that they received an annual appraisal.
- The clinical medical lead told us that doctors could only be revalidated if they had successfully completed all mandatory training.

Critical care

- We spoke with the most recently appointed consultant. They told us they had a mentor and that working alongside another consultant colleague provided them with good peer support and advice when needed.
- We spoke with one consultant who told us that they provided simulation teaching to assist medical and nursing staff practice techniques and procedures. A simulation mannequin had been purchased with a charity donation to assist doctors and nurses with some procedures, such as difficult intubation.
- Reflection on procedures undertaken was made by each group and included what went well and areas for improvements. This enabled staff to practice routine and difficult procedures without putting patients at risk of harm.

Multidisciplinary working

- There was a daily ward round with input from doctors, nurses and physiotherapists.
- There were daily microbiology ward rounds, during which the patients' microbiology treatment needs were discussed. This meant that daily expert advice was provided which reflected changing recommendations, local microbiology changes and any immediate changes needed to respond to national guidelines.
- Multidisciplinary team members, such as the pharmacists and speech and language therapists, had a hand over every time they visited the unit.
- There was a weekly, full multidisciplinary team meeting on each unit that had input from medical, nursing, dieticians, pharmacy, speech and language therapy and physiotherapy to discuss complex patients such as those who had been ventilated for more than five days or had been a critical care patient for more than seven days.
- Three dieticians provided support to the critical care units. The nutrition team undertook three ward rounds a week during which patients with complex or special nutritional needs (including enteral feeding) were reviewed.
- The unit had a dedicated team of 10 physiotherapists. Patients had an assessment of their rehabilitation needs within 24 hours of admission to the critical care units. A plan for their rehabilitation needs was clearly documented in their notes and at their bedside.
- Doctors, physiotherapists and speech and language therapists contributed towards a plan to wean patients off ventilators. This met best practice guidance.
- There were dedicated critical care pharmacists who provided medicines advice for patients receiving critical care.
- A senior speech and language therapist reviewed all patients with a tracheostomy, with swallowing and speech and communication difficulties. Communication aids were available with advice from the speech and language therapists. This met best practice guidance.
- All staff reported that the critical care unit provided effective care because of strong "team working". One senior doctor we spoke with told us: "We provide excellent patient care which is enhanced by our multidisciplinary working".
- There was a critical care outreach team 24 hours a day, seven days a week for the management of critically ill patients in the hospital. There were seven to eight nurses available during the day and six nurses available at night.
- Referral to the critical care outreach team was via an electronic system. The electronic system also alerted the critical care outreach team to deteriorating patients to ensure that they received timely review. The critical care outreach team also reviewed the progress of all patients who were discharged from critical care within 12 hours. Since 2007, critical care had provided four placements each month to enable trainers from the fire and rescue services to learn more about the hospital care of burns patients. This resulted in a change to the dressings and sterile equipment used by the fire service, providing more effective early treatment for casualties. This partnership with West Midlands Fire Service had won awards for innovation.

Seven-day services

- There were at least eight intensive care consultants present in the critical care department between 8.30am and 5pm, seven days a week.
- Overnight on each unit, a registrar was on duty and two consultants were on call from home. Staff we spoke with said that, when needed, the consultant would attend the units within 30 minutes; this met best practice guidance.
- Ward rounds took place twice a day, seven days a week.
- All potential admissions were discussed with a consultant who reviewed the patients within 12 hours of admission.
- Physiotherapy provided a seven-day service for critical care.

Critical care

- Radiology services were led by a consultant who was available for urgent 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 (9.00 am to 3.30pm on Saturday and 10am to 2.00pm on Sunday). During the evenings, urgent medicines were available in an emergency medicines cupboard which could be accessed by senior staff on duty. The electronic medication system was also able to identify the location of medicines. A pharmacist was also on call and would attend within 10 minutes.
- Speech and language therapists and dieticians were available five days a week, although we were told this would be increased to six days before the end of the summer. Dieticians told us that recruitment had already commenced to provide a six-day service and there were plans to extend this to seven days.

Access to information

- Trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides policies and procedures to assist in their own role.
- Information leaflets were available in the visitors' rooms. A booklet, Information for visitors to critical care, explained to visitors about the critical care unit at Queen Elizabeth Hospital, including infection control, possible equipment that may be used and staff who worked in critical care. This information was available on ward noticeboards and on leaflet racks.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had received training about the Mental Capacity Act 2005. Staff told us they would benefit from greater awareness training in recording best interests decisions.
- Patients were, whenever possible, asked for their consent to procedures appropriately and correctly. Frequently within critical care, patients were unconscious or unable to communicate or lacked capacity to provide their consent. We saw written examples of when doctors had acted in the patient's best interests when the patient did not have capacity to consent. We saw that, whenever possible, doctors had consulted with the patient's relatives. The Mental Capacity Act 2005 was adhered to appropriately.

Are critical care services caring?

Outstanding ☆

Summary

We rated caring as outstanding.

Patients and their relatives said that staff was caring and compassionate. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Staff built one to one relationships with patients during their stay, remaining with them even when patients were moved within the unit.

We heard many highly positive comments from patients and their relatives on the caring and compassionate care they had received.

Patients and relatives were given good emotional support and, throughout our inspection, we saw patients treated with compassion, dignity and respect.

We saw strong emotional support to relatives after the death of their loved one.

Staff provided good care by understanding what was significant to patients, and by making arrangements to ensure they retained what was special in their lives. The team supported both patients and their relatives. Staff turned patients beds towards the window to allow them to see the outside would.

Patients were encouraged to take up post discharge support.

Compassionate care

- Patients we spoke with were positive about staff and the care received: "The staff are amazing", "They washed my hair for me, it took ages trying to make me feel good and clean", "No matter what they are doing they are reassuring".
- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. We saw that staff had turned patients' beds around to face the window so they were aware of day and night and the weather outside. Relatives mostly told us that staff were caring. One relative told us: "I really appreciate that some of the doctors speak to me in my language; it shows they respect me. It is very important to me";

another relative said: "I am happy; they are vigilant about his care, I am happy to leave him in the best care". A third relative said: "They share information with us, are considerate and understand our culture and religion".

- Privacy and dignity arrangements for patients were acceptable. Privacy curtains had a note not to enter when closed. We observed on several occasions staff tuck blankets and bedding around patients to protect their modesty and keep them warm and comfortable.
- We observed staff talking to patients and relatives in a respectful and friendly manner. Staff spoke to patients in a caring manner, asking questions such as "how do you feel today?" Staff took personal interest in patients, asking them about their home or social life.
- The critical care units did not currently take part in the NHS Friends and Family Test. Currently all patients who had been ventilated for more than five days, or had a stay of more than seven days, were invited to attend a follow-up clinic to discuss their experiences of the critical care units. The critical care matron told us they were considering including a question about critical care on the electronic ward surveys, to help them more fully understand patients' critical care experiences.
- Staff ensured that patient confidentiality was respected at all times. Staff spoke discreetly and ensured that records were kept securely when not being reviewed or updated.
- We saw staff who turned the beds around for patients so that they could see out of the windows. This was encouraged practice so patients could tell day and night and see the outside world.
- The unit was divided into four areas. Where patients could not be immediately admitted to the appropriate area, nursing staff would be allocated that would remain with them in both their initial area and once moved to the appropriate critical care unit. This ensured continuity of care and built relationships between staff and patients.

Understanding and involvement of patients and those close to them

- The nature of the care provided in a critical care unit means that patients cannot always be involved in decisions about their care. However, whenever possible, relatives were consulted on the patient's preferences and their views were taken into account.
- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.
- The critical care team work closely with the specialist nurses for organ donation. When on-going treatment is decided to be futile the relatives are made aware of this and the possibility of organ donation was discussed. We saw the staff support families during our inspection when a decision had been made to withdraw treatment. Staff told us that if agreement was made by the families to donate their loved ones organ(s) staff would support the family.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support.
- A chaplaincy service was also available to provide valuable support to patients and relatives. The hospital had a faith centre which patients' families could visit for prayer and emotional support.
- Following the deaths of patients on the critical care unit, sympathy cards were sent to the next of kin with contact details of the critical care nurse specialist, should they wish to speak to them.
- After admission, the consultant covering the unit would arrange to meet with relatives to update them on the patient's progress. When necessary, further face-to-face meetings were organised.
- The relatives we spoke with said they had been mostly been updated and had opportunities to have all their questions answered.
- Patients were supported to stay connected to their family and friend. Visitors were encouraged and supported with visiting times that suited them.
- We spoke with one family who told us that staff had supported the partner (who had mobility difficulties) to remain overnight with the patient in a larger sideward until a suitable sideward became available off critical care. Staff had taken the partner to the look at the side ward to check its suitability. This family had the highest of praise for the caring and compassionate staff. The family had been fully informed of the poor prognosis.
- Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

Critical care

Are critical care services responsive?

Outstanding ☆

Summary

The critical care services were responsive to patients' needs; therefore we rated this domain outstanding.

The overall capacity of the critical care units meant that patients received timely care in the critical care unit.

Support for patients living with physical and learning disabilities or dementia was available, if needed, within critical care.

The facilities for visitors were generally suitable.

Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those providing on-going care.

Queen Elizabeth Medical Centre was a specialist trauma centre and provided specialist trauma, burns and plastic treatment to both civilians and military personnel.

Service planning and delivery to meet the needs of local people

- The critical care unit had 100 beds and was funded to provide 65 (level 3) beds. The critical care service was able to flex and respond when required to local, national, international need when patients were flown in from abroad with the support and involvement of commissioners.
- There were four critical care units each providing specialist treatment and care such general surgery, trauma, neurology and cardiac critical care. The matron told us that there were occasions when there was no suitable bed was available for example on the cardiac critical care unit. The matron said that the patient would be admitted onto another unit with suitably skilled and experienced nurses moved to care for the patient until a suitable bed was available on the specialist unit.

Meeting people's individual needs

- Support for patients living with physical disability or dementia was available if needed. However staff we spoke with were unsure of a lead nurse for people with a learning disability. Staff told us that they usually received assistance from families and were also able to use "the communication box" which provided aids for communication.
- Translation services were available, both by phone and in person.
- Staff demonstrated a good understanding of people's social and cultural needs and explained to them how they could raise concerns or make a complaint.
- There were four visitors' rooms available within the critical care wards: one for each unit. Overnight facilities were available on request in a separate building. Information on overnight facilities was also available in the visitors' rooms. We spoke with one family who told us that they had preferred to stay on the unit with their loved one and staff had supported this.
- The trust had a follow-up clinic for critical care patients and relatives. Patients said the clinics had been invaluable, enabling them and their families to speak about their critical care experiences and discuss unpleasant, on-going symptoms (such as hallucinations) which they do not understand with a nurse specialist. Approximately 400 patients per year were followed up through this process.
- An MDT ward round Led by a Critical Care Consultant is held weekly, with the follow up nurse, physiotherapist, dietician and speech and language therapist. The follow up team go to the wards to undertake post discharge visits and see if patients have any concerns about their time in critical care. Once they have been discharged home at 3 months they are invited to the critical care follow up clinic.
- The critical care unit utilised portable ventilator to enable patients who were able to move around the unit and the hospital. We saw these being used.
- Physiotherapists told us that some patients had been able to attend physiotherapy rehabilitation classes away from the units using a portable ventilator.
- Nursing staff told us that the weekend before our visit a patient had been down to the hospital coffee shop using a portable ventilator and other patients in better weather went outside for a short while.
- The critical care unit had three specialist burns rooms for patients who had serious burns both from the central region and nationally.

Critical care

- Critical care also had a patient/relative 'pathfinder' support group which met at least every six months. The pathfinder group were consulted about critical care and any proposed changes to the unit, with a remit to improve services for patients.

Access and flow

- Between May 2013 and July 2014 figures showed that the bed occupancy for adult critical care beds was mainly around 100%. The national average critical care bed occupancy was 86%. The bed occupancy was also above the Royal College of Anaesthetists recommended critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests a unit is too small. However, due to the ability to adapt the number of critical care beds by increasing and then decreasing the number of patients accommodated, this was mostly not an issue for the hospital.
- ICNARC data showed that:
- Non-clinical transfers from critical care were better than the national average.
- The trust performed slightly worse than the national average for out-of-hours discharges and discharges that were delayed for more than 12 and 24 hours.
- Senior managers told us that they frequently experienced difficulties getting patients discharged from critical care to wards.
- The trust told us that, although sometimes a patient's admission to critical care may be delayed, this was usually quickly addressed. They told us that, until a bed was available, the patient would remain in a "safe" area – either theatre recovery or the high dependency area in accident and emergency. Between March and August 2014, two patients were accommodated in theatre recovery because there was no critical care bed available.
- Patients who were discharged from the unit were aware of their discharge plans and had appropriate records or information given to them or to those providing ongoing care.
- All professionals involved with a patient during their admission to the unit contributed to the plan for their discharge.
- Between January and December 2014, 182 operations were cancelled due to the lack of availability of critical care beds.

Learning from complaints and concerns

- There had been six complaints about critical care in the last 12 months. We found that there was an appropriate response to the complaints received. In addition, bereaved relatives were offered support from the bereavement services to support them during the complaints process.
- 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 if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Information on how to raise concerns and make a complaint was on posters displayed in critical care areas.

Are critical care services well-led?

Outstanding ☆

Summary

The leadership of critical care was outstanding.

Staff working in critical care were aware of the trust's vision and demonstrated commitment to its objectives and values.

Critical care leadership supported a high level of safe innovation as a result of staff being empowered and proactive. The leadership drove continuous improvement and staff were accountable for delivering change.

There were appropriate arrangements to identify and manage risks and monitor the quality of the service provided.

Staff were supported by managers and were positive that their achievements were recognised. They felt encouraged to bring ideas for improvements to services and felt that innovation was supported. Staff were proud of the standard of care they provided and satisfied that their achievements were recognised.

There was a Pathfinder group (patients/relatives) set up to review and improve service provision.

The trust were members of the regional critical care and trauma networks

Critical care

Vision and strategy for this service

- Staff were aware of and understood the vision and values of the critical care unit and the behaviours that would achieve these values.
- Senior nurses told us that they discussed the trust's values during ward meetings, handovers, recruitment interviews and staff appraisals.
- Senior nursing and medical staff in critical care told us that the chief executive advocated quality care which drove the organisation's strategy. They told us that the strategic objectives were regularly reviewed.

Governance, risk management and quality measurement

- Governance and performance management arrangements were proactively reviewed and adapted to take account of current models of best practice. The division had monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were reported back to staff.
- The critical care managers encouraged staff to report incidents and staff confirmed that they received feedback on the incidents they reported.
- Critical care consultants were motivated and committed to improving the quality of the service that critical care provided.
- Risks inherent in the delivery of safe care were clearly identified on the unit risk register: for example, difficulties recruiting critical care nursing staff. Supporting actions were identified and discussed at governance and board meetings.
- Senior nurses and the tissue viability nurse told us that all pressure damage was reported as patient harm. All skin damage was investigated, including skin damage caused by devices such as breathing tubes and urinary catheters. We found that, as a result of this proactive approach and learning from investigations, there had been a substantial reduction in the number of avoidable pressure ulcers.
- A root cause analysis was undertaken following each serious incident. The investigations undertaken were detailed and identified actions to reduce the risk of further similar incidents in the future.

Leadership of service

- Within the critical care unit there was a consultant intensivist who was the medical clinical lead for critical care.
- The critical care's matron (band 8) had a specialist qualification in critical care in addition to a management qualification and had overall responsibility for the nursing elements of the service. This met core intensive care standards.
- The unit had supernumerary band 6 or 7 nurses in charge of each shift on each unit.
- The matron and senior nurses told us that they were supported by the divisional management and executive team who were approachable. Staff told us that the medical director, who was an intensive care consultant, continued to work an occasional shift within critical care which they felt encouraged positive relationships and understanding.
- The leadership ensured that there was shared learning and support for critical care staff.
- There was a high level of safe innovation as a result of staff being empowered and proactive. The leadership drove continuous improvement and staff were accountable for delivering change.
- All staff and managers told us that innovation was supported.
  - The tissue viability nurse told us that the incidence of all pressure ulcers (including device caused PUs) had been reduced by reviewing all incidents and shared actions such as ensuring that the patient or device is moved on a regular basis and any tapes etc. are changed frequently and this is also recorded.
  - A dietician told us that the chief executive was "patient outcome focused" and that if it could be shown to improve patient outcomes the proposal would be considered.
- The matron and senior managers told us that there was a culture of openness, honesty and support for innovation within critical care. We were given many examples of innovation which included demonstrating the effectiveness of early rehabilitation of critical care patients, the use of pure water for renal dialysis and the involvement of staff to design innovative facilities for burns patients.
- We found that the leadership were responsive to improve care outcomes and obtain best value for money.
- During our unannounced visit, we saw that two of the units used whiteboards to inform staff of initial findings

of our announced inspection and the need to take appropriate action. It was positive that we found required actions had been taken to ensure that appropriate and safe care was provided.
- The hospital had introduced a new pure water filter to improve renal replacement therapy in critical care. The critical care unit has been modified so that on-tap purified water was provided at each of the 100 bed spaces. Benefits included a number of patient and clinical benefits, but also a predicted saving for the trust (As tap water was used) of about £275,000 annually

Culture within the service

- Staff told us that the hospital was a friendly place to work and they liked coming to work. Several staff said: "This is the best hospital I have worked in"; other staff also commented: "I am proud to work here".
- All but one staff member spoke positively about working for the hospital. Staff told us they would recommend it as a place to work and that senior staff were supportive.
- Staff in several areas we visited commented that they were: "a good team".
- All the staff we spoke with told us that they would bring their friends and family to the trust for care.
- Staff were encouraged to complete incident forms or raise concerns. Staff felt that these concerns were usually adequately addressed and were appropriately responded to by senior managers.

Public and staff engagement

- The trust used a combination of email, intranet messages and newsletters to engage with staff. Managers, including at executive level, were visible in the department.
- Staff felt supported by their line managers and more senior management and said that suggestions for improvements were always considered.
- There were high levels of constructive staff engagement and staff satisfaction as well as a climate of positivity in critical care.
- All patients who had received care of more than five days on a ventilator, or seven days in critical care, were invited to discuss their experiences at a nurse-led critical care follow-up clinic.
- Critical care also had a patient/relative 'pathfinder' group which met at least every six months. The pathfinder group were consulted about critical care and any proposed changes to the unit. The group had a remit to improve services (examples being painting in critical care waiting areas, making the areas more pleasant place to be in, reviewing critical care patient information). The pathfinder group differed from the support group in that patients were invited to attend once they were supported post-discharge.
- The matron was exploring how critical care patients' views could be more fully sought within the electronic patient satisfaction survey that was in place for the wards. This system provides immediate feedback on patient experiences.

Innovation, improvement and sustainability

- Staff told us they had opportunities to raise issues or bring ideas for improvement and they felt listened to. A consultant said, "Managers are responsive to our ideas and any need for changes are always discussed first". Another consultant told us that the "executives listened" when bringing proposals and ideas forward.
- The matron told us that they experienced difficulties recruiting nurses for critical care which had led to innovative recruitment to ensure the service's sustainability. The matron told us they had recently shared recruitment with Birmingham Children's Hospital. Successful applicants had placements on both sites over 18 months and were then able to choose their preferred specialism. The critical care service also provided training to agency nurses to ensure that 'preferred' agencies had nurses with appropriate skills and training.
- There were appropriate systems in place to review service delivery and, when needed, ensure that lessons were learned and appropriate actions taken.
- Critical care had an effective quality improvement plan which demonstrated a commitment to quality care while obtaining best value for money.
- There was a high level of safe innovation as a result of staff being empowered and proactive. Initiatives included:
  - The use of pure water for renal dialysis.
  - Programmes to reduce length of stay including rehabilitation in critical care.
  - Review meetings for long-term ventilated patients.
  - Specialist facilities for burns patients.
- All of these initiatives demonstrated cost saving while providing an improved quality service.

End of life care

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

Information about the service

End of life care services were provided across the hospital and were not seen as being the sole responsibility of the specialist team on site. There were 1,835 in-hospital deaths at the University Hospitals Birmingham NHS Foundation Trust in 2013/14. The trust had one of the largest regional centres for non-surgical cancer treatment and also offered cancer services for teenagers and young people.

The Specialist Palliative Care Team (SPCT) comprised one consultant, one registrar and a team of nurses – 7.62 whole time equivalent (WTE). The SPCT worked collaboratively with all clinical teams to support end of life care. There were strong working relationships throughout the hospital but particularly with the acute oncology services. The team offered a six-day a week service, with plans to increase to seven days from Spring 2015. Out-of-hours cover was also provided.

The number of patients referred to the SPCT had increased in recent years. During 2013/14, 1,597 patients were referred. Between April and October 2014, there had been 744 referrals, which translated as a 25% increase in referrals year on year.

As part of this inspection, we visited 12 wards looking specifically at end of life care and we reviewed the medical records of 28 patients and 60 electronic do not attempt cardio-pulmonary resuscitation (DNACPR) records. We observed care being delivered on the wards and spoke with four patients, who were identified as requiring end of life care. We also observed the weekly multidisciplinary patient review meeting. We met and spoke with 58 members of staff, including doctors, nurses, porters, specialist nurses and ward managers. We met the chaplains and the mortuary manager and were shown the resources and facilities they had available to them. We also met with the bereavement lead for the hospital.

End of life care

Summary of findings

Overall we rated end of life care services at University Hospitals Birmingham NHS Foundation Trust as 'good'. Staff provided compassionate care for patients. Services were very responsive to patients' individual needs and those of their families and next of kin. We saw and heard about many examples where practical, emotional and spiritual needs were considered and met.

Although the trust did not take part in the national care of the dying audit, data from their own survey showed that relatives were positive about the quality of care and their experience of the service. We observed comprehensive and dynamic multidisciplinary working taking place, which covered all aspects of care. The trust's electronic information system ensured that DNACPR records were managed safely. Medicines were prescribed and administered in a safe way and there was guidance available for anticipatory medications.

At the time of our inspection the service was on the cusp of significant organisational change which the trust believed would enhance and improve the service. It was clear that leaders of end of life care services worked collaboratively across the hospital and their commitment to delivering a good quality service was evident.

Are end of life care services safe?

Good

Summary

End of life care services at University Hospitals Birmingham NHS Foundation Trust were safe. Care delivered on the wards was supported by a reasonably well-staffed SPCT. There was evidence that incidents were reported and investigated consistently and appropriately so that lessons were learned. The trust's electronic information system ensured that DNACPR records were managed safely but there were some inconsistencies in the recording of conversations with relatives. Medicines were prescribed and administered in a safe way and there was guidance available for anticipatory medications.

Incidents

- All staff we spoke to on the wards, in the SPCT and in the mortuary were aware of their responsibilities to raise concerns and report incidents.
- During 2013/14 there had been 30 incidents reported relating to patients receiving end of life care. All incidents were categorised as minor, and there were no serious incidents. There was evidence that action had been taken as a result of the reported incidents and lessons had been learned.
- There were six incidents reported in the mortuary relating to exposure to infection, missing/incorrect identification and documentation issues. There were action plans in place which showed that steps had been taken to ensure lessons would be learnt from the incidents.

Environment and equipment

- In 2011, the National Patient Safety Agency recommended that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. These syringe drivers had been withdrawn from the hospital and all nursing staff throughout the hospital had been retrained to use the preferred McKinley syringe driver.
- The SPCT told us there were 30 syringe drivers in the trust and, at the time of our inspection, they could only account for 25 of them. They told us this is due to patients who wish die at home, being transferred out to the community with the pump and subsequent issues

with the pumps not being returned. Two incident reports had been raised by staff in the last 12 months relating to the unavailability of syringe drivers. However, ward staff and the SPCT confirmed that access to this equipment was not routinely a problem.

Medicines

- Staff told us that patients who required end of life care medicines were prescribed anticipatory medicines – medication that patients may need to make them more comfortable in the latter stages of life. We examined the records of six patients receiving end of life care and found that anticipatory medication was appropriately prescribed. This is usually where doctors issue a prescription before it is needed, in anticipation of managing symptoms, such as pain and nausea that are common near the end of a patient's life.
- There were clear guidelines for medical staff to follow when prescribing anticipatory medicines for patients.
- We also noted that anticipatory prescriptions were discussed at the weekly multidisciplinary team meetings.

Records

- All patient records were held electronically, including DNACPR status records. The system allowed only doctors at registrar grade or above to complete the electronic form; other staff were not allowed access to this part of the information system. This ensured that DNACPR decisions were only signed-off by a doctor with the appropriate authority. The rule base for the electronic system ensures that decision can only be made by SpR and above
- When the electronic form was completed, it was automatically set to expire after seven days, although this could be extended by the authorising doctor in some circumstances. At the end of the period the patient's status automatically reverted to "for resuscitation" if it was not reviewed and re-signed by the doctor.
- When the form was completed, an icon appeared on the main patient information screen, indicating that the patient was "not for resuscitation"; the icon changed as the status end date approached, alerting staff to the need to review the status.
- If the status was not reviewed and expired, an electronic alert was raised in the resuscitation office. The office administrator systematically followed up the patient's status with the relevant consultant via email. The email was endorsed by the trust's palliative care consultants. This process ensured that DNACPR records were reviewed appropriately.
- The electronic system allowed the resuscitation officer to review all the DNACPR records across the hospital at any time. Data could be extracted from the system and analysed for a wide variety of factors – from the location of the patient to the time the DNACPR record was signed.
- Data was taken from the system on a quarterly basis and reviewed by the trust's resuscitation steering group.
- In May 2014, the trust carried out an audit of 58 patients who had died at the hospital: (57) 97% of patients in the sample had a DNACPR recorded on the information system; one person did not (and were "for resuscitation" by default).
- Out of the 57 patients in the trust audit who had a DNACPR according to the records, there was no record of discussion of this for 40 patients. In 22 cases, relatives of the patients did not have a discussion either. The most common reason recorded for no discussion with relatives was "none present". However, in nine out of these 22 cases, a discussion was clearly documented in the medical notes and not in the electronic notes, indicating that the electronic records were not being updated in a timely manner.
- We looked at 11 DNACPR records and compared them to the medical notes. We found that five DNACPR records indicated that there had been no discussion with relatives, but the medical records showed a discussion had taken place at a later date; the electronic records had not been updated. Our own review of the DNACPR records and medical notes was consistent with the outcome of the trust audit.
- Some departments in the hospital – radiotherapy, Ward 301, outpatients and the emergency department – occasionally used a paper-based resuscitation status card. The resuscitation lead nurse told us that these forms were used until the patient was recorded on the electronic information system. These forms were not routinely audited.
- If patients were transferred to alternative care settings, a version of the record could be printed so that a copy could be transferred with the patient.

End of life care

Safeguarding

- All the staff we spoke to in the SPCT understood their safeguarding responsibilities and were aware of the policies and procedures to follow.
- Three out of the nine (33%) nursing staff in the SPCT required update training on safeguarding adults and children.

Mandatory training

- All staff in the SPCT were up to date with training on infection control, fire and information governance.
- Two out of the nine nursing (22%) staff in the SPCT required updates on hospital life support and three required updating on manual handling.

Assessing and responding to patient risk

- Patients were referred to the SPCT by staff on the wards using the online referral system. This enabled ward staff to make referrals 24 hours a day, seven days a week. Nursing staff told us that, if they were unsure, they could ask for advice from the team who were always helpful and supportive.
- The SPCT could respond to deteriorating patients quickly and told us that ward staff usually called them if a referral was urgent.
- The trust had an up to date DNACPR policy in place which is due for review in October 2017. The policy included a decision-making framework for clinicians.

Nursing staffing

- The SPCT included nine nursing staff (7.62 WTE), to support other qualified staff on 40 wards at the hospital. Managers told us they were in the process of recruiting more nursing staff to the team.
- There were two end of life champions for each ward.
- Staff on the wards told us that there was usually sufficient staff on duty to ensure that people who were close to the end of life would have the support and care needed.

Medical staffing

- The trust employed one full-time palliative care consultant and one registrar, both of whom worked closely with local hospice.
- For one session a week the hospital-based consultant worked at the hospice and a hospice-based consultant worked at the trust.
- An on-call service was provided with hospice- and hospital-based doctors providing support to the wards 24 hours and day, seven days a week.

Major incident awareness and training

- The mortuary had a plan in place in the event of a major incident. Staff we spoke to were aware of the plan and the mortuary manager was able to talk us through the key arrangements. This included using temporary storage and the use of additional facilities at local undertakers if needed.

Are end of life care services effective?

Good

Summary

University Hospitals Birmingham NHS Foundation Trust provided effective end of life care for patients. Although the hospital did not take part in national audits, The trust had a range of training for ward staff that was being rolled out to ensure that staff were aware of their responsibilities when caring for a patient at the end of their life and of the facilities available. We observed comprehensive and dynamic multidisciplinary working taking place, which covered all aspects of care.

The trust has its own pathway for end of life care patients used across the hospital.

Evidence-based care and treatment

- The Liverpool Care Pathway was never implemented at the University Hospitals Birmingham NHS Foundation Trust. Instead, the hospital used a locally developed framework called the Supportive Care Pathway (SCP). The pathway was developed in the NHS Pan Birmingham Cancer Network, which was established in 2001 and brought together organisations across Birmingham responsible for delivering and commissioning cancer care.
- The SCP provided nurses and doctors with a framework within which they could assess, plan and deliver care and treatment for patients at the end of their lives. The pathway was supported by a set of guidelines for the management of patients covering agitation, pain, nausea and vomiting and respiratory tract secretions. All of the guidelines we looked at should have been reviewed in 2007. Since our inspection, the trust told us that these guidelines have been reviewed and updated.
- The SCP was in place on all wards across the hospital. We saw the SCP in use on elderly care wards and oncology wards.

End of life care

- Senior managers told us that the SCP electronic recording was only being used in some areas of the hospital, and plans were in place to make this trust wide within the next few weeks. Evidence from the trust's audits showed that documentation was not being fully completed and sometimes not used until the last few days of life.
- Nursing staff told us that, where the SCP was not used, they used the hospital's standard care plans and their own professional judgement with regards to caring for the patient. The trust was developing an addition to the hospital's information system to replace the SCP.
- It was not clear how the trust was currently assuring itself that care was delivered to patients requiring end of life care in accordance with National Institute for Health and Care Excellence (NICE) guidance. We were not able to see audits to show that care provided was of similar/ equivalent standard.
- In September 2014, the trust carried out a bereavement benchmarking audit on each ward; 29 wards took part. Wards used a red/amber/green rating system to assess how they were doing on three different factors relating to communication and skills. Ten wards rated themselves as 'green' for all three factors; all other wards were either all 'amber' or a mix of amber and green.
- The trust had six further local audits, either in progress or in development.
- In the mortuary, a commercial software application is used to manage quality, safety and risk across the department. The software includes a module that manages the audit cycle and the audit data. The trust provided us with a sample of two types of audits it carries out; examination audits and vertical audits. Examination audits are where a procedure is observed in the mortuary and assessed against a number of key standards. The examples we reviewed included preparing and presenting a body for viewing, routine post mortem examinations and use and maintenance of body hoists. Vertical audits are where a patient is pathway tracked through the department to ensure all correct processes and procedures have been followed. We saw three samples of these audits. Where processes had not been adhered to we saw that actions required had been noted.
- The trust had an organ donation policy which adhered to national guidelines. The framework process for donations made reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.
- The trust had a bereavement care procedure for ward staff. The procedure outlined the process for last offices (the procedures performed to the deceased patient shortly after death has been confirmed) and movement of the patient to the mortuary.
- The SPCT use the Somerset Cancer Register database (The database is used in over 90 Trusts across England and covers 13 tumour sites) to record activity. The database collected all the information necessary to make sure that a patient was seen, diagnosed and treated as quickly as possible.

Pain relief

- Ward staff told us that the SPCT were available for support and advice in managing pain. Ward staff we spoke with recognised the importance of good pain relief and ensuring that patients were as comfortable as possible.
- The trust had a number of pain relief standards that they regularly monitored:
  - 100% of patients with a palliative care diagnosis code who were receiving regular analgesia for background pain should also be prescribed with analgesia for breakthrough pain. The trust achieved 95% for the period April to June 2014.
  - 100% of palliative care patients who were prescribed with both analgesic medication for background pain and analgesia for breakthrough pain should also be prescribed with laxatives. The trust achieved 100% for April to June 2014.
  - 100% of palliative care patients on the end of life pathway should be prescribed at least three out of the following four medications to be taken as required: injectable analgesics; injectable sedatives; anti-sickness medicine; and anti-secretory medication. The trust achieved 88% for April to June 2014. We asked the trust what action plans were in place to improve compliance, but these were not provided.
- We observed that anticipatory prescriptions were in place. Patients we spoke to had no concerns about the way their pain was managed.

End of life care

- The SPCT had been involved in a national study looking at cancer pain – the Edinburgh Pain Assessment Tool (EPAT) which involved the recruitment of 106 patients. The palliative care consultant was the local principal investigator for the study

Nutrition and hydration

- Nutrition and hydration needs were included in the SCP.
- Patients told us they were happy with the quality and quantity of the food and felt they had plenty to drink.
- We saw evidence from the patients' notes and from talking to staff that patients with no or low appetite were being encouraged to eat.
- Referrals were made to dieticians and speech and language therapist for advice around oral feeding and discussions around alternatives if appropriate.
- We noted at the weekly multidisciplinary meeting that most patients referred to the SPCT also had a referral to the speech and language therapy service.

Patient outcomes

- Since 2009, the trust had carried out a survey of relatives in relation to the care given to their dying relative.
- For the period September 2013 to September 2014 the trust received 473 responses from relatives of patients who received end of life care, giving an overall return rate of 31%. The results showed positive feedback around communication and information – for example, 89% of respondents said they were given the chance to talk to someone about their concerns. Reported levels of emotional support were over 75%; and 83% of respondents reported that religious, cultural and spiritual needs were considered.
- The trust told us they did not participate in the National Care of the Dying Audit. The trust had a requirement to send out a retrospective questionnaire to bereaved relatives and so wanted to avoid an additional survey being sent to grieving families.
- The trust did not use the End of Life Care Quality Assessment Tool. This is an online self-assessment tool to help providers of end of life care monitor the quality of services. Progress could be assessed against a set of core measures structured around a range of outcomes, standards and frameworks, including NICE guidance.
- The trust's operational procedure stipulated that patients referred to the SPCT should be seen within two days. Data from the past 12 months showed that 97% of patients referred were seen within one day. Staff on the wards told us that the team were very responsive and usually arrived on the ward within the hour. The trust's electronic information system allowed staff to make referrals at any time of the day or night.

Competent staff

- All staff in the SPCT were up to date with their appraisals.
- The trust introduced training around the priorities of care for dying patients and families in 2013. The training covered a number of aspects, including physical care and communication. Following training, staff were given a pocket-sized reference card to remind them of the priorities, which they showed to us.
- As at July 2014, this training had been delivered to 330 band 5 nurses and was part of the band 2/3 programme and the trust preceptorship practical experience and training programme. Of band 2/3 staff, 162 had been trained to date.
- There was a two-day palliative care training programme which was open for ward staff who had an interest in end of life care to attend. The trust told us that 29 ward staff had completed this training in the last 12 months.
- The trust had also introduced communication training which guided staff through a nine-step process to respond to difficult conversations. The Priorities of Care (PoC) for dying patients and their families training resources were originally launched in 2013 and was given to 40 staff from across all the wards which was dedicated to PoC and communication skills training.
- The trust has identified two end of life care champions for each ward area and there were plans in place for additional training for them. Training has been on hold awaiting the completion of the changes to the DNACPR records and other documentation. We are told these will commence 14 April 2015.
- Advanced care planning training workshops were held in October for 39 staff who engaged in advance care planning and end of life care conversations, which included band 6 & 7 nurses.
- All new consultants to the trust received a session on end of life care as part of their induction programme delivered by the bereavement service senior sister. As well as end of life care initiatives in the trust, the sessions included the responsibilities of consultant teams following the death of a patient.

End of life care

- In July 2014 the trust held a seminar for medical staff on DNACPR records and, in particular, recording evidence of discussing DNACPR with relatives: 20 clinicians attended the seminar. The trust was planning further seminars on end of life care.
- Porters were trained by the mortuary manager (usually six months after commencing in the post) in removal of the deceased.
- All new junior doctors received a copy of the booklet Bereavement Care for Doctors. Foundation year 1 and 2 doctors also received training on end of life care and responsibilities following a patient's death.
- Junior doctors we spoke to on the wards told us they felt well-supported to deal with palliative care and were aware of trust policies and procedures. They also confirmed that they had been given training.

Multidisciplinary working

- A weekly multidisciplinary team meeting took place to review all the new patients referred to the SPCT and review any on-going concerns with existing patients.
- The multidisciplinary team meeting was attended by nursing, medical and therapy staff. The chaplaincy service also attended. We observed part of the meeting and saw how each patient was thoroughly discussed and an action plan agreed. Discussions covered DNACPR status, discharge plans and strategies for emotional support, and also included support available for the family where needed.
- The holistic approach taken by the multidisciplinary team was enhanced by the use of the trust's electronic information system, providing real-time information such as test results, prescriptions, scans, and so on.
- We also noted that, for each patient, there were also discussions about their cognitive and mental capacity and any discharge plans.
- Consultants for the local hospice also attended the multidisciplinary team meeting. This provided continuity of care, not only when patients were transferred to the hospice, but also when consultants from the hospice were covering the service out of hours.

Seven-day services

- At the time of our inspection, the SPCT offered a six-day service, 8am to 5pm Monday to Friday and 8am to 4pm on Saturdays. Managers told us they were in the process of recruiting two additional nurses to enable them to provide a seven-day service.
- The trust had a full-time consultant and registrar who provided an out-of-hours service, working an on-call rota in conjunction with three consultants based at the local hospice.
- Ward staff told us that the out-of-hours service was effective and support and advice was available if it was needed.

Access to information

- All the information needed to deliver effective care and treatment is available to ward staff and the SPCT through the trusts informatics system. This includes assessments, care plans, DNACPR status and test results.
- We saw that ward staff were able to refer patients to the SPCT through the informatics system in a timely way.
- The informatics system allows the specialist team to review records at any time, even if they are not physically on the ward. This allows them to provide timely support to ward staff if, for example, they telephone for advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to on the wards were able to describe the process they would go through if they felt a patient required a mental capacity assessment and what they would do if a person lacked capacity and required a best interest decision. They confirmed that families and independent advocates would be involved as much as possible.
- Mental capacity considerations were included in the SCP.
- Nursing staff told us they could access a mini mental state test on the information system if they had concerns. They said they would report the outcome to the doctor.
- The trust has a step-by-step guide for practitioners on the Mental Capacity Act 2005, which included guidance on best interest decisions.
- Staff we spoke with confirmed that mental capacity awareness training was included in their induction.
- We observed that each patient's mental capacity was reviewed and discussed at the weekly multidisciplinary meetings.

Are end of life care services caring?

End of life care

Good

Summary

Staff at University Hospitals Birmingham NHS Foundation Trust provided compassionate care for end of life care patients. We saw that staff, specialist teams and other services were committed to meeting emotional and psychological needs. We were given examples by patients of how staff had "gone that extra mile" to meet their needs.

The chaplaincy team provided a caring service which not only supported patients but also relatives and staff at times.

We noted that dignity was maintained for deceased patients. However, we did observe one isolated occasion where the level of respect shown could have been improved.

Compassionate care

- Staff demonstrated a strong commitment to providing compassionate care for dying patients, one nurse talked to us about the "privilege" of nursing people at the end of their lives.
- Staff recognised the cultural needs of some patients who needed to be surrounded by family at the end of their life. Staff were flexible and pragmatic in their approach to accommodating these needs. For example, some patients from ethnic groups were a large number of relatives would visit the patient or want to participate in the patient's care or be present after patient had passed away. The ward staff were mindful of the fact that large numbers of relatives/friends would be present as was the 'tradition' in many communities and accommodated this and worked around this while caring for the patient, as long as it did not interfere with care for the patient in question or other patients on the ward.
- We observed one healthcare assistant delivering care to a patient and saw that they were respectful and caring, explaining to the patient what they were doing at all times.
- Patients told us that curtains were used to maintain dignity when procedures were being carried out or personal care was being delivered.
- Patients spoke highly of the respect shown by all the staff. One patient told us she had been "treated as a person, not a number". Another patient described how supportive staff had been, particularly when it came to managing their pain.
- Patients in side rooms told us that staff "pop in and out" regularly to check on them.
- We observed the porters on one ward transferring a deceased patient. Although the patient was already covered, the porters did not close all the curtains and the porters could be observed moving the patient. On leaving the ward area, the doors/curtains to the other rooms and bays were left open so other patients could observe the trolley being moved off the ward. The porters' behaviour during the transfer was not in keeping with the task at hand.

Understanding and involvement of patients and those close to them

- Although we were not able to speak directly with relatives of patients receiving end of life care, we saw a range of evidence that families were involved and steps were taken to ensure they understood care management plans.
- For example, staff talked to us about the importance of involving families and we saw a number of medical notes where discussions had been clearly documented. Evidence from the trust's bereavement survey also showed that families felt involved in their relative's care.
- Patients told us that staff kept them informed about the changes to their medication, which alleviated their symptoms.

Emotional support

- One patient told us that, although they were unhappy with their terminal diagnosis, they had been able to come to terms with it with help from the ward staff and the clinical psychology team.
- Another patient described a situation where they were in distress and how the staff helped them by sorting the problem and supporting them emotionally.
- The hospital's faith and community centre was situated at the heart of the hospital, giving relatives, patients, families and staff easy access to spiritual, religious and pastoral care. The 16-strong chaplaincy team represented six faiths and were able to contact representatives of other faiths if needed.
- The chaplaincy team worked closely with ward staff for patients receiving end of life care. Staff told us about the

chaplains and how they helped to support families and patients. We were also made aware of the support chaplains had offered staff in caring for dying patients and staff spoke highly of the support offered.
- Chaplains were available weekdays and on Sundays. An out-of-hours service was also available and the chaplains aimed to be on the ward within 30 minutes. Staff told us they usually arrived within this time.

Are end of life care services responsive?

Outstanding ☆

Summary

We judged this domain to be outstanding. End of life care services at University Hospitals Birmingham NHS Foundation Trust were very responsive to patients' individual needs and those of their families and next of kin. We saw and heard about many examples where practical, emotional and spiritual needs were considered and services were flexible enough to accommodate them. The trust was working with the local community to ensure that services were coordinated and consistent. A high proportion of patients who died at the trust were referred to the SPCT and access to the team was readily available. The trust took a proactive approach to ensuring that cultural and spiritual needs were met. Although the trust did set targets for fast discharge, we did not find any evidence to suggest this was a concern.

Data from their own survey showed that relatives of deceased patients were positive about the quality of care and their experience of the service.

Service planning and delivery to meet the needs of local people

- The trust was collaborating with Birmingham Cross City and Birmingham South Central clinical commissioning groups and other organisations to develop an integrated palliative care and end of life strategy. The strategy would bring together commissioners and providers to ensure end of life care services were coordinated and consistent across the community. As part of this strategy, the trust had applied to be a pathfinder organisation for the "Dying Well Community Charter project", supported by the National Council for Palliative Care and Public Health England. The launch event took place on Thursday 19th March 2015.
- The new site hospital was opened in 2010 and had 40% single room spaces with ensuite facilities. Although some end of life care was delivered on the old site wards too. This meant that there were sufficient single room spaces for patients at the end of life who needed privacy. Staff and managers told us that there had been no issues relating to availability of single rooms. The trust's bereavement survey showed that 99% of family members felt the environment was appropriate during the last few days of their relative's life.
- We were told about and observed a supply of folding beds around the wards. These were used to allow relatives to stay with their family member during the last few days of life. Ward staff told us that families were welcome to stay and were able to be accommodated on the wards.

Meeting people's individual needs

- We saw many outstanding examples of staff taking steps to meet the individual needs of patients and relatives.
- Patients and relatives were supplied with a range of written information to help them prepare for what was likely to happen in the last few days and hours of life, coping with bereavement and the practical aspects of dealing with the death of a family member. There was also a range of leaflets explaining DNACPR, the role of the SPCT and chaplaincy services.
- Comfort care packs had recently been introduced for relatives who were staying with their family member. The packs contained toiletries, snacks and a courtesy exit car pass and an information leaflet. The pack was designed to help support the family of a dying patient. Staff collected the packs from the bereavement office and they could be obtained out of hours if needed.
- Families and carers were actively encouraged to spend as much time with their relative and to participate in their care. For example, the comfort packs also included glycerine swab sticks for families to provide mouth care to their relative.
- Discreet postcard-sized window signs had been introduced on the wards to identify patients receiving end of life care; these acted as prompts for domestics and housekeepers to offer refreshments and ensure overnight beds for relatives were supplied. We observed some of these window signs in use on some of the wards we visited.
- Following death, relatives were provided with a bereavement pack, which included a comprehensive

booklet with practical and emotional support and advice. It also included a poem, bookmark and commemorative stone to remember their loved one. Survey results confirmed that 95% of relatives received the pack. Comments on the survey showed that families were very positive and appreciative of the pack.

- Hospital porters were called to the ward to move deceased patients, usually within four hours.
- Deceased patients were moved around the hospital using the corridors that were limited to use by staff, thus preserving the dignity of the deceased patient.
- The chaplaincy service was able to describe many examples of how they had met the emotional and spiritual needs of patients and relatives. This ranged from being someone to talk to, through to taking part in funeral arrangements and services.
- The chaplaincy service offered a multi-faith annual memorial service each October for people who had died at the hospital in the previous 12 months. Relatives were invited to attend this event.
- There was a separate service for the relatives of young people who had died at the hospital.
- Each ward was provided with Faith requirements for patients at or near the end of life – a guide for staff explaining the requirements for patients approaching death, when death was imminent and immediately after death for six different faiths. Staff referred to this document during our discussions and it was in use on the wards we visited.
- The religious / spiritual support for both patients and relatives was very good with regular visits to the wards from the chaplaincy. There were a number faiths represented amongst the team (e.g. Christian denominations, Hindu Priests and Imams). The chaplaincy can also call upon others as needed and are happy for the family to bring their own religious leader. There is a list of religious leaders who could be contacted out of hours who would be able to attend at short notice.
- We met a number of people in the chaplaincy team from various faith groups during our visit.
- Wards had communication boxes which included basic aids such as hearing loops to help staff communicate with patients and relatives with communication difficulties.
- Translation services were available in person and over the phone for people whose first language was not English. Staff used translators rather than family members when breaking bad news.
- In oncology outpatients, there was one full-time member of staff offering practical advice and support. Other staff were also available to support emotional needs.
- As part of the Birmingham Bereavement Project, the trust introduced the role of medical examiner in April 2012. The purpose of the project was to create a single, unified system for dealing with the process of death certification, improve the quality and accuracy of recorded causes of death and increase and improve communication with the bereaved. This was a pro-active service delivered to grieving families. The medical examiner would call families first.
- The trust continued with the model and had 10 consultants, each doing one session per week in this role. As well as scrutinising the notes and agreeing the cause of death with the referring team, the medical examiner offered families a follow-up telephone call to discuss the cause of death. The bereavement lead nurse also told us that the medical examiner would meet with families if requested.
- This work was supported by medical examiner officers who coordinated the process and had a key role in liaising with families.
- The bereavement service told us they were expected to give paperwork to families the second working day following death at the latest but that it could be the next working day for deaths that were not reported to the coroner.

Access and flow

- During 2013/14 there were 1,835 in-hospital deaths at University Hospitals Birmingham NHS Foundation Trust. During the same period, the SPCT received 1,597 referrals, equating to 87% of all deaths at the hospital: 25% of referrals were non-cancer patients and figures for April to October 2014 showed that this was increasing.
- The SPCT organised themselves into three sub-teams: oncology; medicine; and other, including surgery, coronary care and renal. This arrangement allowed ward staff to develop good working links with the team.

End of life care

Each SPCT sub-team made daily visits to their allocated wards. Staff in the SPCT rotated between the three teams every six months to ensure that their skills were kept up to date.

- At the time of our inspection, the trust did not measure, as part of a formal audit, the percentage of patients dying in their preferred location. However, the SPCT did record this information on the Somerset database and the trust was currently looking at ways to utilise the data. As part of the trust's bereavement survey, relatives were asked if they felt the hospital was the right place for their relative to spend their last days: 83% responded positively.
- The trust did not have targets set to demonstrate performance for rapid discharge. For local patients, the trust was working on this as part of the Birmingham integrated palliative care and end of life strategy with local clinical commissioning groups and other agencies.
- The lead nurse told us that, as a tertiary centre, rapid discharge could be challenging for patients who had to travel significant distances, and where the trust did not have links with the community services in the patient's area. However, staff made every effort and explored all possible options for appropriate discharge.
- The organisation usually managed to achieve discharge of patients at end of life in 24 to 48 hours. The staff told us they had done it within 4 hours where necessary.
- Staff on the wards told us that the SPCT were very supportive and, where quick discharge was required, it was usually not a problem.

Learning from complaints and concerns

- Between April and September 2014, the trust received 36 complaints relating to the care and treatment of deceased patients.
- The bereavement lead nurse told us that they actively reviewed any complaint that came to the trust specifically about end of life care or care after death. Where appropriate, they offered complainants a telephone call discussion as part of the review process.
- Evidence from trust's reports showed that actions were taken following a complaint. For example, complaints from relatives highlighted poor communication and feeling isolated while on the wards. As a result of this, the trust implemented communication training to help staff deal with difficult conversations.

Are end of life care services well-led?

Good

Summary

The end of life care service at University Hospitals Birmingham NHS Foundation Trust was well-led. The trust was aware of the key challenges that needed to be addressed and had plans in place. At the time of our inspection, the service was on the cusp of significant change which the trust believed would enhance and improve the service.

It was clear that leaders of end of life care services worked collaboratively across the hospital and their commitment to delivering a good quality service was evident. Although there was no documented strategy in place, ward staff were aware of their responsibilities when caring for patients at the end of their lives.

The service had just been reconfigured, bringing specialist palliative care, bereavement and chaplaincy together in one team. We saw this team as the early stages of this reconfiguration.

Vision and strategy for this service

- In the trust's annual plan for 2014/15, the trust set itself a target of improving standards of care for end of life patients and families. In order to achieve this, the trust recognised it needed to develop a trust strategy for end of life care, which was currently being drafted.
- A recent decision was taken to restructure services and bring end of life care, chaplaincy and bereavement services under single management arrangements.
- The memberships from the end of life core steering group and the bereavement services steering group were also being combined and representatives from the public governors had been invited to join. The first meeting of the combined services was held on Wednesday 10 December 2014.

Governance, risk management and quality measurement

- The end of life care core steering group reported to the care quality group chaired by the executive chief nurse and providing updates to the executive board. The membership of the steering group included the key

nursing and medical staff. The steering group oversaw development of the end of life care strategy, support and training for staff, and review and action on any nationally developed initiatives.
- The trust did not have performance indicators to measure the quality of end of life care services and relied on feedback, complaints and the annual bereavement survey to assure itself of the standards being achieved.
- There were three moderate risks relating to end of life care on the end of life care register:
  - Failure to document conversations regarding DNACPR.
  - Patient wishes to die at home being unfulfilled due to issues with community services.
  - Loss of syringe pumps in the community, resulting in unavailability for patients receiving palliative care medication in hospital.

Leadership of service

- The executive chief nurse represented end of life care at board level to ensure that issues and concerns were raised and highlighted.
- The palliative care consultant provided clinical leadership and worked closely with the lead nurse for end of life care at the trust. They took an active role in a number of audits and were directly involved with a number of key developments in relation to end of life care.
- During 2014, the end of life care lead nurse had taken up the post of interim associate director of nursing for one of the clinical divisions; this had meant that they had less time to focus on promoting end of life care and developing services. At the time of our inspection, the interim post was due to close and the end of life care lead nurse was looking forward to spending more time on end of life care.
- Managers we spoke to on the wards were supportive of end of life care and committed to ensuring that they and their staff delivered good quality care.

Culture within the service

- Many staff we met on the wards were passionate about providing good quality care to patients at the end of their lives. Many talked about responding quickly, managing pain effectively and communicating well with the family. Staff also talked about the support and advice offered by the SPCT and how they drew confidence from them.
- The SPCT were clearly dedicated to providing high-quality end of life care. Staff we spoke to were looking forward to the additional nurses joining the team so they could expand the service to seven days a week.

Public and staff engagement

- The lead nurse for end of life care told us about a series of focus groups held in 2013 to record staff views on end of life care. Staff talked about how they felt about looking after a patient in the last few hours of life and what the trust could do to support them in their work.
- The lead nurse told us that some of this feedback was used to develop training programmes and provide supporting information to wards.
- The annual bereavement survey provided the trust with feedback on end of life care services. The report provided evidence to the trust of good practice and identified where further attention was needed.
- The 2013/14 survey returned over 1,000 written comments from relatives which reflected both positive and negative views. The bereavement nurse told us that, if a respondent had included contact details, they had proactively followed up all their feedback.

Innovation, improvement and sustainability

- Comfort care packs had recently been introduced to help support relatives who were staying with their family member. The packs contained toiletries, snacks and a courtesy exit car pass and an information leaflet.
- The trust had applied to be a pathfinder organisation for the Dying Well Community Charter project supported by the National Council for Palliative Care and Public Health England. The launch date for this initiative was March 2015.
- The trust was currently developing electronic records to support the process of having significant conversations with relatives and enhancing the DNACPR record to include treatment escalation and limitations.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at The University Hospital Birmingham were mainly located in one area on the ground floor, near the main entrance and divided into four areas. Some services were offered at the old Queen Elizabeth Hospital site in Nuffield house and the Wellcome building.

The service offered care across 31 specialities clinics across areas of medicine including cardiology, rheumatology, gastroenterology, diabetes management, dermatology, haematology, endocrine, neurology, renal, respiratory, multiple sclerosis, elderly medicine, stroke, urology and pain management. There are surgical clinics including ophthalmology, ear, nose and throat, colorectal, vascular, orthopaedics, dermatology, hands, burns and plastics, trauma, neurosurgery, cardiac surgery, oncology, breast and maxillofacial.

The University Hospital Birmingham provided an outpatients service for local patients as well as nationwide. As a result the service had significant number of referrals. On average the outpatient's service saw approximately 2,000 patients a day running 802 clinics a week.

We inspected the service by interviewing staff including managers, conducting focus groups and undertook observation over three days. We observed the patient environment, observed clinics in operation, care and treatment and clinical records. We received comments from patients who contacted us to tell us about their experiences and we reviewed performance information about the trust. During our visit we spoke with 54 patients and relatives and 71 members of staff including reception and booking staff, medical secretaries, managers, nurses of all grades, therapists, volunteers, students, trainees, staff grade doctors and consultants. Within radiology we spoke with 30 patients and staff including managers, radiographers, radiologists, assistant practitioners, students, nurses, clinical scientists and administration staff.

Outpatients and diagnostic imaging

Summary of findings

The hospital had recently been built (during the past four years) so had a new finish, furnishings and equipment. Patients we spoke with felt that the department was always clean. We saw robust infection control audits and cleaning rotas.

Staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults. Patients told us they felt safe in the hospital and we saw their dignity was respected. Staffing levels were judged to be safe by the staff and department managers. Staff had received the required mandatory training in order to keep patients safe.

We saw good use of evidence based guidelines and protocols. Staff were proactive in developing their own where none existed. We saw staff audited their work to ensure they were meeting the guideline standards and providing patient's with best practice.

Patients told us treatment was discussed with them and they were involved in the decision making process.

Staff praised the support they received from the trust with continual professional development and training. Staff said they were able to identify their training and experience needs in their regular appraisals and supervisions. We noted several of the senior nurses had links with the universities and some were completing their master's degree in their area of expertise.

We noted there were infection control audits, cleaning and refurbishment audits, a governor walk round to gain patient's perspectives and that clinical audits were well established to ensure quality.

We saw most staff were kind, caring and compassionate however we noted some complaints were raised around poor staff attitude.

We saw issues within outpatients around the service planning and access and flow through the department. During our inspection we spoke with some patients who had waited as long as two-three hours for an appointment. We asked senior staff about waiting times, they told us patients only waited up to 45 minutes.

We noted that delays were due to staff overbooking clinics; seeing patients with complex conditions; delayed start to the clinic and emergency patients. We saw there was no action plan for planning the service accordingly to reduce the amount of delays and there were no targets set. There was a lack of clinic space for medical staff. We observed some medical staff had 10 minute slots to see each patient. Some medical staff told us this was not enough time especially for people who had complex conditions. However the average appointment time booked was 20 minutes.

We saw within outpatient's, gaps where local leadership was not developing action plans for areas of poor performance such as delays and overbooking. Although monitoring took place we did not see actions associated to effect change. However we saw there were plans at a strategic steering group to review areas for improvement which was due to commence January 2015. We noted local leadership for the service required further development. Some of the management team confirmed this and said they felt the recent development of the strategic steering group meeting would be essential in filling the current gap for the direction of the department and would provide clear vision which could be cascaded to staff.

For the diagnostic and imaging department we noted that overall the safety for patients and staff, responsiveness and leadership of the service was that of a very high standard.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Summary

We saw most staff were reporting incidents but some staff in outpatients told us they were not clear about what incidents needed to be reported. Staff confirmed incidents were being under reported and this meant learning and tracking of trends were missed.

We saw robust infection control audits and cleaning rotas. The hospital was four years old so had a new finish, furnishings and equipment. We noted emergency resuscitation trolleys were recorded as adequately checked, but this was effectively done.

Staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults. We saw staff were able to appropriately deal with the deprivation of a patient's liberty. We saw they discussed and involved the family with decision making and completed all relevant paper work to ensure the person's safety. Patients told us they felt safe in the hospital and we observed their human rights being respected.

Staffing levels were safe and staff had received the required mandatory training in order to keep patients safe.

Incidents

Outpatients

- The trust used an electronic incident reporting system to record incidents, accidents and near misses. Staff confirmed they had all received training on the use of the system.
- Incidents were categorised, investigated and action plans for improvement provided to the appropriate staff. The service managed concerns promptly and investigations were thorough. There was an open approach culture.
- Learning and changes implemented were disseminated through staff meetings; we saw evidence of this from minutes of the patient council meeting, preventing harm meetings and managers meeting. Nurses also told us that they did this at their band 6 meetings.
- We found most staff were aware of reporting incidents in line with the trust's policies and demonstrated knowledge and understanding of the system. Some staff in outpatients however were not clear on what incidents needed to be reported. Staff were sometimes unclear of who would be responsible for logging more serious incidents and gave us examples of some that were not recorded. Staff confirmed incidents were being under reported and this meant learning and tracking of trends were missed.
- All staff confirmed that when they did log an incident they received feedback and support from their immediate managers.

Diagnostic Imaging Department

- We saw all incidents that were recorded internally and any notifiable radiation incidents were declared to the Care Quality Commission IR(ME)R inspectors.
- There had been no recorded never events in radiology during the 12 months preceding our inspection.
- All staff were aware of how to report an incident. The imaging managers were an integral part of all executive board meetings for root cause analysis of incidents and robust action plans were evidenced following on from incidents and notifications through their governance framework.

Cleanliness, infection control and hygiene

Outpatients

- All the outpatient areas we visited were clean. Patients we spoke with felt that the areas were always clean.
- We saw most areas had cleaning rotas on display. All clinics we visibly clean and all surfaces were wipeable in accordance with the trust infection control policy.
- We noted managers undertook an infection control audit and action plans were provided to those areas that needed further cleaning or refurbishing.
- When observing staff in clinics we saw they followed infection control procedures. Personal protective equipment such as gloves and aprons were readily available in clinical areas.
- Hand alcohol gel was available in all clinical areas. We did not see any public reminders for patients to wash their hands but did see posters displayed by sinks instructing staff how to effectively wash hands. In the Nuffield House diabetic clinic, there was a large wall mounted sign reminding people to wash their hands at the entrance to the clinic area.

- We saw examples of hand hygiene audits in a variety of clinics we saw from the results staff maintained a good level of hand hygiene.

Diagnostic Imaging Department

- All radiology areas we visited were clean.
- All areas we visited were subject to infection control audits which were evidenced.
- Staff that we saw followed the Trust hand washing policy and in line with evidenced based audits this has taken over from hand gel hygiene
- Hand alcohol gel was available for visitors and patients
- Signage was apparent for correct hand washing and use of alcohol gel

Environment and equipment

Outpatients

- The hospital had been built four years prior to our inspection so had a new finish, furnishings and equipment. We saw from the infection control audit that walls had become marked and had been repainted during that time.
- We spoke to one senior nurse who had given up her room for a doctor to see patients and the nurse was working in a store room.
- The staff we spoke with agreed they needed more space and said managers were aware of the issue. Doctors felt that action was not being taken quickly enough. We saw evidence that managers were looking into expanding the department, Staff told us there was adequate equipment available in all areas throughout the department.
- Emergency resuscitation trolleys were checked on a regular basis, although we saw the ambu-bags did not have an expiry date; the defibrillator in area 1 was not portable appliance tested (PAT) and sterile packaging had been broken.

Diagnostic Imaging Department

- A full quality assurance programme existed for equipment maintenance. At the time of our inspection no x-ray equipment was outside of agreed tolerance time frames for testing.
- Adherence to the radiation regulations was good and a trust Radiation Protection Advisor (RPA) and Radioactive Waste Advisor were in post. We discussed with senior managers the need for a greater number of audits against their Schedule 1 procedures and this was agreed
- All new modalities were fully procured and checked prior to clinical use including equipment on loan. Risk assessments were carried out in line with patient requirements and training and monitoring were in place.
- We found Radioactive Waste management by the nuclear medicine management team was exemplary, the department was well audited against all relevant regulations and there was evidence of a robust quality management system. We discussed the detailed processes of safe disposal of radioactive waste at length with staff during our inspection. This included disposal from both inpatients and outpatients, different ward areas and the waste pipes in place in the hospital for disposal of the radioactive waste.
- A rolling capital equipment replacement programme was in place with a clear five year service provision projected plan. This plan included increased numbers of MRI scanners and a potential outpatient diagnostic centre in the community.
- There was consistent radiation protection awareness throughout the department and within cardiology where imaging services were provided for invasive procedures.

Medicines

Outpatients

- Medicines and FP10 prescription pads were stored in locked cupboards in the department. Nursing staff ordered all medicines through the hospital pharmacy. Throughout the department where appropriate staff maintained lockable medicine fridges that had daily temperature checks undertaken

.Diagnostic Imaging Department

- Local dose references levels were evidenced at the time of inspection by the inspection team and these fell below acceptable national levels and through a dose audit CT doses were monitored by the radiation protection service. The radiologist clinical lead informed us that following on from this audit dose reduction software was installed in CT.
- Within cardiac imaging there was monitoring underway to enable frame rates for diagnostic and interventional procedures to potentially be lowered which in turn would reduce patient doses.

- Within interventional radiology, a trial was underway utilising a software package that allowed occupational radiation exposure to be monitored through a red/amber/green radiation "hot spots" visual aid. The education brought about through this would in turn provide greater patient safety due to greater dose awareness.

Records

Outpatients

- All records in the department were held electronically. Staff told us it was very convenient and efficient. All staff told us they thought the informatics software was easy to use and had received training on how to use it.
- Staff told us the trust was going to pilot the sharing of the electronic records with GPs. They thought this was a good idea and it would save time sending letters.
- We reviewed the quality of notes and records. We saw them to be detailed and of a good standard. We saw documented consent, up to date past medical history, discussion of ongoing concerns, and a holistic assessment and risk assessments.
- Paper notes were stored securely in the department and all computers were locked and timed out after short periods to ensure data protection.

Diagnostic Imaging Department

- Patient records were held securely on the radiology information system with role based access and secured through password protection.
- Risk assessments were the responsibility of area leads which ensured that all patient safety concerns and equipment needs were assessed within each modality by the expert for that area.
- Risk assessments were up to date and reviewed and revised regularly.

Safeguarding

Outpatients

- Staff told us that they received training in safeguarding of children and vulnerable adults. We saw evidence of the training undertaken.
- Staff received safeguarding training at induction and at regular intervals and this was well-attended. The hospital target is 90%, documents supplied demonstrated that nursing staff had achieved 73% compliance with safeguarding adults level 2. Medics were not required by the hospital to undertake this level having completed level 1 of which 100% compliance had been achieved (hospital wide).
- Staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults.
- We saw staff dealing with a deprivation of liberty case. We noted they discussed and involved the patient's family with decision making and completed all relevant paper work to ensure the person's safety.
- Patients told us they felt safe in the hospital and we observed their dignity was respected. Patients made comments such as "Excellent care and respect from staff".
- The division in which outpatient's services lie, as a whole was not meeting the local target for safeguarding adults' level two 2014.
- We noted that further work could be done in order to better protect frontline staff from patients who were verbally aggressive. Reception staff told us about incidents of dealing with patients who became aggressive. Staff told us they had received conflict resolution training however we did not see them able to effectively reassure patients and resolve the situation. Reception staff did not always document this as an incident. Nursing staff showed better awareness of how they would manage patients who became aggressive and record the incident.

Mandatory training

Outpatients

- We saw evidence from the training audit that the outpatients department was meeting the local target for mandatory staff training in relation to: - fire training, corporate induction, equality and diversity, infection control, information governance, local induction, manual handling, medication induction, safeguarding adults' level one and major incident training.
- Staff told us they were able to attend the mandatory training and received updates on their payslips as a reminder for when it was due which, they thought was convenient.
- The division in which outpatient's services lie, as a whole was not meeting the local target for basic life support for 2014.

Outpatients and diagnostic imaging

Diagnostic Imaging Department

- Mandatory training was 100% compliant.

Assessing and responding to patient risk

Outpatients

- Reception staff told us that part of their role was to monitor patient safety. We saw reception staff monitoring patients in the waiting room and staff gave us examples of how they would react when they thought someone's condition was deteriorating.
- We were told that walk in patients were never turned away and staff always tried to ensure patients were seen.
- We saw evidence of risk assessments included in the patient records we looked at. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for vulnerable patients with more than one medical condition and/or long term conditions.
- We observed the common risks in the department during the inspection were: deteriorating patients in waiting areas and informatics software giving patients' incorrect details of their appointments. Local managers told us they did not recognise some of these as a risk.

Nursing staffing

- We spoke to the head of the outpatient's services and to one matron who had responsibility for managing the department, liaising with the different specialties and managing the nursing staff. They told us they worked closely with a group support manager who reviewed the performance of the department. We saw evidence from the group support manager that they calculated the required staffing hours and that they were fully staffed at all banding levels. Managers were able to tell us how they reviewed the staff skills required to run different clinics.
- Staff turnover and sickness for the outpatients department was low compared with national averages. We observed staff being flexible and agreeing to help out in different clinics if someone was off sick.
- Staff told us the number of patients they see had increased significantly over the year prior to our inspection and managers agreed the workload had increased. Due to this rise in demand they had recently recruited extra staffing.
- Managers told us they did not use agency staff. Staff told us they were happy to work overtime if the clinics ran over the scheduled time for which some were paid.. Some staff told us they were able to claim the extra time owed in lieu but did not do so because they did not have the time to take it.
- We noted staff nurses, clinical support workers and technicians in the department were supported by a Sister on a day to day basis. All staff told us they felt supported by their immediate managers.
- Nursing staff told us that although they were busy, they felt they provided good and safe patient care. They felt that staffing was generally sufficient and they confirmed the use of agency staff was rare.
- Some clinics were supported by clinical nurse specialists who told us they worked well with the medical team and felt supported.
- There was good evidence of therapist involvement in clinics. We noted dieticians, physiotherapists and speech and language therapists had their own lists but were also available to see patients on an ad hoc basis. They said and patient's told us they appreciated this.

Medical staffing

Outpatients

- Individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates who agreed the structure of the clinics and the senior doctors agreed patient numbers.
- The medical staff that we spoke to confirmed that they felt their staffing numbers were good but the issue was that they did not have enough space for junior staff to attend clinics. There was enough staff to see the number of referrals that were coming through. We saw evidence that managers were planning to discuss the role of junior doctors at the next strategic steering group and also discuss expanding the service into the community or a move to seven day working.
- Some specialist doctors told us they had to reduce the amount of out-of-county referrals they accepted if those patients could be seen elsewhere.
- The medical staff that we spoke with felt they had a good relationship with outpatient nursing and clerical staff. They said they could discuss issues with them and were well supported by these staff.

Diagnostic Imaging Department

- We found staff levels were very good. There were no vacancies in the radiographer workforce and at the time of our inspection. There were no radiologist vacancies

and this was monitored in line with demands on the service for increased capacity. We were told that with this in mind, three additional consultant posts would shortly be considered.
- Radiology management informed us that agency staff were never used and any gaps in service workforce were filled with the department's existing staff through locum bank services.

Major incident awareness and training

Outpatients

- Staff had completed major incident training and were able to describe the department's role in the event of a major incident. We saw staff in division C in which outpatient's services reside was 100% compliant with major incident training and this exceeded the national average target.

Diagnostic Imaging Department

- A Trust major incident plan was in place in which radiology services had an integral role. We noted the plan was readily available to staff within Imaging services and staff told us it was rehearsed regularly.

Are outpatient and diagnostic imaging services effective?

Summary

We saw good uses of evidence based guidelines and protocols. Staff were proactive in developing their own local guidance if they did not exist nationally. We noted staff audited their work to ensure they were meeting the guideline standards and providing patients with best practice.

Most patients we spoke with were positive about their treatment. We observed this and saw evidence of this and of staff asking for consent before treatment in patient records.

Staff praised the trust's support for continual professional development and training. They said they were able to identify their training and experience needs in regular appraisals and supervision meetings. We noted several of the senior nurses had links with the universities and some were completing their master's degrees in their area of expertise.

Evidence-based care and treatment

Outpatients

- Medical and nursing staff adhered to best practice and guidelines which were appropriate to their specialities. Where applicable staff adhered to guidance from the National Institute for Health and Care Excellence (NICE). If national guidelines were unavailable staff gave examples of best practice based on recent evidence.
- Clinical nurse specialists were members of relevant British Associations which provided up to date research protocols and guidelines. The multiple sclerosis clinical nurse specialist had recently implemented the most advanced drug treatment available for patients and was aware of all the protocols and guidance available for the treatment. The clinical specialist stoma nurse showed us examples of using best practice in line with guidelines.
- We saw audits that staff reviewed the treatment they were to providing patients against the NICE guidelines. Where they were not meeting certain areas we noted they disseminated recommendations for staff learning. For example the endocrinology team saw they were meeting 29 of the NICE guideline recommendations as oppose to 41 suggested.
- The clinical nurse specialists disseminated information at national conferences and through research publications. They told us they networked with colleagues of the same specialism nationwide.
- Clinical specialist staff were aware of recent publications and evidence in relation to their field of expertise.

Diagnostic Imaging Department

- The department was ISO accredited (National quality standard accreditation) for radiation protection services.
- Work was underway to adopt and implement a high dose procedure/skin dose policy. Although not a regulatory requirement this demonstrated the application of good practice.
- We observed the World Health Organisation (WHO) checklist was utilised throughout interventional radiology, CT and ultrasound, and this was audited regularly. We did not evidence this as this audit was due at the time of inspection. We did however see the use of the checklist on a number of cases within interventional radiology at the time of the inspection

- Staff had full access to all clinical systems for test results which were required for imaging and intervention to proceed. The Picture Archiving Communications System (PACS) allowed for instant access to imaging and reports and this interfaced well with the wider Trust.
- The department participated in local and national research trials. Cancer peer review was discussed with the clinical scientists along with the national breast screening service quality review and audit which are up to date and meet all national requirements

Pain relief

Outpatients

- We spoke to patients who may be experiencing pain in the dermatology department and burns and trauma unit. Patients felt that their pain was not a priority to staff. Patients' told us they had been asked if they were in pain and some were told by staff they could have analgesia before treatment but patients told us that staff did not follow through with administering any pain relief.

Patient outcomes

Outpatients

- The trust was part of the Shelford group of hospitals, a group of hospitals that are similar in size and undertake the same level of clinical work.

Competent staff

Outpatients

- Staff praised the trust's support with continual professional development and training. Staff said they were able to identify their training and experience needs in appraisals and supervisions which were held regularly. We saw from the General Medical Council survey medical staff rated the educational resources as better than the expected national average target.
- Managers told us they felt strongly about promoting staff education in the department and would prioritise study days and study leave. Staff told us it was the best place that they had worked in terms of education and continuous professional development.
- We saw several of the senior nurses had links with the universities and some were completing their master's degrees in their area of expertise. We were also told by junior staff nurses that they were supported in completing their degrees.
- An induction process was in place for new staff.

Diagnostic Imaging Department

- Continual professional development (CPD) was fully supported and performance review and clinical supervision for staff that required it was in place. This was evidenced through the training matrix and staff files.
- The department had regular discussions and had integrated with other local trusts for knowledge sharing and problem solving.
- The training matrix was currently being reviewed to give managers and modality leads a clearer vision of staff competencies by modality and individual x-ray equipment.
- A robust induction for new staff was in evidence and training records were seen for all staff bands.
- Underperforming staff or staff that managers had concerns about were effectively managed and were performance reviewed as necessary.

Multidisciplinary working

Outpatients

- All staff that we spoke to were proud of how well they worked together as a team. We saw evidence of this in patient records, observed this during clinics and were told this by patients.
- Some staff expressed difficulty working with external professionals such as GPs as they found it difficult to find time to speak over the phone to get any updates of the patient's condition. Staff said this was due to both parties being busy seeing patients. Staff told us they looked forward to when the informatics software would be available to share with GPs as they felt this would offer continuity of care for the patients.
- Patients also expressed frustration about communication between the clinics and the GPs.

Diagnostic Imaging Department

- Multidisciplinary working was fully supported with participation from both radiologists and specialised radiographers. Image sharing was possible through informatics software which, was robust and enabled tertiary referrals to be handled effectively at multidisciplinary team meetings and throughout the patient pathway. It had been identified by trust executive team that due to an increase in demand for

radiologist support at multidisciplinary team meetings, the department would be adversely affected and the trust therefore intended to employ three additional radiologists.

Seven-day services

Outpatients

- When we discussed this, senior managers recognised that some services were already seven day working but that more specialties would need to consider this due to the large number of referrals. We noted this was raised at a managers meeting and the plan was that the future of the service would be regularly discussed at the strategic steering group.

Access to information

Outpatients

- Staff told us they had access to all policies and procedures on the trusts' intranet.
- The trust told us they have developed an informatics system which patients could access from home to allow them to discuss their treatment with staff, self-manage and monitor their own health. We spoke to one patient who used this service and said it was very convenient and they felt in control of their health.
- Patients received letters about their appointments. Some patients were able to choose their appointment and book it themselves online. Patients received text message reminders.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- We saw evidence that staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated knowledge and understanding of MCA and DoLS.
- We observed one incident where staff responded in a timely manner in order to safeguard the patient and involved the family through the MCA and DoLS assessment.
- We observed and saw evidence in patients' records that staff asked for consent before treatment.

Are outpatient and diagnostic imaging services caring?

Good

Summary

We saw most staff were kind, caring and compassionate. We saw some complaints were raised around poor staff attitude.

Staff involved patients and their families in their treatment and care. Staff provided reassurance and emotional support for patients.

Patients told us that staff discussed treatment options with them during the consultation.

Patients told us treatment was discussed with them and they were involved in the decision making process.

Compassionate care

Outpatients

- Patients told us the staff were very caring and friendly.
- We observed staff caring for patients in a compassionate manner. We saw staff stopping to assist patients in corridors and showing concern for the person's welfare. We saw staff listened to patient's needs and concerns. Apart from the complaints received about managing patients' pain we observed examples of compassionate care.
- When observing reception staff we saw some of their mannerism to be inconsistent with patient's needs. We observed some that were helpful and kind to patients. We also saw some receptionists being abrupt, rude and unhelpful.
- Reception staff told us they had received conflict resolution training. We noted PALs had recorded this as a theme in their complaints about the service.
- We saw that all clinical staff were very polite and compassionate with patients.

Diagnostic Imaging Department

- Patients informed us that staff were friendly, polite and courteous to them and their dignity was maintained at all times. We saw this happening. Communication about patient's care was good and radiographers and radiology department assistants took time to explain procedures clearly and comprehensively.
- We noted within the last 12 months there were two complaints on the radiology complaints register

regarding patients' perceptions of staff attitude and behaviour. These were addressed at senior management level and identified staff were scheduled for and underwent customer care training. Management informed us that all the patients involved were spoken to in relation to their complaints.

Understanding and involvement of patients and those close to them

Outpatients

- We spoke to one person with learning disability who told us they brought their parent to their appointments. The patient said they always involved them both equally in the decision making because it was important to them. Staff made sure both of them understood the treatment.
- We spoke to one parent of a young adult with epilepsy who told us staff invited them to multi-disciplinary meetings. They valued this and appreciated being involved in the discussion of their child's care and treatment.
- We spoke to one patient who was deaf and required an interpreter. The patient told us an interpreter had been booked for them every time they had attended a clinic. They told us they felt they had very good care from the staff and that all treatment was explained clearly.
- Patients told us they felt involved and well informed about their care and treatment.
- Patients told us treatment was discussed with them and they were involved in the decision making process. We observed this and saw evidence in patient records

Emotional support

Outpatients

- Patients gave us examples of how staff had emotionally supported them through a diagnosis and treatment. Patients told us staff were caring, supportive and professional.
- We observed staff with distressed patients and saw they comforted patients.
- Patients told us staff were reassuring and kind.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Summary

We noted issues around the service planning and access and flow through the outpatient department. We saw challenges with capacity and flow that were not resolved.

In the diagnostic imaging department we saw exemplary practice to manage patient flow and reduce waiting times.

We saw that in outpatients some patients waiting as long as two-three hours over the appointment time. We asked senior staff about waiting times, they told us patients were not kept waiting longer than 45 minutes. There were some differences between what we had seen, what was on the waiting time audit and what managers told us.

We found delays in outpatients were due to staff overbooking, seeing patients with complex conditions in short time slots, delayed start to the clinic and seeing emergency patients. There was no plan for organising the service in a way to reduce the amount of delay and there were no targets set to achieve this. There was a lack of clinic space for medical staff. Some medical staff had 10 minute slots for some patients and some medical staff told us this was not enough time especially for people who had complex conditions. However the average appointment time booked was 20 minutes. We saw there was little communication amongst staff at the IT department who set up the appointment schedule, the medical staff and the booking service. The medical staff felt they were not listened to although they had raised the problem with the booking service before.

The outpatient department had consistently favourable performance ratings relative to several national average targets and we found the turnaround in radiology to be very good.

The percentage of patients waiting less than 18 weeks from referral to treatment was good but those waiting more than 31 days from diagnosis to first definitive treatment and less than 62 days from urgent referral was worse than the

national average and sometimes below the national standard. It was noted that the Trust had a cancer improvement plan in place which had been shared with Monitor and the Clinical Commissioning Group (CCG).

GP referral to first definitive treatment was consistently below the national average.

Staff in outpatients told us they did not log the majority of complaints they received and this meant the department was therefore unable to respond and better meet patient's needs.

In diagnostic imaging we saw good models of practice to support patients flow through the service such as radiographer reporting. We saw extremely good models of practice such as rapid turnaround of reports and engagement with referrers to improve patient access and routes to imaging. Complaints for the Diagnostics department were well responded to.

Service planning and delivery to meet the needs of local patients

Outpatients

- The department was consistently above the standard for referral to treatment within 18 weeks, noted from data provided to us by the trust. We saw booking staff worked towards patients being booked in a minimum of 8 weeks and if they were unable to meet this target then they would raise this for the specialties to monitor and book.
- The department had consistently favourable performance relative to the national average for the 6-week diagnostic target, noted from data provided to us by the trust.
- We found a favourable lower than average trend of patients who 'did not attend' their appointments compared to the national average trend.
- From the data provided to us by the trust we noted the follow-up to new ratio was amongst the highest in the country and, over time, was consistently higher than the national average. In discussion, two consultants told us they felt this was due to the nature of the first referral from either a GP or other secondary care consultant being reluctant to manage the patient's on-going clinical care. This meant that patients were cared for by the trust for longer than anticipated. We also heard from two patients that they had requested to continue their care at the trust as they felt unhappy about their previous care in other places. Inevitably this increased the number of attendances in outpatients. The trust is a tertiary centre and as such will treat patients who are more complex this can result in the follow up to new ratio increase.
- We saw that all areas fed back to managers the amount of delays they experienced and why. Delays were due to overbooking, seeing patients with complex conditions, delayed start to the clinic and seeing emergency patients. We noted there was no action plan for planning the service in a way that would reduce the amount of delays and there were no targets set to achieve this improvement. We saw from an audit on delays that between August 2014- January 2015 Area one had 119 delays, Area two 270, Area three 69 and Area four 97. Over the same time period the trust recorded on a 173 occasions delays were due to over booked clinics and the number of complex patients booked leading to delays was 269. The trust undertook 802 clinics per week the delays constituted 3% of clinics.
- We discussed the lack of strategic service planning with managers. We noted they were aware of the lack of targets and had recently set up a new 'strategic steering meeting' for managers in order to strategically steer the future of the department. They were planning to review the growing demand on the service and discuss how they could branch out into the community or become seven day working. The aim was to better serve the patients and to ensure the needs of the population were being met.
- Following the inspection the trust informed us that a number of metrics were recorded and shared with the divisions on a monthly basis. Which were further reviewed at the Performance Review Meetings on which the chief executive was a member.
- We saw an audit of the amount of letters sent to GPs within the 10 day national target. The department was 76% compliant with this target but was aiming for 85%. There was an action plan in place which the trust confirmed following the inspection.
- We saw some medical staff had 10 minute slots for seeing most of their patients. Some of these medical staff told us this was not enough time especially for people who had complex conditions. However the average appointment time booked was 20 minutes. The

booking service told us that if GPs don't specify the person needs a longer appointment then they don't know to book a longer slot. We saw there was no action plan to resolve this with GPs.
- Clinical nurse specialists allotted 30 minute slots which we saw met the needs of their patients. We saw these clinics were able to run to time. We noted there were no issues with access, booking or patient flow for specialist nurses.

Diagnostic Imaging Department

- Senior managers held monthly meetings with the clinical commissioning groups where different aspects of the service were discussed and changes were made if necessary. We saw examples such as, a band 7 mammography radiographer liaising with local GP's with the aim of increasing the uptake of breast screening in the local population. This is viewed as outstanding practice and demonstrated that the radiology department were responding to the needs of the local population.
- Water coolers had been made available for patients in waiting areas.

Access and flow

Outpatients

- We saw some risks throughout the department that although they were identified or monitored by senior staff such as, overcrowding and long waiting times, no resolution had been found at the time of the inspection. Patient's told us there was not enough car parking spaces and they did not want to pay to park. Patients' thought the train station nearby was very convenient.
- We observed the common issues in the department during the inspection were: overcrowding and obstructed waiting areas, long waiting times, patients' leaving without being seen, walk in patients without appointments
- We saw some waiting areas became increasingly busy and corridors were obstructed when patients started to gather. Receptionists told us that they tried to ensure corridors were not obstructed but that patients worry that they will not hear their names being called if they sat in a different waiting room. Receptionists were aware of the safety risks and told us they tried to manage the risk. We saw waiting areas had designated areas for patients in wheelchairs however we noted there was not enough space when the clinic was at full capacity. Patients told us it was overcrowded.
- Doctors were concerned that there were not enough rooms. They told us rooms were allocated on a 'first come, first served' basis. We asked doctors if clinics had to be cancelled. They all told us they did not but that if they had a supporting junior doctor, the junior doctor might be unable to secure a room so all the patients would have to be seen by the one senior doctor. Sometimes the junior doctors would have to see patients in other clinical areas due to the lack of rooms but assured us that they were still supervised by the consultant. The trust had rolled out a training programme for relevant staff to try and reduce this occurrence.
- Patients received letters about their appointments which they thought were adequately informative. Some patients were able to choose their appointment and book it themselves online. Patients received text message reminders of follow up appointments. Some thought this was convenient others were unaware of what the appointment was for. Patients told us communication was poor around appointment bookings. We found that the booking service had received few complaints.
- Medical staff told us they were frustrated with the booking system as it booked too many patients in at a time. A doctor showed us one example where they had four patients all to see at 8.30am. They told us that overbooking the service caused long delays and waits.
- We noted there was a lack of communication amongst staff at the IT department who set up the appointment schedule, the medical staff and the booking service. The medical staff told us they felt as though they were not listened to as they had raised the problem with the booking service before. However following the inspection the trust informed us of a process to change appointment but staff we spoke to were unable to describe it to effect a change.
- When we discussed waiting times with the medical secretaries they told us the medical staff deliberately over booked the service and only gave 10 minute appointments to patients because they felt the pressure

of so many referrals. One secretary told us a doctor had a five month wait and had stopped booking patients from out-of-county to be able to better manage the workload.

- We saw some patients waiting at the clinic as long as two or three hours over the agreed time for their appointment. Some patients showed us their booking letters which informed them there may be required in the department for up to three hours. This may have been because they were required to attend other diagnostic services or clinics within the department 'One Stop Clinics'. However, patients that had been attending regularly during the months before our inspection said that long waits at the clinic were normal.
- When we looked at the waiting lists and the waiting rooms we observed on average patients waited one to two hours in the waiting room. Patients complained to us that they were not offered refreshments. Staff told us they gave patients food vouchers. Water fountains were available along with vending machines and refreshment outlets. However, patients told us they were afraid to leave their seats in case they missed their name being called.
- We saw from the department's audit of waiting times that 45% of patients were seen in 30 minutes, 27% were seen between 30-60 minutes and 12% were seen after 60 minutes. The audit showed these rates were consistent from May 2014 to December 2014. We asked senior staff about waiting times and they told us patients only waited up to 45 minutes. The trust confirmed during our inspection six patients waited more than two hours.
- Patients told us and we observed that patients would book in, get weary of waiting and leave without being seen. We asked senior managers if this was monitored. They told us it was not.
- We observed the department had a significant amount of patients that walked in wanting to be seen either without an appointment or who had mixed up their appointment date. We observed the staff were caring and did not turn patients away but this contributed to long waiting times. We noted staff had estimated a 10% figure for people that came without an appointment. We noted there was a gap in the service planning for 'walk-ins'.
- Only ophthalmology reviewed the types of patients that they saw as emergency walk-ins and telephone calls. They reviewed symptoms, treatment and what times they accessed the service in order to better plan emergency care.
- The booking service displayed targets in their offices as motivation for reducing waiting times for answering calls which aimed at being in line with the national target.
- We received several complaints from patients that the signage for outpatients and the layout was confusing. We noted signage had improved in the month prior to our inspection although our observations over three days were that patients lost their way and were confused by the number of reception desks. Receptionists told us that navigation had improved since there was better signage put in place but patients still got confused because they were often seen in different clinic areas each time they visited. We saw volunteers at the entrance of the hospital assisting patients with the self-check in machines and showing patients the way.
- The signage within the department was being continually monitored by senior staff to make improvements to support patient's navigation of the department.
- We saw waiting times were communicated to patients by nurses on an ad hoc basis in some clinics. Screens in the main waiting room displayed waits when they ran to over 45 minutes.
- We saw that the service was consistently exceeding (better than) the national average for the 18 week referral to treatment non-admitted (non-cancer) pathway. The national standard was 95% and this was consistently exceeded.
- From data provided by the trust we saw the percentage of patients waiting less than 31 days from diagnosis to first definitive treatment and less than 62 days from urgent GP referral to first definitive treatment was consistently below the national average. The 31 day target (national standard of 96%) fell below the national standard in 2014/15. The 62 day urgent referral to first treatment National standard 85%) fell below the national standard in 2014/15. Both of these measures had remained below the national average throughout 2013 and 2014. It was noted that the Trust had a cancer improvement plan in place which had been shared with Monitor and the Clinical Commissioning Group (CCG).

Outpatients and diagnostic imaging

- Within outpatients pharmacy we observed a system which enabled patients to have their prescriptions filled within 10 minutes with the use of the informatics system and robotics technology. Therefore reducing wait times and it encouraged patients to commence their medications in a timely fashion as they had very limited waits to receive them.

Diagnostic Imaging Department

- There was a perception by A&E staff that delay to discharge was at times due to radiology. We saw insufficient evidence to confirm this and found at the time of the inspection the turnaround in radiology to be very responsive. Referral to medical exposure in CT for trauma and stroke pathways was less than 15 minutes with all other referrals being responded to within 30minutes for plain film imaging.
- The IT systems were regularly audited and identified issues were dealt with promptly. Numerous in-house solutions had been developed by the technically advanced members of the radiology IT team which ensured a very responsive approach as the ability to implement this system locally was seen as better than adopting outside commercial solutions. There was an excellent skill mix within the IT team which allowed rapid response and a proactive approach to all issues. The PACS team gave good support to all MDT's and trauma imaging and were able to integrate images from other trusts swiftly via the image exchange portal.
- Diagnostic Imaging was a key department in the stroke and trauma pathways and average time from referral to CT was less than fifteen minutes. Primary percutaneous coronary interventions and emergency interventional radiology had a rapid response from the Imaging team with a maximum of 30 minute call in time.
- GP patients were offered a walk in service which had extended hours. At times the department was busy and staff responded by moving from quieter areas to assist colleagues or transferring patients to alternative rooms. The radiology department is constantly monitored throughout the day for gaps in service and to meet ongoing needs. This was evidenced at the time of the inspection
- Lists were not cancelled due to equipment failure or through a lack of appropriately trained staff.
- We observed that patients were made aware of how to access results.
- A shift system for radiographers allowed a smooth transition to the hospital at night and an extended day in inpatient x-ray had been implemented to prevent overload to the emergency department during change over.
- CT and MRI were operating twelve hour days and both services were available seven days a week. This was to cover the demand for the service and to offer patients a greater choice regarding appointment times.
- The Imaging department ran a suite of Interventional Radiology (IR). Two of these rooms were fronted with an anaesthetic room and were often used by the surgical team. These rooms were run as operating theatre rooms and only sterile procedures were carried out in them. There was a five-bed day ward used for patients recuperating from IR procedures and a two-bed surgical area also within the IR suite
- Senior managers met twice weekly with the chief operating officer to address and discuss waiting times for radiological examinations. An in house business intelligence package had been developed by the radiology IT team at the request of the senior manager, which incorporated a waiting time tracker updated a number of times daily. This was demonstrated during the visit.
- All patients were provided appointments within the six week target and the majority within four weeks. Any outstanding appointments showing a wait time of greater than six weeks were predominantly follow up's and interventional procedures which were not calculated for the purpose of waiting time targets as is accepted practice
- Radiologists and advanced practitioner radiographers ensured that report turnaround times were excellent. A dashboard for radiologist reporting to monitor performance had once again been developed by radiology IT and senior managers had access to live data to ensure image reporting issues were easily identified. This was also evidenced at the time of the inspection
- In 2014 a backlog of plain film reporting existed due to an increased demand to report cross sectional imaging. The department were very responsive by arranging local contract arrangements with departments that did not require a formal radiological report. The expectation was that the referral teams reported on their own

images and undertook audit to ensure compliance. To reduce the burden an outsourced reporting company was utilised to ensure workload was cleared and returned to a manageable level.
- Three consultant radiologists were on call after 5pm for interventional, neuro and trauma radiology and a specialist registrar was available 24 hours for CT reporting.
- Senior managers were considering consultant radiologists being on site until midnight.
- Advanced practitioner radiographers reported emergency department axial and appendicular skeleton images in order to develop their role and also to reduce the plain film workload for radiologists.
- The Head of Nuclear Medicine was the practitioner responsible for the DEXA scanning service. They and another member of the technical team reported the scans. There was also another technician training to report at the time of our inspection.
- All emergency CT and MRI scans were reported within four hours and all urgent and inpatient imaging within twenty four hours. Ultrasound scans were reported during each US session. GP waiting times were seven days or less. This was monitored on the patient tracker system.

Meeting patients' individual needs

Outpatients

- Patients who received long term care from the department told us they were known to the staff and were able to ring for emergency appointments when they needed to. We saw staff reassuring patients with long term conditions that if they needed advice or to be seen they were to ring the reception and request an appointment.
- The outpatient service was planning to become a seven day service to be able to better meet patient's needs.
- Cardiology staff told us they have made the system flexible enough for any recommended investigations to be done the same day of the initial appointment.
- Patients complained to us that finding their way through clinics was confusing. We saw how the signage could be confusing as there were four areas which were numbered and then the reception desks were also numbered. Staff told us they had tried to make it less confusing by having different coloured seats in certain areas.
- There were toilets for disabled people and large x-ray rooms with lifting aids. The cubicles were spacious with room for wheelchair access.
- Staff told us patient changing facilities were recently altered following patient feedback.
- There were separate male and female changing cubicles enabling patient privacy and dignity.
- We saw there was a range of different seating available for patients but bariatric patients complained that the seats were too low and it was difficult to get out of them.
- We saw volunteers were on hand to help patients check in to the correct area.
- The department tried to encourage patients to feedback through the friends and family test; we saw comment cards on reception desks.
- The trust tried to gain the view of patients by conducting a 'governor walk around'. Staff responded to comments made such as: 'better communication over waiting times', this is now displayed on plasma screens, 'lack of feedback forms', feedback forms are now available throughout the department and, 'difficulty in contacting the hospital to change an appointment'. The trust had responded with a new system which allowed e-mail correspondence to change appointments and the text reminder service will allowed response option to change appointments.
- The department worked with charities to be able to better meet the needs of patients that were deaf and blind.
- Patients told us that their privacy and dignity was maintained at all times, with curtains pulled across and doors closed. Patients were offered chaperones during treatment.
- We were told by staff long waiting times were due to the clinical staff trying to ensure all patients were seen and that they didn't have to wait months for an appointment. We saw clinical staff often worked over time to ensure they saw all patients and worked over their contracted hours to ensure patients were seen. This included patients without appointments that walked in needing to be seen.
- We saw there were leaflets on the walls in the outpatients department for patients. Staff told us they monitored this and ensured relevant information is available.
- Patients told us staff gave them both verbal and most of the time, written information about their care and treatment.

Outpatients and diagnostic imaging

- We saw the hospital had several volunteers and a large information desk near outpatients where patients could gain further information or advice about the hospital. The Patient Advice and Liaison
- Service (PALS) was located next to the outpatient's department.

Diagnostic Imaging Department

- There was a clear strategic vision and this was to provide high quality, safe care to patients. There was constant performance monitoring to ensure targets were met for reporting and appointments
- Demand and capacity were measured and projected future needs of the department were clear and well managed.
- Women were chaperoned for intimate examinations and people had the right to choose a same sex radiographer to undertake their examination.
- Single sex changing and waiting areas were in place and gowns and dressing gowns were in good supply.
- The radiology IT team was well led with a programme of audit to monitor quality and IT systems to identify action that may be required for future service provision.
- Senior managers regularly attended staff and modality meetings and we were shown minutes of meetings and action plans that were developed to ensure the service was constantly and consistently monitored to adapt to patient and clinicians needs and requirements.
- Patient discharge sheets were available to service users giving them means to contact the department following examinations

Learning from complaints and concerns

Outpatients

- We asked reception staff, nurses and medical staff if they logged patients' complaints about waiting times and they told us they did not.
- We noted from the list of complaints provided by the trust in advance of our inspection that there were few in relation to outpatients' services. We found this to be unreliable data due to staff under reporting. We saw only four complaints had been received February-September 2014 two of those were about the waiting time at clinics. We spoke to 54 patients most of whom complained about the waiting times. Long term patients told us they had complained several times and nothing had been done about it.
- Staff told us patients were happy once they had been seen they received good care and treatment. Patients we spoke with supported this statement.
- We saw from the department audit 2014 that complaints had been 'stable' and there had been no PALS concerns. Complaints included attitude of reception and nursing staff along with administration issues. We saw they had received 25 complaints and 10 compliments.

Diagnostic Imaging Department

- Patient surveys were carried out throughout the trust and complaints to radiology were internally triaged according to severity.
- We saw that complaints were well responded to. For example new curtains were put on changing cubicles and pictorial changing instructions were developed in response to monitoring patient feedback.
- Staff told us how patients are informed if they wish to comment or complain about the radiology service. A complaints feedback group met regularly to act promptly to elements of the service that required change.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Summary

We found areas still requiring improvement within outpatients. A system of audits was in place and a governor walk round gained patient's perspectives.

Although performance monitoring and assessment of the quality of the outpatient service took place, local leaders could not demonstrate it use to effect positive change. We found that effective leadership at a local level needed further development. This was confirmed by some of the management team who were optimistic that recent plans put in place would address this. We noted the culture of the service to be a positive one overall.

The Radiology Department was well led and structured to ensure all services were patient focussed. There was continuous performance management of all staff who were given feedback by the seniors to their team members. All sections of the Radiology department had a positive

atmosphere and all staff approached during the visit were confident in their approach to work and had great confidence in their managers. All performance targets were being met and were monitored continuously by the managers.

Vision and strategy for this service

Outpatients

- Senior staff were aware and had been involved in developing visions of expanding the service. They told us they were aware of the demand for clinics and an increase in referrals. Senior staff went to monthly steering groups in order to discuss the vision and strategy for the department.
- Junior staff gave us of examples where change in the department had not always been communicated to them which left them feeling confused.
- The senior staff that we spoke with were aware of the current strategy for the department.

Diagnostic Imaging Department

- Demand and capacity were measured and the projected future needs of the department were clear and well managed.
- We found the radiology IT team was well led with a programme of audit to monitor quality and IT systems to identify action that may be required.
- Senior managers told us they regularly attended staff and modality meetings.

Governance, risk management and quality measurement

Outpatients

- The department had areas which needed to be addressed and although performance review meetings were undertaken regularly at an executive level, local management could not demonstrate how improvements were going to be achieved. However we were made aware of a strategic steering meeting which had its first meeting in January, but no action plans had been developed at the time of our inspection as a result of this meeting.
- We noted a manager had recently been working closely with the pre-operation assessment team in making the access and patient flow better. We asked if the management team had plans to review any other clinics. They were unable to provide any specific plans of what needed to be reviewed although again did recognise the service needed to expand.
- We noted from the agenda for the upcoming new strategy steering group meeting that they plan to review waiting times trends, develop booking rules, review the role of the junior doctors, audit the use and times of clinics and review national targets.
- We noted that head of outpatients conducted a random sample audit to review how long it took a deteriorating patient to be admitted to a ward. We saw the average wait was three hours.
- We saw there was a system of infection control audits and cleaning and refurbishment audits in place. Clinical audits were well established to ensure quality. A governor walk round was conducted to gain patient's perspectives.
- The department completed and maintained a risk register. Risks recorded on the register were; misfiling or incorrect details being scanned into the computer system, sharps, theft, falls, aggression and health and safety in relation to computer use.
- We noted from the risk register records that managers ensured risks they did recognise were minimised by allocating a nominated individual to oversee the risk.
- We did not see items on the risk register relating to overcrowding or lack of clinic space.
- Following the inspection the trust informed us that risks such as overcrowding were represented on the speciality risk register. However, this should also be present on the outpatients risk register as it had a direct impact on the service.

Diagnostic Imaging Department

- There was a robust governance structure; this was evidenced by regular attendance at radiation protection and clinical governance meetings whereby members of the Trust board, senior radiology management and medical physics representatives must be in attendance to be at quorate. Clinical governance meetings were held monthly. The radiation protection committee sat twice a year and the health and safety committee sat monthly. All incidents were discussed at these meetings. We viewed six months of meeting minutes which evidenced the work that was being undertaken
- The risk register was regularly reviewed and revised. We noted at the time of our inspection it logged issues

concerning portering, increased activity, radiologist involvement at proposed future multidisciplinary team meetings and the requirement to establish an interventional radiologist at the Birmingham Children's Hospital.

- We found a clear governance framework with regular radiation protection, clinical governance and health and safety committee meetings. Senior managers were involved in root cause analysis for adverse events and there was excellent incident management locally.
- Internal quality assurance and review of policies was regularly undertaken We were shown minutes of meetings and procedural documents which were clearly reviewed regularly and subject to version control to ensure only the most up to date policies and procedures were available to staff.
- Weekly meetings were held with radiologists and they also had a clear service line lead and the two corroborated in order to monitor all aspects of service. Radiologists audited their work as did radiographers and peer review was evident to ensure consistent and best practice.
- Clinical teams and GP's were encouraged to feed back to radiology regarding patient outcomes local leaders informed us.

Leadership of service

Outpatients

- When we spoke to local leaders of the service we found they were not aware of many of the issues that patients had raised with us however later provided us with a list of the issues that they planned to discuss at the strategic steering meeting which correlated with the issues we found. Some of these issues had been longstanding and the timeliness of response appeared delayed.
- We found staff also did not see all the issues we raised with them from speaking with patients and our own observations as concerning.
- We noted a lack of effective local leadership of the service and this was acknowledged by some of the management team. They told us they felt the strategic steering meeting that was planned would be essential in filling this gap and would provide clear visions which could then be cascaded to staff.
- We discussed our observations of some reception staff's negative behaviour with senior clinical staff. They told us that as they did not manage the reception they did not feel comfortable in raising an issue with them. We noted barriers to staff feeling able to escalate concerns over colleagues' poor attitude and ineffective management of this However there was a process of regular contact with the line management of the reception staff and the local management of outpatients.

Diagnostic Imaging Department

- Senior managers were well supported by four heads of department divided by modality. Within each modality there was a superintendent supported by radiographers of all grades, radiology department assistants and assistant practitioners. Staff told us they were fully aware of the management structure and their accountability within it.
- The department had an education coordinator, six reporting radiographers, one CT colonoscopy radiographer, one interventional radiographer and one consultant radiographer in breast screening.
- Radiology staff told us they were well supported by management and modality leads. All staff were aware of who their line managers were and also gained regular sight of senior managers. Imaging leads were clearly visible and operated a shop floor presence.
- All area leads undertook image quality audits and provided excellent feedback to radiographers and assistant practitioners working within their areas.
- There was a full appraisal process and a 360 degree review in place for radiologists.

Culture within the service

Outpatients

- We observed the culture of the service to be a positive one overall. Staff praised their managers, enjoyed their jobs and felt valued despite some feeling unheard at time over complaints around lack of rooms, scheduling and concerns about other staffs' attitudes.

Diagnostic Imaging Department

- Staff told us they were encouraged in an open culture to address worries or concerns about patients and their own well-being and managers were responsive, sensitive and approachable to this.

Outpatients and diagnostic imaging

Public and staff engagement

Outpatients

- We saw the trust exceeded the national average response rate April 13- Jul 14 in gathering comments from patients by the Friends and Family Test.
- From the staff survey 2013 we saw the results for staff feedback was better than the average national expected feedback rate. Staff had commented to us that they were happy with the quality of care they were able to provide to patients, that their role made a difference to care, that they received well-structured appraisals and support from immediate managers.
- We noted staff in the ophthalmology department had gathered patient perceptions of the use of a glaucoma passport which contained all their treatment. Staff felt the tool was helpful aide memoire.
- The department had patient council who gave feedback on the hospital. One person's feedback was that signs for areas in outpatients should be bigger for patients with eyesight difficulty. We saw the matron acknowledged this for the next order of signage. Staff fed back the positive feedback received from the Friends and Family test.

Innovation, improvement and sustainability

Outpatients

- We discussed the lack of capacity and demand for more clinic space with managers and they agreed there was a demand for clinics and that they needed to look at alternatives. One alternative was the possibility of moving one of the services out in to the community. We noted from the managers meeting that they had plans to audit any ground level rooms near outpatients which may be unoccupied.
- To manage both flow and patient outcomes the trust had adopted an improvement in service. This was QHB@Home (supported recovery at home) and Recovery@Home it involved good multidisciplinary working such as a multidisciplinary team of nurses, physiotherapists and occupational therapists who supported patients within the community for up to 10 days while awaiting social services to take over their care.
- We saw staff across various departments reviewed and audited the safety, side effects and adherence to NICE guidance or protocols.
- The steering strategy group plans to review waiting times trends, develop booking rules, review the role of the junior doctors, audit the use and times of clinics and review national targets. We saw this group was filling the gaps noted during the inspection.
- We saw staff had initiated several audits but we saw a lack of targets and action plans from the audits for staff to learn from and work towards.

Outpatients (sexual health services)

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

Information about the service

The University Hospitals Birmingham NHS Foundation Trust provided sexual health services from clinics across Birmingham. The sexual health service saw 32,846 patients between February 2014 and January 2015. These were integrated clinics providing both genitourinary medicine and sexual and reproductive health. (There had previously been two separate services: sexual and reproductive health and genitourinary medicine. The nursing staff within these two services merged over the past three years, forming one integrated service.)

The service was for adults but had processes and safeguards in place if under 16's did attend.

An HIV clinic was provided in the outpatients department at the hospital. The trust had recently been awarded a five-year contract by Birmingham City Council and Solihull Metropolitan Council to expand its provision of sexual health services across Birmingham and Solihull.

We inspected five satellite clinics – Greet Health Centre, Quinton Lane Health Centre, Soho Health Centre, Whitall Street Clinic, Boots the Chemist (66 High St Birmingham) – and the HIV clinic. We spoke with 17 patients and 35 members of staff.

We held a public listening event for the lesbian, gay, bisexual and transgender (LGBT) community on 12 January 2015. Ten people attended this event.

We reviewed 24 patient feedback comment cards and reviewed records as part of this inspection.

Summary of findings

Staff received mandatory and specialist training to meet patients' needs. Staff were knowledgeable about incident reporting and received feedback on lessons learned Infection control procedures were being followed. Medicines were being stored appropriately.

Evidence-based care was provided by competent staff and in accordance with national guidelines. An annual schedule of national and local audits took place to monitor the effectiveness of treatment. The results were regularly monitored within governance meetings and reported back to staff to implement changes to practice where required.

We found the sexual health services to be caring. Patients spoke highly of the staff and the service they had received. Patients were treated with dignity and respect. Patients felt supported and were given clear explanations about their care and treatment.

There was flexible access to clinics with booked and walk-in appointments. Early morning and evening appointments were available to accommodate people who worked during the day. Clinics were situated across Birmingham to provide more local services.

Some nursing staff who had previously worked in sexual and reproductive health service felt unsupported, undermined and not valued by management. However, there was a disparity between staff groups as medical staff and nursing staff who had previously worked in genitourinary medicine did feel well-supported. Medical

Outpatients (sexual health services)

staff who previously worked in sexual and reproductive health service felt the same. We acknowledged that this was a newly integrated service but improvements were needed to ensure that all staff felt supported.

Are outpatients (sexual health services) safe?

Good

Summary

Sexual health services were safe.

Staff received mandatory and specialist training to meet patients' needs. Staff were knowledgeable about incident reporting and received feedback on lessons learned. Appropriate safeguards were in place in the event of a health emergency, and if someone under the age of 16 presented to any of the clinics.

Infection control procedures were being followed.

Medicines were being stored appropriately.

Staff were knowledgeable about safeguarding procedures.

Incidents

- Staff were aware of the procedure for reporting incidents using the trust's electronic recording system. 40 incidents were reported between 16/01/2014 – 17/12/2014.
- Most staff described an open, friendly culture in which they were confident to report incidents.
- There were no themes observed on review of the incident log.
- Incidents were investigated locally by the matron and then discussed at senior management meetings. We saw minutes of the September 2014 operational manager's meeting which discussed an incident where a staff member sustained a blow to the head due to the location of a printer. The printer was then relocated to avoid further incidents.
- Staff told us they received feedback at weekly staff meetings on lessons learned from incidents. We saw minutes of these meetings.

Cleanliness, infection control and hygiene

- The clinic rooms and reception areas were visibly clean.
- There was sufficient personal protective equipment such as gloves and aprons available and patients told us they saw staff using it prior to procedures.
- Patients told us they saw staff washing their hands.

Outpatients (sexual health services)

- We saw that staff adhered to the bare below the elbows policy recommended for best hygiene practice.
- Staff had received training on infection control. Documents supplied by the trust demonstrated 100% compliance with this training.
- Clinical and domestic waste was managed appropriately. Sharps boxes were being used appropriately and were all dated.
- All staff received training in hand hygiene on 19 January 2015. We were told that only three staff had to undertake the practical hand-washing session twice. The matron informed us that hand washing technique was monitored and that where issues were highlighted staff were given further training. The service did not provide results of hand hygiene audits.

Environment and equipment

- The HIV clinic was based within outpatients at the hospital. Satellite clinics were situated across Birmingham within health centres. One clinic was run at Boots Chemist. We observed all areas were clean and tidy.
- Most equipment used for examination was single use.
- Equipment, including resuscitation equipment and oxygen, was checked on the days the clinics were in operation and a record was kept of these checks and audits. We looked at a sample of the records and observed the checks had taken place.

Medicines

- Medicines were stored securely in locked cupboards.
- Clinicians used electronic prescribing whereby prescriptions were written electronically and sent direct to the pharmacist. We were informed by the Matron that there was a trust wide process in place to audit electronic prescribing. Specific results were not provided.
- Medicines that required refrigeration were kept in a locked fridge. Records indicated that temperatures were checked daily and we found them to be within acceptable limits.
- However, there were three occasions between December 2014 and January 2015, at the Soho Health Centre, where the fridge temperatures were out of range and no action had been taken. We highlighted this to the nurse who said they would address this with the staff at the clinic.

Records

- Electronic patient records were in use for all patients. They were stored securely and staff had access via use of passwords.
- Nursing, medical and other members of the multidisciplinary team all entered information on to the same record. This was good practice as it allowed staff to review the patient's condition in a chronological manner, ensuring that the reader had a clear picture of what was happening at any given time. Records indicated the position title of the professional delivering care.
- There were private kiosks at some of the clinics where patients could register their details on to their patient record. If a patient responded "yes" to specific questions then further self-assessments opened for them to complete. This information was then sent directly through to the clinician they were about to see. Clinicians told us that this helped them provide tailored information and advice during the consultation.
- Staff told us that the computer system was very slow and this contributed to patient delays. We were told that the trust was planning to remedy this. Staff were unaware of when this was likely to happen.

Safeguarding

- Staff told us they had received training in children's and adult's safeguarding. Records provided by the trust demonstrated that 99% of staff had completed level 1 and 83 % level 2 protecting vulnerable adults training. 95% of staff had completed level 1, 92% level 2 and 77% had completed level 3 safeguarding children and young people training.
- Staff showed us how they accessed the trust's safeguarding policy on the intranet, which was also relevant to the community setting. There were specific children's safeguarding policies and procedures relating to children under the age of 16.
- Staff were provided with support, advice, guidance and training regarding children's safeguarding from specialist teams from another provider.
- Staff we spoke with were aware of how to raise safeguarding concerns and of what constituted a safeguarding issue. Staff we spoke with regarding safeguarding issues were knowledgeable about domestic violence and sexual assault.

Outpatients (sexual health services)

- Staff had a contacts and referral system in place for cases of suspected or confirmed sexual abuse or domestic violence – for example, Women's Aid or the Rape & Sexual Violence Project (RSVP) where support and counselling could be provided for patients.

Mandatory training

- Staff told us they were up to date with their mandatory training. Documents received from the trust demonstrated 89% of staff had completed mandatory training which included amongst others infection control, equality and diversity and medicines management.

Assessing and responding to patient risk

- Policies and procedures were in place if patients became acutely unwell whilst being treated in the satellite clinics. Patients were reviewed by doctors and closely monitored by the nursing staff until an ambulance was available to transfer them to the nearest hospital.
- Staff were trained in basic life support as part of their mandatory training, in order to give emergency life support to a patient who may require it.

Nursing and Medical staffing

- We saw (and staff confirmed) that there were adequate numbers of staff to meet patients' needs. We were informed by the Matron that regular review of performance reports including waiting times, both 48 hour access and in-clinic times, reason for attendance, skill mix, patients that did not arrive and those turned away facilitated the development of the clinical rota.
- Minutes of a senior management meeting (April 2014) discussed that staffing levels had been monitored and adjusted to reflect the number of patients attending the satellite clinics.
- There were 39 qualified nurses, 27 healthcare assistants and 26 doctors providing care across the clinics. All the clinics were consultant led. Doctors were available at the clinics the majority of the time. When doctors were not on-site, a consultant and senior registrar were available via telephone providing a 24 hour on-call service.
- Staff told us that they predominantly used their own colleagues via the trust's bank (overtime) staff to cover shifts in the event of sickness.
- Agency staff were only used at the Whitall Street Clinic for healthcare assistants. These personnel had to complete a competency training programme prior to commencing work. They were then booked on a block contract so they became familiar with the policies and procedures in that area.

Major incident awareness and training

- Staff were able to show us where the major incident plan was on the trust's intranet and received guidance as part of their mandatory training.
- Regular fire drills took place and staff were aware of action they should take if there was a fire.
- Staff were aware of procedures in the event of power failure. For example, staff would write paper records and then input these on to the patient electronic record as soon as power resumed.

Are outpatients (sexual health services) effective?

Good

Summary

The sexual health service was providing effective care and treatment.

Evidence-based care was given according to national guidelines, provided by competent staff.

An annual schedule of national and local audits took place to monitor the effectiveness of treatment. The results were regularly monitored within governance meetings and reported back to staff to implement changes to practice where required.

Evidence-based care and treatment

- The service provided evidence-based practice in line with the British Association for Sexual Health & HIV (BASHH), the British HIV Association (BHIVA) and the Faculty of Sexual and Reproductive Healthcare (FSHR) guidelines. These guidelines were approved by the National Institute for Health and Care Excellence (NICE). We confirmed this through discussions with the consultants and from the records reviewed.
- We saw examples of audits demonstrating how the trust was complying with the FSHR standards. Areas for improvement were also highlighted and disseminated to staff. For example we saw an audit looking at combined hormonal contraception (CHC) and the risk of venous thromboembolism. The aim was to compare

current documentation for prescribing CHCs in Birmingham Sexual Health Service clinics with national FSRH guidance. Areas for improvement amongst others included recording discussions on the risks including VTE signs. This was presented at the quality improvement meeting and results emailed to all clinical staff. A re-audit was planned for six months' time.

- Quality indicators for example, the percentage of HIV testing of Black African Women were discussed in clinical governance committee meetings and at the sexual health service management meetings (held monthly). We saw minutes of these meetings. To help improve outcomes, information on the quality indicators was also available to all staff via the trust's intranet. We saw that the service had a comprehensive audit schedule in line with NICE guidelines. Where shortfalls were highlighted, action plans were developed and communicated to staff to promote improvements.
- Consultants also carried out weekly records audits and line managers reported back any improvements in practice required to individual staff.

Patient outcomes

- All audits were registered through the trust with appropriate approval obtained.
- The outcomes of completed audits were presented at staff meetings and were also discussed at the clinical governance committee (meetings held every three to four months) and at the consultants' quality improvement meetings (held every three months).
- The trust monitored whether patients were offered an appointment within 48 hours and whether they were seen within 48 hours. Data received from the trust showed that, between January 2014 and January 2015, 100% of patients were offered an appointment within 48 hours. (In August 2014, the figure was 99.8%).
- Patients seen within 48 hours ranged from 60.3% to 76.4%. Some patients would choose not to be seen within 48 hours and this was respected.

Competent staff

- All the staff we spoke with said they had received an annual appraisal. Staff had attended specialist courses in relation to sexual health services, for example Advanced Diploma in GU medicine, Diploma in sexual health and contraception, sexually transmitted foundation course, contraception and sexual health and non-medical prescribing courses.
- All the consultants were on the specialist register for genitourinary medicine (GUM)/HIV and reproductive and sexual health. They also attend regional, national and international meetings within the sector.
- The above qualifications were confirmed by documents supplied by the trust.
- Documents received from the trust confirmed 100% compliance with appraisals.
- Medical staff we spoke with were well-supervised and supported by their consultants and were up to date with their revalidation.
- Weekly update training was in place for all members of staff covering different sexual health topics.

Multidisciplinary working

- There was a system of multidisciplinary working within the HIV clinic. This involved, nurses, doctors, phlebotomists, dieticians, psychologists, a counsellor, pharmacists and social workers.
- The sexual health clinics had input from doctors, nurses and healthcare assistants. Staff were able to refer patients for counselling as required.
- Nurses in the satellite clinics had contacts with social services and the police when referrals were necessary – for example, safeguarding referrals or alleged sexual assault.
- Nurses had referral pathways for patients who had been subject to domestic violence or sexual assault – for example, Women's Aid or RSVP – where support and counselling could be provided for patients.

Seven-day services

- Most of the satellite clinics were open Monday to Friday until 7pm. The Boots clinic also opened on Saturdays between 9.30 - 4pm and Sundays 11-3pm. The HIV clinic had late opening on Wednesdays between 0830-8pm.

Access to information

- Staff had access to records and test results on the trust's electronic patient records system.
- Clinicians explained how the electronic patient record ensured they had up-to-date information to enable them to provide health education and advice as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All the patients we spoke with confirmed that clinicians had gained their consent prior to carrying out any procedures. This was recorded in the notes.

Outpatients (sexual health services)

- Staff were aware of how to assess a patient's capacity to consent using the Mental Capacity Act 2005. However, staff did not use a trust mental capacity assessment form.
- Clinicians used Gillick competency and followed Fraser guidelines when consenting under 16 year old patients for treatment.
- Staff were also aware of the procedures for making best interest decisions for patients without the capacity to consent. Staff received training in the Mental Capacity Act within their safeguarding training.
- Staff told us that if they had any concerns that a patient using the service had mental health issues or learning difficulties came they would speak to their manager or a consultant.

Are outpatients (sexual health services) caring?

Good

Summary

We found the sexual health services to be caring.

Patients spoke highly of the staff and the service they had received.

Patients were treated with dignity and respect.

Patients felt supported and were given clear explanations about their care and treatment.

Compassionate care

- All of the patients we spoke with said their dignity was preserved and they were treated with respect.
- One patient told us, "The doctor respected me, I was not embarrassed, they were very kind". Another patient said, "[The staff] are lovely, very helpful, they are really nice".
- Staff told us that all patients were offered a chaperone. This was confirmed by all the patients we spoke with and was recorded in the patients' records.
- We received 24 patient feedback forms during our inspection, all of which were very positive about the services received. One comment was, "Very discreet, professional and non-judgemental". The service had commenced using the 'Friends and Family' feedback forms a few months ago but had not received sufficient responses back to analyse results.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us they had received clear explanations about their treatment and after-care, delivered in a way they could understand. One patient told us, "They explained everything, just what I needed". Another patient said, "They explained everything properly and made sure I understood everything".
- All of the patients we spoke with told us they were provided with information about after-care following their procedure or treatment. One patient told us, "They explained after-care to me and complications".

Emotional support

- We used translators to speak with two patients whose first language was not English. Both patients were happy with the service they had received. One patient told us, "It is very nice, I feel comfortable to always come in".
- One patient had explained how they had been quite distressed prior to being seen and had been given support during their appointment. They told us, "They reassured me and gave me peace of mind".
- A psychologist and counsellor were available to provide emotional support at the HIV clinic. Staff were also able to refer patients from the satellite clinics for counselling services as required.

Are outpatients (sexual health services) responsive?

Good

Summary

We found the sexual health services to be responsive to patients' needs. There was flexible access with booked and walk-in appointments. Early morning and evening appointments were available to accommodate people who worked during the day. Clinics were situated across Birmingham to provide more local services.

Translators were available to assist patients whose first language was not English. However, we noted that patient leaflets and posters were only available in English.

Staff received feedback about learning from complaints to help them improve their practice.

Outpatients (sexual health services)

Service planning and delivery to meet the needs of local people

- There was flexible access to the service with both pre-booked and walk-in appointments available at all clinics.
- Several clinics provided out of hours appointments up to 7pm. The HIV clinic ran a Wednesday service up to 8pm. Boots The Chemist clinic also opened on Saturdays between 9.30 - 4pm and Sundays 11- 3pm.
- Satellite clinics were positioned in different locations around Birmingham to provide local services. We observed from a map that these services were well spread out. People told us at listening events that the clinics were in good locations.
- The trust had just won a tender to provide additional sexual health services across Birmingham and Solihull, increasing service provision to meet the needs of the local population. Detailed plans were in development to address this increase in service.

Access and flow

- Most patients we spoke with found the service very flexible and liked the fact that you could book an appointment online or via the phone or just walk in and wait for an appointment.
- Some patients had experienced problems with the central booking line where they were given incorrect information. This resulted on one occasion, a patient turning up for a specific procedure but being told on arrival that it could not be carried out.
- Appointments were available at some clinics prior to 9am and evening and weekend appointments were available to accommodate people who work during daytime hours.
- Patients were provided with written information to take home to supplement their understanding of treatments delivered.
- There were mixed views about waiting times. Some patients said they rarely waited a long time, while others complained of long waits. However, patients said that staff usually informed them if there was going to be a long waiting time.
- Staff told us that the slow computer system to input patient records did impact on patient waiting times. The impact on waiting times had not been audited. This had been reported because the trust said they were planning to change to the trust server.
- Nurses had access to referral pathways for patients who had been subject to domestic violence or sexual assault – for example, Women's Aid or RSVP – where support and counselling could be provided for patients.

Meeting people's individual needs

- Wheelchair access and toilet facilities were available at all the clinics for patients with reduced mobility.
- The service had access to translators for patients whose first language was not English. We saw translators assisting patients at two of the clinics during our inspection.
- We noted that information leaflets and posters were only available in English. This was not representative of the multi-cultural population that the service treated.
- We held a focus group for the lesbian, gay, bisexual and transgender (LGBT) community. We had mixed feedback, with some very positive and some negative comments where patients felt they had been treated differently. Some patients felt as though it was assumed they were heterosexual. A positive comment was, "I've used the sexual health at QE many times. They are fantastic! I found them to be flexible, understanding and helpful." There were some negative comments about Whitall Street relating to waiting times and not being able to be seen if they had arrived towards the end of the clinic.
- All staff received training in equality and diversity as part of their mandatory training. Documents received from the trust demonstrated 100% compliance with this training.
- Staff we spoke with were knowledgeable about how to care for people living with learning disabilities.
- Staff knew how to access extra support from the learning disability lead nurse within the hospital

Learning from complaints and concerns

- Not all patients we spoke with were aware how to make a complaint. However, posters were displayed in English in waiting areas requesting patient feedback.
- Some patients had noticed the patient feedback boxes in the waiting areas and were aware of how to provide feedback.
- Senior managers discussed complaints in their monthly meetings. We saw minutes of these meetings.

Outpatients (sexual health services)

- Staff told us they were informed of lessons learned from complaints in their weekly staff meetings. Some complaints had been received regarding waiting times. The service had increased opening times to include weekend and evening clinics to address this.

Are outpatients (sexual health services) well-led?

Good

Summary

There were good governance structures to monitor audit outcomes, risks, incidents and complaints.

There were examples of innovative practice currently taking place – for example, use of the electronic patient record and clear plans to expand the service.

Some nursing staff who had previously worked in sexual and reproductive health felt unsupported, undermined and not valued by management. However, there was a disparity between staff groups, as medical staff and nursing staff who had previously worked in genitourinary medicine did feel well-supported. Medical staff who previously worked in sexual and reproductive health also felt supported

Vision and strategy for this service

- The senior management had a clear vision and strategy for the service. This involved plans to expand, as they had recently won the tender to provide sexual health services in more locations across Birmingham, including Solihull (commencing August 2015).
- Staff were engaged in this process and had attended meetings and workshops to inform them of the proposed changes.
- Staff told us they had been able to express their views within their weekly team meetings.

Governance, risk management and quality measurement

- We saw that governance meetings were held across the sexual health services to highlight change to practice and present audit data.
- Minutes of these meetings showed that audit data, risks, incidents and complaints were discussed. For example, the problems with the toilets at the Boots Chemist clinic were discussed on the risk register.
- Staff said they were kept up to date at their weekly team meetings.

Leadership of service

- The senior management team, including the clinical lead, matron and head of sexual health, felt well-supported and listened to by the executive team.
- Medical staff felt well-supported by their managers and spoke of clear leadership within the service.
- There had previously been two separate services: sexual and reproductive health and genitourinary medicine. The nursing staff within these two services were merged over the past three years, forming one integrated service. Formal management changes commenced in November 2014.
- The genitourinary medicine staff were pleased with the support they received and felt happy working within the service. Some of the sexual and reproductive health staff told us they felt unsupported, undermined and not valued by the management. They also felt there were fewer opportunities for them to progress.
- The matron told us that they were aware that some staff were not happy with the changes to the services. They told us they had introduced weekly training sessions for all staff to attend, to help integrate the staff. We acknowledge that this service was in the early stages of integration.
- One clerical staff member also said they did not feel supported or listened to by their manager.

Culture within the service

- Most staff described an open, friendly culture in which they were confident to report incidents. They were happy to work in the service.

Public and staff engagement

- An annual patient survey was conducted and results reported back to staff via their weekly team meetings. Staff told us that, in response to the survey, the service had changed opening times to accommodate people who worked during daytime hours.
- Patient comment forms were available in all the waiting areas.
- Staff told us they felt engaged in the tender process to increase the sexual health service provision.

Innovation, improvement and sustainability

- Clinicians described the electronic patient record as an innovative practice that they were proud of.

Outpatients (sexual health services)

- The nursing staff had introduced an electronic key fob system to access drug cupboards. This ensured that only qualified staff had access but reduced the time trying to find who held the drug keys.
- There were innovative plans working with their partner agencies to provide information to enable them to signpost patients to their services. For example, they were working closely with GPs, pharmacists and homeless groups, among others.
- There were plans to introduce self-sampling kits which patients could request online and pick up from a pharmacy.
- The service was going to use social media to let patients know the location and opening times of services.

Outstanding practice and areas for improvement

Outstanding practice

Emergency medicine

- We considered the use of theatre technicians to support trauma teams in the A&E 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 for patients.
- ▪ Strong local leadership and excellent team working was evident in; Oncology, CDU and Ambulatory care services. These services were exceptionally well-organised resulting in excellent patient outcomes.

Surgery

- We saw excellent MDT working and sharing of good practice.
- Patients described receiving excellent care and treatment being delivered
- Wards were exceptionally clean and tidy
- Medical feedback app.

Critical Care

- Critical care had two specialist 'burns shock rooms'. The critical care service had influenced the design of these specialist rooms which had showering and plumbing facilities. These facilities enabled burns patients to shower, scrub and redress their burn without leaving their rooms. This stopped patients from being exposed to temperature swings and having to use theatre time for dressings, reducing the risk of cross-infection and unnecessary patient moves. These rooms provided excellent facilities for effective management of burns patients.
- The critical care unit has been modified so that on-tap purified water was provided at each bed space for renal replacement therapy. Benefits included improved patient experience and significant cost savings.
- The physiotherapy rehabilitation service in critical care had demonstrated improved patient outcomes, including a reduced length of hospital stay and improved mobility on discharge from critical care compared to those patients who did not receive the enhanced rehabilitation programme.
- The units used simulation exercises and a mannequin to provide effective teaching of routine and difficult procedures for medical and nursing staff without placing patients at risk.
- Training by fire and rescue staff had resulted in more effective care of casualties, particularly those with burn injuries.

Diagnostic imaging

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Senior managers held monthly meetings with the clinical commissioning groups where different aspects of the service were discussed and changes were made if necessary. We saw examples such as, a band 7 mammography radiographer liaising with local GP's with the aim of increasing the uptake of breast screening in the local population. This is viewed as outstanding practice and demonstrated that the radiology department were responding to the needs of the local population.
- The Imaging department ran a suite of Interventional Radiology (IR). Two of these rooms were fronted with an anaesthetic room and were often used by the surgical team. These rooms were run as operating theatre rooms and only sterile procedures were carried out in them. There was a five-bed day ward used for patients recuperating from IR procedures and a two-bed surgical area also within the IR suite.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Emergency medicine

1. By failing to ensure a clean environment and that staff comply with policies and procedures, the provider is not ensuring that (a) service users, (b) persons employed for the purpose of carrying on the regulated activity and (c) others who may be at risk of exposure to a healthcare-associated infection arising from the carrying on of the registered activity are protected against the risks of acquiring such an infection.

This is something which is required as part of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 & 12(f) & (g) Regulations 2014 In safe care and treatment in relation to cleanliness and infection control, but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the regulation overall at the location.

1. By not ensuring that patient vital signs are checked and recorded in a timely manner, the provider is not ensuring the safe delivery of care and treatment in a way which reflects published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.

This is something which is required as part of Regulation 9 & 9(3) (b)-(h) Regulations 2014 In person centred care in relation to care and welfare of service users, but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the regulation overall at the location.

1. By failing to provide a suitably appointed mental health assessment room the provider is failing to ensure that service users and others having access to the premises are protected the risks associated with unsafe or unsuitable premises by means of a suitable design and layout.

This is something which is required as part of Regulation15 & 15 Regulation 2014 Premises and equipment in relation to the safety and suitability of premises, but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the regulation overall at the location.

1. Consultant handovers to junior doctors should be formalised to ensure that when consultants leave the department temporarily, junior staff are supported in relation to their responsibilities. To enable them to deliver care and treatment to service users safely and to an appropriate standard.

This is something which is required as part of Regulation 23 & 18(2) Regulation 2014 In staffing in relation to supporting workers, but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the regulation overall at the location.

Surgery

- The trust MUST ensure that resuscitation equipment thoroughly checked on each ward and spot checked to ensure compliance.

This is something which is required as part of Regulation15 & 12(1)(e) Regulation 2014 In safe care and treatment in relation to Safety, availability and suitability of equipment , but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the regulation overall at the location.

Action the hospital SHOULD take to improve

Hospital Wide

To maintain audit activity to demonstrate continued improvement in patient outcomes.

Surgery

- Hand washing facilities for visitors should be clearly signposted and staff should ensure it is adhered to.
- Patients' records should be consistently completed with all areas of documentation dated and signed appropriately.
- Further cross-directorate networking would ensure learning from incidents and complaints was fully embedded across the entire organisation.

Outstanding practice and areas for improvement

End of Life Care

- Ensure that all significant conversations around DNACPR decisions are recorded in the medical notes and on the electronic record so that staff can be assured that conversations have taken place.
- Participate in national audits to enable the service to benchmark patient outcomes against other trusts and identify areas for improvement.
- Implement a range of performance indicators for the end of life care and the SPCT to enable them to measure patient outcomes, identify areas for improvement and share good practice. Specifically, the measures should include:
  - An audit of patients dying in their preferred location.
  - Targets for rapid and fast track discharge.

OPD only

- The provider could improve on ensuring staff report all incidents and near misses as this could lead to a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse.
- The provider could improve on identifying and reviewing risks and monitoring these on the risk register as this could lead to a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse.
- The provider could improve on ensuring all emergency resuscitation trolleys are adequately checked as this could lead to a breach of Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.
- The provider was not monitoring the performances and/or did not have sufficient action plans in place for :- waiting times for an oncology diagnosis, 62 days from urgent GP referral to treatment time, waiting times in clinics, overbooking, seeing patients with complex conditions, delayed start to the clinic and seeing emergency patients.