Heart of England NHS Foundation Trust

Birmingham Heartlands Hospital

Quality Report

Bordesley Green East, Birmingham,
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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	Requires improvement
Urgent and emergency services	Inadequate
Medical care	Requires improvement
Surgery	Not sufficient evidence to rate
Maternity and gynaecology	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Heart of England Foundation Trust is a large NHS provider of acute hospital and community services in Birmingham and Solihull. The hospitals are in the East and North of Birmingham and one smaller site in Solihull West Midlands. There is also the Birmingham Chest Clinic which is in the centre of Birmingham The trust has some community services in Solihull. We did not inspect the community services or the Chest Clinic. The three acute sites are Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. Along with the community service the trust serves approximately 1.2m people. The Birmingham Heartlands site is where the trust headquarters are located.

We carried out this unannounced responsive inspection because the trust was in breach with regulators Monitor, and we had received intelligence which warranted our response and so we arranged the inspection. The inspection took place between 08 and 11 December 2014. We had inspected the service in November 2013 and the trust was still working through compliance action plans.

This inspection was an unannounced responsive inspection and as such we will not be rating the service. The purpose of the report is to share with the trust and the public the evidence we gathered during that inspection. It is also important to note that at the time the trust was in transition with many changes within the trust executive team, some of whom were in interim posts. This had been precipitated by the previous Chief Executive resigning in November 2014.

Our key findings were as follows:

- Widespread learning from incidents needed to be improved.
- Appraisals for staff were not widely undertaken achieving 28% compliance at the time of our inspection.
- Staffing sickness and attrition rates were impacting negatively on existing staff.
- The congestion within the hospital was having negative impacts across all the core areas we inspected. For instance the number of patients having to wait in recovery more than 30 minutes was high.
- Discharge arrangements required improvement; we saw that only 35% of patients were discharged on or before their planned date of discharge.
- The care of the deteriorating patient was generally managed well.
- Arrangements for patients with reduced cognitive function were not always effective. This meant that some patients did not receive the level of care and support they required.
- The leadership was in a transition phase with many in interim posts.
- The culture within the trust was one of uncertainty due to the number of changes which had occurred.
- Staff could not communicate the trust vision and strategy.
- Governance arrangements needed to be strengthened to ensure more effective delivery.
- IT reporting needed to be improved to ensure reporting was accurate.

We saw several areas of outstanding practice including:

- On the Acute Medical Unit (AMU) at Birmingham Heartlands Hospital (BHH) local complaints resolution was very responsive to patient's needs. The complainant was invited to a meeting and given a recording of the discussion. This appeared to resolve complaints quickly.
- AMU, Ambulatory Care, wards 10, 11 and 24 provided excellent local leadership, services were well organised, responsive to patients individual needs and efficient which resulted in excellent patient outcomes.
- The Practice Placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.

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

- BHH Emergency department appeared at crisis with overcrowding and lack of flow, leading to a high stress, high risk environment for both patients and staff.

Summary of findings

- Arrangements for patients who required mittens were not undertaken to maintain patient's safeguards.

Importantly, the trust must:

- The trust must take effective action to achieve consistent staff compliance of infection control procedures within the emergency department.
- The trust must address the ambivalence held by staff about reporting incidents as they may be underreporting and trust could miss important trends.
- The trust must ensure that staff are clear about clinical responsibility for patient's awaiting handover by Ambulance services in the emergency department at Heartlands.
- The trust must take effective action to address the crowding in the majors area of the ED department and ensure that staff on duty can see and treat patients in a timely way.
- The trust must ensure all patients requiring items of restraint such as hand control padded mittens are supported with a mental capacity assessment, a DoLS and are regularly reviewed by the MDT which is recorded in the patient's notes and mittens are replaced when soiled. A consistent practice must be adopted across the trust.
- The trust must provide sufficient staff to operate the second obstetrics theatre at night, and prevent delays occurring.
- The hospital must improve the information available to outpatients departments to ensure that these are monitored and action taken to improve services through audit, trending and learning.
- The trust must take effective action to address the overcrowding in the majors area of the ED at Good Hope and ensure that staff on duty can see and treat patients in a timely way.
- The trust must review the operation of rapid assessment of patients to improve its consistency and effectiveness.
- The trust must ensure all fire doors and exits are free from clutter.

There were also areas of practice where the trust should take action, and these are identified in the report.

As a result of this, the trust will be subject to regulatory action as requirement notices and a comprehensive inspection will be carried out to confirm this.

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	Inadequate 	The trust had put in place processes to identify and manage risk to patients but not all were effective. There was a system for reporting incidents but staff views about the effectiveness of incident reporting were ambivalent. There was a streaming system to try to promote the flow of patients through the department and improve access to the services. The trust had provided or embedded the services of other stakeholders to support the response to patient's needs. There was a rapid assessment team in the major's area. However this area remained crowded, patients were waiting for beds to become available so they could be admitted to wards and staff did not have the room to see and treat people in a timely way. We heard no evidence that staff at any level were aware of a vision or strategy for resolving the problems faced by this emergency department on a daily basis. High risk and high stress from overcrowding and poor patient flow had become accepted as standard practice by nursing and medical staff and their leaders. Crisis was normalised within the emergency department and staff just got on with it and tried hard to cope. Local leaders were without the appropriate support to change this. Local leaders told us the trust was not responsive to escalation.
Medical care	Requires improvement 	Medical Care services at Heartlands Hospital required improvement despite the fact that care was delivered by compassionate and dedicated staff.

Summary of findings

Incident feedback for staff was poor and safety thermometer incidents had steadily increased over the last three months. Staff had not attended all mandatory training. Completion of risks assessments and responding to patient risks required improvement across some medical wards. Nurse staffing levels and appropriate skill mix was problematic across all medical wards and the ability to safely discharge patients in a timely manner was a concern. Staff did not feel involved in decisions about the wards they worked in. Local level leadership was supportive and nurturing, however communication and support from senior management and executive level was described as unsupportive and at times aggressive.

Surgery **Not sufficient evidence to rate**

Staff received feedback on lessons learnt from reported incidents. The World Health Organisation (WHO) five steps to safer surgery checklist was not always done in the anaesthetic room, data was input later due to IPAD connection problems which could lead to errors. There was no clear structure for theatre management. We could not identify clear leadership/ ownership.

An acuity tool was not being used to assess staffing levels on some surgical wards. Therefore staffing levels could not be accurately identified as adequate. However planned and expected staffing was monitored.

There were delays transferring patients from recovery to the wards because the wards were not ready to receive them. The discharge hub was not working well to assist in the discharge of medically/ surgically fit patients. The surgical wards did not use the “All about me” documentation (booklet with personalised information provided by family) to support people living with dementia.

Summary of findings

Staff said they did not feel supported by the trust senior management team. They said they were “Talked at not talked to,” and were not consulted about things that concerned them such as ward risks.

Maternity and gynaecology

Requires improvement

Safer staffing information were not visible for women and visitors to the ward. The midwife to birth ratio was worse that the recommended average. Current arrangements for the cover of a second obstetrics theatre needed to be improved. The hospital did have an onsite consultant 24 hours a day, 7 days a week which was meeting national guidelines.
Staff involvement in future planning of service delivery was lacking. We also noted that facilities and specific arrangements for people with disabilities were not robust.
There was a lack of visible leadership and the staff were unclear about the maternity strategy and felt powerless to affect service development and delivery. Staff worked well in their teams, but there was little interdepartmental co-operation.

Outpatients and diagnostic imaging

Requires improvement

The outpatient department at Heartlands Hospital require improvement to ensure that patients receive a service which is responsive to their needs and is well led. The lack of performance information, use of complaints and patient feedback meant that the service could not adapt and improve services for patients. There was a lack of visibility of senior managers within the department and no clear vision for the services undertaken within outpatients.
Diagnostic services and specialised services were led by enthusiastic and creative leaders who improved service for patients based on information and comments from patients.
Whilst patient complaints were low we could not ascertain if this was due to low expectations or lack of formal reporting of complaints. Patients we spoke with were generally satisfied with the service

Summary of findings

provided but expressed concern over delays, booking systems and the poor environment. There was a lack of information available to patients both in written form and verbally on their care and treatment. Some areas inspected such as the cardiorespiratory waiting area was unfit for the purpose.

Birmingham Heartlands Hospital

Detailed findings

Services we looked at

<Delete services if not inspected> Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Birmingham Heartlands Hospital

Birmingham Heartlands Hospital is the largest in the trust. Based in Bordesley Green Birmingham which is on the east of the city. It is also where trust headquarters are based. There are approximately 700 beds. The hospital is located in a more deprived area of Birmingham.

The hospital provides emergency services and elective and trauma surgery.

Trustwide information.

The population is culturally diverse with 46.9% non-white residents.

This trust is a Foundation Trust which means it is a not-for-profit, public benefit corporation. It is part of the NHS and provide over half of all NHS hospital, mental health and ambulance services. NHS foundation trusts were created to devolve decision making from central government to local organisations and communities.

Heartlands and Solihull Hospitals merged in 1995 and were joined by Good Hope Hospital in 2007. Finally joined by Solihull Community services in 2011. The organisation became a Foundation Trust in 2005.

The trust annual income was over £600m (2013/14).

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper

Inspection Manager: Donna Sammons

The team included CQC inspectors and a variety of specialists: Within the team were specialist advisors who had experience in accident and emergency, surgery and theatres including maxillofacial surgery, Medicine including respiratory medicine, cardiology and maternity and gynaecology. Within the team the specialists held positions which included;

- Professor of Medicine
- Consultants
- Junior doctor
- Registered Nurse and a newly qualified Nurse
- Registered Midwives
- Paramedic
- Associate Director of Governance
- Unit and Hospital Managers

Within our team were two experts by experience, who had experience either individually or with a family member having used the services of a NHS provider.

You should also be aware that experts who take part in the inspections are granted the same authority to enter registered persons' premises as the CQC inspectors.

Detailed findings

How we carried out this inspection

We carried this inspection out as an unannounced responsive inspection; and therefore the trust had no advanced notice of our inspection visit. We visited the three acute sites and talked to patients and staff including focus groups. Following the inspection we reviewed documents supplied to us by the trust.

We considered the trust under three of our five domains, and asked

Are services safe?

Are services responsive to patient's needs?

Are services well led?

We looked at four of our eight core services in detail and also looked at trust wide leadership. We visited

- Emergency Department (A&E)
- Medicine
- Maternity
- Outpatients and diagnostic imaging.

We looked at surgical services but an internal technical difficulty has prevented us being able to write a report at the detail we would wish, and summary information only has been provided.

Facts and data about Birmingham Heartlands Hospital

We have no additional facts about the service as this was an unannounced inspection so we were not able to develop a data pack for the trust and team.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	N/A	N/A	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Surgery	Not rated	N/A	N/A	Not rated	Not rated	Not rated
Maternity and gynaecology	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

Safe	Requires improvement
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

Heartlands Hospital is located in Bordesley Green, East Birmingham, covering east and central

Birmingham and serves a diverse urban population. It is a large site consisting of modern buildings, purpose built.

The emergency medicine directorate covers services at three hospital sites within the trust, Birmingham Heartlands Hospital, Good Hope Hospital at Sutton Coldfield and Solihull Hospital. Approximately 250,000 people attend the trusts' emergency departments each year.

The emergency department at Heartlands Hospital had 17 major and 15 minor cubicles, five resuscitation trolleys and included nine cubicles for children.

During 2013/14 there were 113,661 attendances at Birmingham Heartlands Hospital adult and paediatric emergency department and this resulted in 37,985 emergency spells of admissions to the hospital.

We visited the hospital unannounced on 9 December 2014, spoke with 12 patients and their relatives and 15 staff in a range of roles including from West Midlands Ambulance Service. We observed the care provided to patient's and looked at records.

This visit was undertaken to follow up on intelligence which led us to believe there may have been breaches in regulation occurring and follow up on outstanding non-compliance from a previous inspection November 2013.

We found in November 2013 that there was no effective triage facility for patients within the emergency department, and the speed of decision making and treatment needed to improve. The hospital struggled with patient flows as the emergency department continued to see increasing numbers of patients. The trust produced an action report to improve its services and we have been in regular contact with the trust to monitor the progress of the action plan.

Urgent and emergency services

Summary of findings

The trust had put in place processes to identify and manage risk to patients but not all were effective. There was a system for reporting incidents but staff views about the effectiveness of incident reporting were ambivalent.

There was a streaming system to try to promote the flow of patients through the department and improve access to the services. The trust had provided or embedded the services of other stakeholders to support the response to patient's needs. There was a rapid assessment team in the major's area. However this area remained crowded, patients were waiting for beds to become available so they could be admitted to wards and staff did not have the room to see and treat people in a timely way.

We heard no evidence that staff at any level were aware of a vision or strategy for resolving the problems faced by this emergency department on a daily basis. High risk and high stress from overcrowding and poor patient flow had become normalised by nursing and medical staff and their leaders. Local leaders told us the trust was not responsive to escalation. Crisis was normalised within the emergency department and staff just got on with it and tried hard to cope. Local leaders were without the appropriate support to change this.

Are urgent and emergency services safe?

Requires improvement

Summary

The trust had put in place processes to identify and manage risk to patients but not all were effective. There was a system for reporting incidents but staff views about the effectiveness of incident reporting were ambivalent.

The trust had policies and procedures for control of infection but we saw a number of breaches of infection control good practice. Not all staff complied with the trust policy at all times.

The paediatric emergency department was a large open space but the major's area of the department was cramped and not able to accommodate the number of patients that regularly arrived or the staff needed to treat and care for them.

There was a standardised procedure for the safe management of drugs but compliance with it varied across the emergency department.

Patient records were generally completed fully and staff were aware of their responsibilities in respect of safeguarding children and vulnerable adults.

The trust had an ambulance handover system and streaming and triage system in place. Some prioritising systems such as for patient's attending with chest pain were not working effectively. There was uncertainty about who was responsible for the large number of patient's waiting to be handed over to hospital staff by the ambulance service.

Despite busy and crowded conditions in the major's area, patients had a national early warning score assessment within 15 minutes of arrival. Not all patients for who it was appropriate, had the assessment repeated within the hour however to check for deterioration in their condition.

The department was running beyond its capacity, there were sufficient medical staff on duty to respond but they did not have the space to see patient's quickly. The nursing staff team were short of two qualified nurses and this increased the pressure on the team who had also to look after patient's ready to be admitted to wards but waiting for beds.

Urgent and emergency services

Incidents

- This was an unannounced inspection so we did not ask the trust in advance to share information with us. The emergency department clinical director across all three hospital sites told us that there had been two recent incidents requiring investigation; which involved moving a patient to make room for another seriously ill patient, whose condition may have been identified earlier.in order to deal with an in house cardiac arrest and a cerebral haemorrhage that was missed by medical staff.
- The trust used an electronic system for reporting incidents. Staff at all levels we spoke with told us they had access to this and understood their responsibility to report incidents. However, they also said that they got little or no feedback on the reports and had no confidence that any action was taken or lessons learned.
- Senior nursing staff in the paediatric emergency department told us that they did raise incidents but these were not actioned, for example a severe shortage of available oxygen saturation and pulse (Spo2) monitors.
- We looked at the process for reporting incidents and noted that there was a free text box for adding information that did not fit the drop down menu of incident categories.
- The trust had responded to our concerns earlier in 2014 about learning from incidents. The emergency department trust wide action plan included devising and distributing a monthly bulletin for all staff called 'Risky Business'. This was written by the consultant lead on risk for the directorate across all three hospital sites.
- We noted that learning about headache from the missed cerebral haemorrhage incident that required investigation appeared in a risky business bulletin. Nursing and medical staff referred to these publications when we spoke with them.
- Another publication called ED (Emergency Department) Pearls was distributed to doctors in the directorate. The risk lead consultant told us that these dealt with issues that have arisen from clinical incidents and the directorate then map these in with education and teaching. We saw an example of this on headache.
- There were contradictory views about incident reporting.
- A trainee doctor told us that they didn't have time to report incidents through the electronic system and they were not aware of any formal arrangements for learning from incidents.
- The consultant risk lead for the directorate said that the reporting culture was good, and matrons looked at and evaluated reported incidents on a daily basis, but acknowledged that getting information back to staff who reported incidents was a weakness in the system.
- The clinical director for the emergency department said that the reporting system was cumbersome and the directorate 'probably under reported'.
- We noted that the list of incidents waiting to be closed on the electronic system for ED across all three hospital sites was 157 at the time of our visit. The matron told us that this number of incidents should not still be 'open' and potentially not fully dealt with.
- The clinical director told us that the department conducts incident reviews and now includes the case for mortality and morbidity and gave an example of one during the previous week for cardiac arrest in the department.

Cleanliness, infection control and hygiene

- There were hand wash gel dispensers on walls at regular intervals around the department and also in the waiting area and supplies of personal protective clothing in all clinical areas for staff to use.
- Nursing and medical staff were 'bare below the elbow' in keeping with the trust policy. However we saw a number of breaches of infection control good practice. Not all staff complied with the trust policy at all times.
- For example a non-clinical leader was in the department wearing a suit jacket and tie. We asked why this was and they said they were just 'popping in and out of clinical areas'. This was not a good example to junior staff. They complied with the trust policy after our intervention.
- One doctor took a blood sample from a patient without wearing gloves. They then handled their security access card and a door plate to gain access to the sluice room without first using the hand wash gel that was mounted on the wall by the door. They said "Okay, yes" when we raised this with them but returned to the patient without indicating they would clean their hands.
- One staff nurse wore the same pair of gloves moving from treating one patient the resuscitation bay, to using the computer key board, to treating a different patient.

Urgent and emergency services

- When we arrived at 9am the major's areas of the department were dirty and untidy. For example there were some used tissues/wipes left on the floor for a number of hours, the blood gasses testing machine had blood smears on it which could contaminate the next sample to be tested.
- Audits for availability of alcohol gel at the point of care and evidence of adherence to trust uniform policy, personal protective clothing and bare below the elbow were part of the set of metrics of care indicators collected by the emergency department.
- We noted that resuscitation trollies and cubicles were thoroughly cleaned down after use.
- Housekeeping staff were reduced to only one in post at the time of our visit and it was the responsibility of nursing staff to clean their own equipment.
- We observed that there was a serious problem with management of disposal of clinical waste (orange bags) in the hospital. We escalated our concern to the operations manager before we left the site and were assured that it would be dealt with.

Environment and equipment

- The major's area of the department was cramped and not able to accommodate the number of patients that regularly arrived or the staff needed to treat and care for them. Nurse Managers told us that the department had lost a waiting room in the reconfiguration of the building.
- During our inspection all five resuscitation beds were occupied. Nursing staff told us this was usually the case and on a couple of occasions over the past year they had fitted seven patients in to the five cubicle bay; "We manage, we have already identified the next patient on their way."
- The paediatric emergency department was a large open space. Senior nursing staff told us there was a severe shortage of equipment however, such as availability of Spo2 monitors.
- Cardiac arrest trolley checks that we looked at in the minor's area were completed and up to date.

Medicines

- There was a standardised procedure for the safe management of drugs but its compliance varied within the emergency department.
- The controlled drugs records book in the paediatric emergency department was up to date and administration records were signed by two staff as they should be for safety and security.
- However the controlled drugs record book in the adult major's area showed two recent entries for the administration of morphine that had only one signature. Some medication in store in packets was beyond their expiry date.
- We raised this with a nurse on duty who was not aware of it and wasn't sure of what action would have been taken in relation to it.

Records

- We looked at 13 sets of adult patient records and 10 sets of paediatric patient records, including risk assessments. They were generally fully completed.

Safeguarding

- Staff that we spoke with in different roles were aware of their responsibilities within the trusts policies for child and vulnerable adult safeguarding.
- Junior nurses told us they had undertaken safeguarding training and that the department made 'quite a lot of safeguarding referrals'.
- The prompt for safeguarding consideration was shown as done on the records for seven patients out of the ten patients that we looked at.
- The ED department across all three hospital sites reported in its November 2014 edition of Risky Business a significant increase in enquiries about children at home (the invisible child) by ED staff treating adults with mental health issues, alcohol and drug misuse between 2014 to 2014.

Assessing and responding to patient risk

- When we arrived at 9am there were very few patients in the general waiting area of the emergency department. In the major's area however, there were patients waiting on trolleys and chairs in the corridors, all of the treatment bays were occupied and the area was overcrowded and looked chaotic.
- When patients booked in at reception they were streamed for paediatric, major or minor injuries/ conditions and their details logged on an electronic system.

Urgent and emergency services

- A GP service operating within the department had access to the electronic system and it selected and saw patients who had presented with conditions that did not need the emergency department services.
- Advanced nurse practitioners saw patients streamed through the minor's route. Consultants and nurse managers told us that this worked very well.
- West Midlands Ambulance Service provided a 20 hour day handover support service within the department. Ambulance crews conducted a hand over of a patient to a HALO (Hospital Ambulance Liaison Officers) in the major's area and the HALO booked the patient in to the emergency department.
- The HALO remained in a clinical role of responsibility for the patient until they were assessed by nursing staff. However the HALO was not able to make a clinical decision during the time that the patient waited. This could take up to an hour when the department was very busy.
- Ambulance crew told us that at busy periods they cannot handover patients to a nurse, doctor or HALO and this often results in patients being left in the corridor.
- Ambulance crews were not clear about who had responsibility for patient's when they were in a queue and sometimes felt it necessary to stay with patients they felt had potential to deteriorate; 'the HALO may be responsible for a large number of patients as well as the turnaround of vehicles'.
- This lack of clarity with respect to clinical responsibility for queuing patients was echoed by nurses in the rapid assessment team (RAT).
- Records for 10 adult patients in the majors area showed that all had a standardised National Early Warning Score (NEWS) assessment undertaken within 15 minutes of admission although 4 of the 6 patients for whom it was relevant, did not have the assessment repeated within an hour. One patient had been over 3 hours in the department and had not had the assessment repeated.
- Records for three patients whose records were available to us, waiting on trollies in corridors around the time of our arrival showed all three had NEWS assessments within 15 minutes of arrival. One patient age 87 scored at 4 (the top of the low range of risk,) had not had the assessment repeated after one hour as would be expected. When we asked about this a doctor repeated the assessment and said the patient's score remained at 4. Notes for three other patients waiting on trollies in corridors were not available to us at the time we asked as the patients were in the process of being assessed.
- Managers showed us the overview of current capacity that was electronically tracked. It showed that there were four patients in the paediatric department, five patients in the resuscitation bay, ten patients referred for medical beds within the hospital and waiting for those beds to become vacant and ten patients waiting in the major's area to be seen.
- The matron told us that those ten patient's had been rapidly assessed.
- It was a cold day and patients were waiting on trollies in a draughty corridor. Ambulance crews told us they were beginning to leave patients in the vehicles.
- The matron told us that a crate of extra blankets had been ordered before we arrived to address this. However one patient waiting to be handed over by ambulance staff in the hallway near an open door was underdressed in their night wear. We had to point this out to the ambulance crew before the patient was given an extra blanket.
- Not all of these systems were working effectively. Reception staff told us about the system in use to ensure that any patient arriving with chest pains were seen and assessed within 15 minutes. It included sending the patients straight through to the mayor's area and giving them a large red card to hold so nursing staff could visually identify them while they waited and prioritise their assessment.
- At 10.30am we spoke with one patient who appeared worried and uncomfortable and they told us they had chest pain and had not yet been seen by nursing or medical staff. They confirmed they had been sent straight to the major's area but were not given a red card. Reception records showed that the patient had already been waiting over 15 minutes when we spoke with them. They were not given a red card because reception had run out of them. They were assessed for chest pain within 40 minutes of arriving in the department.
- Consultants told us that overcrowding in the emergency department had been reported as an incident through the Electronic system 'numerous times' but was ignored

by the trust. “The escalation process doesn’t exist in reality. The trust is not responsive to escalation. Escalation fatigue is commonplace”; “there is no point in escalating as no changes are forthcoming”.
- We noted that the emergency directorate risk register across all three hospital sites had ‘impact of extended stay in ED’ ranked as a high risk.

Nursing staffing

- Matron told us that the department had rostered 14 nurses and was short of two nurses on the morning of our visit due to staff sickness.
- All nurses on duty were qualified with the addition of two health care assistants. The department was dealing with a backlog of patients from the previous day when 396 patients had arrived at the department.
- There was a nurse on duty in charge of the paediatric emergency department. Senior nursing staff
- told us that they were aware of ‘regular’ staff resignations in the paediatric emergency department.
- The clinical decisions unit (CDU) also part of the emergency department, was staffed by one nurse and one health care assistant.
- Matron told us that vacancies and gaps in the rosters were usually filled with bank staff (these are the trust’s own staff covering extra shifts) with the use of ‘a couple’ of agency nurses that regularly work for the trust and were therefore familiar with the department.
- Two patients we spoke with were confused or distressed, alone in a cubicle and found it difficult to express themselves. All nursing and care assistant staff were busy elsewhere at the time.
- Nurse Managers told us that there were not enough nurses and healthcare assistants to look after patients with complex needs who were waiting hours to be admitted to the wards as well as treat patient’s arriving through the door.

Medical staffing

- On duty were two consultants, two senior house officers, two middle grade doctors and two advanced nurse practitioners and one trainee doctor. In CDU there was a trainee nurse practitioner certified (NPC) on duty. A nurse consultant was expected on duty at 10am.
- Advanced nurse practitioners saw patients in the minor’s stream of the service.
- The emergency medicine consultant told us that the department was running at 100% capacity and was as busy at night as during the day seven days a week and throughout the year. Staffing levels had been increased overnight to respond to this .
- We did not note any issue about availability of medical staff during our visit.

Major incident awareness and training

- There were supplies of major incident equipment, written protocols and staff jackets which identified specific roles, easily available and neatly organised on the wall of a staff meeting room.

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

Inadequate

Summary

The trust had put in place systems to improve the responsiveness of the ED department but these were not meeting the needs of the local population on a daily basis.

There was a streaming system to try to promote the flow of patients through the department and improve access to the services. The trust had provided or embedded the services of other stakeholders such as GP, community nursing and the ambulance service to support an appropriate and proportionate response to patient’s needs. The minor’s area of the ED was staffed by advanced nurse practitioners.

Flow through the department was nevertheless very poor and the majors department was crowded. Patients had been bedded down over night and others were also waiting in corridors to be admitted to wards. The premises did not meet people’s needs. There was insufficient space for staff to see patients in a timely way and some medical staff were unoccupied while they waited for cubicles to become free.

People were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis and treatment. People were experiencing unacceptable waits for some services. There was a rapid assessment team but metrics collected by the department showed that on some days many patients were waiting up to 30 minutes

after arrival to be assessed. The trust was not meeting target times for ambulance handover; patients to be seen by a clinician or the national target for seeing, treating and discharging 95% of patients within four hours of arriving.

Escalation procedures were ineffective as daily operations/ site meetings did not effectively assess the whole hospital situation or risk level to support the emergency department.

There was no structured approach to supporting patients with complex needs such as mental ill-health and dementia. There was a social worker based within the department and there were plans to convert a small room to provide a domestic violence in reach service.

Service planning and delivery to meet the needs of local people

- There was a streaming system to try to promote the flow of patients through the department and improve access to the services.
- This included a GP service provided by the trust operating within the department from 10am to 10pm. This service saw on average 60 patients who came to the emergency department each day.
- A community matron worked closely with the department to support effective discharge with community care from social care commissioners and providers.
- The West Midland Ambulance Service provided 20 hours of staffing each day to the majors stream in order to support and speed up the ambulance handover process.
- Nurse managers told us that the paediatric emergency department was going to lose three beds in the near future because of a building reconfiguration plan.

Meeting people's individual needs

- Information that we requested from the trust during the inspection did not demonstrate comprehensively the progress being made within their Equality Delivery System.
- We saw one patient shouting at staff and being racially abusive to them. Staff nurses acted appropriately and used conflict management strategies diffuse the situation. The patient left the department.
- One patient who had been waiting for 90 minutes in the draughty corridor told us that their care had been good despite the overcrowded situation.
- A consultant told us that they spoke a number of languages and there was no difficulty getting quick access to interpreters for a wide range of Asian and Eastern European languages. Trainee doctors told us that they used the language telephone line and found it effective.
- At one point in the day we noted that there were 11 people in the main waiting area of the department and eight of them were using a language other than English.
- There was no information or guidance on display about using the department in any of the waiting areas except a small leaflet written in English.
- There was no specific system in place to support patients with learning disability or living with dementia and enable staff to identify them and respond appropriately to their specific needs while they waited in the department.
- Two patients with mental ill-health were alone in cubicles for some time and seemed confused and disorientated when we spoke with them.
- There was a social worker based within the department and staff told us of plans to convert a small room to provide a domestic violence in reach service.
- A system for collecting a range of care indicator metrics had been set up within the department across all three hospital sites. These metrics/ quality markers were to provide assurance supporting a regular process across the directorate and develop a risk assessment approach.
- The pain management metrics for ED/majors for example required evidence that appropriate analgesia had been offered to a patient within 30 minutes of assessment. We found from 10 sets of adult patient notes that a pain score of over six out of ten had been recorded for seven patients. Five of those patients were not offered analgesia in the ED.

Access and flow

- When we arrived at 09.10 there were five patients on trollies in corridors in the major's area of the department.
- Staff told us that four patients had been bedded down in the minor's area over night and this was common practice and happened most nights.
- Ambulance crew told us that there had been 35 ambulances lined up waiting outside the department during the day before our visit.

Urgent and emergency services

- Senior nursing staff told us that in the major's area on the day of our visit; 11 patients had remained in the department for over four hours; two patients for over 10 hours; one patient for over 11 hours in the minor's area and one patient for over 12 hours in the resuscitation bay. Ten patients were waiting in the major's area to be seen.
- The major's area remained crowded all day and we noted on a number of occasions up to 15 medical and nursing staff of different grades and roles standing crowded together within the nurses station, many simply waiting.
- Doctors told us that they could not treat patients as they had run out of space in which to do it. We observed doctors introduce themselves to a patient waiting on a trolley, apologise and tell them that they would be able to see them as soon as a cubicle became vacant.
- One doctor told us they were often asked to see patients in corridors or in the relative's lounge.
- Ten patients had been referred for medical beds within the hospital and were waiting for those beds to become vacant.
- We noted that there were eight empty beds in the adjoining Clinical Decisions Unit which was part of the emergency department.
- Another frail patient waiting in the draughty corridor told us they had been waiting for two hours to go home after seeing an advanced nurse practitioner (ANP).
- When the trauma call went off we observed the resuscitation team efficiently move a patient out of a resuscitation cubicle into the corridor and prepared the space for the incoming patient, the consultant was present and ready to receive the patient.
- Consultants told us they had major on-going concerns with delays and capacity problems. They were worried that an incident might happen.
- The trusts metrics showed the emergency department at Heartlands Hospital had missed its target for assessing patients within 15 minutes of arriving each day from 5 November 2014 to 16 November 2014. Patients had been assessed within 30 minutes of arriving on each of those days.
- For the same period, the target of one hour from time to arrival to seeing a clinician was not met on nine of the 13 days. Most patients were seen within 75 minutes but on one Saturday the average time was one hour and forty minutes 8.November2014.
- From 5 November 2014 to 16 November 2014 the department had missed the national target for seeing, treating and discharging 95% of patients within four hours of arriving for 12 out of the 13 days. On six days it fell below 90%.
- For four days during the same period over 10 patients, waiting to be admitted to wards, waited over eight hours in Heartlands Hospital emergency department.
- For four days during the same period 10 or more patients waited over 30 minutes to be handed over by ambulance staff, on one day three patients waited for one hour.
- Escalation procedures were ineffective. We observed an operations/site meeting held at 4pm with senior nursing, medical and operational managers. It did not effectively assess the whole hospital situation or risk level to support the emergency department.
- In the 24 hours preceding our arrival there had been 80 breaches of the national target to see, treat and discharge patients within four hours of arriving at the emergency department.

Are urgent and emergency services well-led?

Inadequate

Summary

There was no credible statement of vision and guiding values. We heard no evidence that staff at any level were aware of a vision or strategy for resolving the problems faced by this emergency department on a daily basis. High risk and high stress from overcrowding and poor patient flow had become normalised by nursing and medical staff and their leaders.

The emergency department generated real time data to measure performance against key target points of response to patients when they attended the department. A system for collecting a range of care indicator metrics had been set up within the department to manage risk. The 'impact of extended stay in ED' ranked as a high risk on the trust wide risk register.

There was no effective system for identifying , capturing and managing issues and risks at team, directorate and organisation level, with significant issues that threaten the delivery of safe and effective care not always receiving

adequate action to manage them. The trust had very recently developed a Standard Operating Procedure for emergency department escalation trust wide at all three hospital sites. However local leaders told us the trust was not responsive to escalation. Daily operations/site meeting were ineffective in addressing the risk from overcrowding and patient flow through the emergency department.

Local leadership was not engaged and staff believed the chaos and overcrowding was normal. Even newly trained staff assumed that every ED nationally was operating in this way and the problems could not be solved at a local level.

There were high levels of stress and work overload. Crisis was normalised within the emergency department and local leaders were without the appropriate support to change this.

Vision and strategy for this service

- We heard no evidence that staff at any level were aware of a vision or strategy for resolving the problems faced by this emergency department on a daily basis.
- The trust had developed the role of advanced nurse practitioners in the department across all three hospital sites. Leaders at Heartlands Hospital emergency department told us that they provided essential support now and were highly valued, but although clinically capable, they lacked any departmental oversight.
- High risk and high stress from overcrowding and poor patient flow had become normalised by nursing and medical staff and their managers.

Governance, risk management and quality measurement

- The emergency department trust wide generated real time data to measure performance against key target points of response to patients when they attended the department. These included ambulance handover time, time to assessment, time to treatment and the length of time patients waited in the department.
- The emergency directorate risk register across all three hospital sites had 'impact of extended stay in ED' ranked as a high risk. However there was no updated review of this situation on the register which stated 'review in 2013'.
- The risk lead for the directorate told us that it had been reviewed and this risk was also on the trust risk register and not just regarded as an emergency department risk alone.
- In response to safety concerns expressed by the emergency department directorate, we noted the trust had developed a Standard Operating Procedure for emergency department escalation trust wide at all three hospital sites. This was due to be introduced operationally on 9 December 2014. It relied on data collected hourly by a band 7 nurse and inputted to the emergency department matrix.
- A system for collecting a range of care indicator metrics had been set up within the department to manage risk.

Leadership of service

- The emergency directorate shared consultants and advanced nurse practitioners across three hospital sites. There was a clinical lead for each hospital and the clinical director was responsible for all three sites. There was a matron at Heartlands Hospital emergency department.
- Local leadership appeared to be weak. For example; local leaders did not challenge medical and senior administrative staff who were not complying with trust policy on hygiene and control of infection. They were not aware that the red card system for chest pains was not working effectively.
- Local leaders told us the trust was not responsive to escalation. Staff in the ED just got on with it and tried hard to cope and look after patients properly.
- The operations/site meeting we observed was ineffective in addressing the risk from overcrowding and patient flow through the emergency department.
- They told us there had been a push within the trust to address the patient flow issue in majors but despite this there remained a block in discharges from 2pm to 8pm daily. The number of staff available to emergency care was diluted when a high number of patients were waiting to be admitted to speciality wards and needed to be looked after.
- Despite the fact that the majors area was overflowing with patients medical staff were unoccupied at times and this was not being managed.
- Some local leaders appeared exhausted and others were cynical about achieving improvement and fearful of imminent calamity.

Culture within the service

- Medical staff and newly trained nurses told us that the department provided a very supportive learning environment.

Urgent and emergency services

- We noted that staff were doing their best to provide care and treatment under relentlessly difficult conditions. Looking after the team was absorbing local leader's energies at the expense of firm leadership.
- Local leaders told us that 'escalation fatigue was commonplace' and they were surprised that staff sickness levels were not higher than they were.
- We noted that staff believed the chaos and overcrowding was normal. Even newly trained staff assumed that every ED nationally was operating in this way and the problems could not be solved at a local level.
- Crisis was normalised within the emergency department and local leaders were without the appropriate support to change this.
- Innovation in practice was supported and encouraged by local leaders.

Medical care (including older people's care)

Safe	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Birmingham Heartlands Hospital is the largest of the three hospitals and is located in Bordesley Green, East Birmingham, covering East and Central Birmingham. The site has a total of 750 beds, 628 of these are divided between acute medical and surgical beds.

There are 13 medical wards with four additional wards providing medical care as the second speciality.

We inspected Heartlands medical care services on 9 December 2014 and visited medical care wards and also wards where patients with medical care needs were staying; wards 2, 24, 26, 28, AMU (acute medical unit), Ambulatory Care, Beech ward (acute stroke) and the Hyper Acute Stroke ward.

We talked to 27 patients including some of their relatives and 100 staff to include: health care assistants, nurses, senior ward sisters, ward managers, senior managers, medics and consultants.

Summary of findings

Medical services at Heartlands Hospital required further improvement despite the fact that care was delivered by compassionate and dedicated staff.

Incident feedback for staff was poor and safety thermometer incidents had steadily increased over the last three months. Staff had not attended all mandatory training.

Completion of risks assessments and responding to patient risks required improvement across some medical wards.

Nurse staffing levels and appropriate skill mix was problematic across all medical wards and the ability to safely discharge patients in a timely manner was a concern.

Staff did not feel involved in decisions about the wards they worked in. Local level leadership was supportive and nurturing, however communication and support from senior management and executive level was described as; unsupportive and at times aggressive.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Summary

Medical services at Heartlands Hospital required improvement. Staff reported incidents but received limited feedback to learn from lessons.

A decrease on performance in all four areas relating to safety thermometer audits over the last three months meant patients safety was an issue. Infection control across medical wards was satisfactory. However, completion of documentation and responding to patient risks was a concern. Staffing levels across medical wards was safe, but heavily supported by bank and agency staff that were not always familiar with operation of the wards and individual patient needs. Local leadership was good; however communication to ward staff from senior management and executive leadership required improvement.

Incidents

- There were systems for reporting actual and near miss incidents across the medicine division and staff told us they reported incidents when they occurred. Staff told us they found reporting staffing level concerns particularly difficult as the incident reporting system options were not straightforward. Staff told us this discouraged staff to report staffing concerns electronically. In many cases only verbal concerns were raised. This was a similar picture across all three hospital sites
- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There had been no (zero) reported never events within the last 12 months across medical wards.
- Opportunities to learn from incidents and obtaining feedback from senior colleagues did not occur, nurses told us they did not have the time and senior management did not make this a priority.
- The Trust monitored its mortality rate on a monthly basis using the Hospital Standardised Mortality Rate (HSMR) available from Dr Foster and on a quarterly basis using the Summary Hospital Level Mortality. However one ward sister was unaware of the mortality folder on their ward and told us they did not know what it was for or what happened to the data collected.
- Doctors told us mortality reviews were carried out monthly without nursing input. Doctor's felt nursing input would make the review more meaningful, but nurses were too busy to be involved.

Safety thermometer

- Results of the safety thermometer were displayed on every ward and area we visited to include pressure ulcers, falls, VTE (venous thromboembolism) and CAUTI (catheter acquired urinary tract infections). The results related to that individual ward or area and showed comparison with results for the previous month.
- Reported, avoidable pressure ulcers on ward 2 had decreased since August 2014 and had stabilised from September 2014. Incidents of falls for the same ward had increased between September and October 2014, however falls with injury had decreased and remained at zero from August 2014. AMU incident figures showed no reported pressure ulcers since December 2013, however, there had been a sharp increase in falls since August 2014 which stabilised from September 2014. Beech ward recorded a small increase in reported avoidable pressure ulcers between September to October 2014 and a 50% decrease in falls with injury from September.

Cleanliness, infection control and hygiene

- All staff were aware of current infection prevention and control guidelines.
- There were sufficient hand wash sinks, hand gel, towel and soap dispensers in all wards except one. The hand gel dispensers to Ward 28 Infectious diseases ward were both empty.
- We observed staff consistently following hand hygiene practice and 'bare below the elbow' guidance. Aprons and gloves were readily available in all areas.
- 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.

- All wards carried out a monthly audit which looked at infection control procedures such as commode cleanliness. Results were displayed on ward corridor and we saw action plans in place for wards who had not met the standard.
- For example, ward 2 had been placed in a red zone because it had not met the required standard of cleanliness; we were told an action plan had been put in place to improve future practice.
- Two out of three patients who wore hand control padded mittens to reduce the risk of patients pulling out their NG (nasogastric tube) and self-harming had dirty mittens. We asked staff how often the mittens should be changed, one nurse told us when dirty another nurse told us weekly. We asked if the mittens could be replaced with clean ones, however the ward had none available and could not locate another pair in the hospital.
- We were told new mittens would be ordered that day.

Environment and equipment

- Resuscitation equipment on most wards had been checked regularly, equipment was in date, appropriately packaged and ready for use. However, the resuscitation trolley on ward 2 was piled up with papers and boxes of gloves, which made access to equipment in an emergency a problem.
- Pressure relieving mattresses 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.
- Ward 2 nurses reported lack of nebulizer equipment throughout the Heartlands hospital site. We were told how five patients required a nebulizer at the same time. There was only one available which had to be shared between five patients. This meant a delay in patients receiving their medication.

Medicines

- One patient on ward 2 was asleep with three tablets on his chest which was clear he had spat out. This was brought to the attention of nursing sister.
- A patient on ward 28 was prescribed a further I.V (intravenous infusion) at 5am which had not been administered until the inspection team alerted the nursing staff at midday.
- All wards had appropriate storage facilities for medicines, and safe systems for the handling and disposal of medicines. All ward based staff reported a good service from the pharmacy team.
- The trust had a pharmacist as controlled drugs (CD) 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. Regular check of controlled drugs balances were recorded.
- Nurses and doctors had achieved 100% in medicine management training.
- Fridge temperatures were regularly checked, recorded and adjusted as appropriate.
- However, we found no evidence that temperatures within medication storage rooms were checked.

Records

- Patient records included a range of risk assessments: manual handling, falls, nutrition and pressure ulcer damage with associated care plans. Risk assessments were completed and reviewed weekly in most wards except ward 2, where we saw three patient's records had no recordings for several days for skin inspections.
- Two patients on ward 28 had no VIP score completed for more than 24 hours. A VIP score is the Visual Infusion Phlebitis score used for monitoring infusion sites. The VIP score determines when an infusion device should be removed, to avoid harm to the patient and is should be completed at each nursing intervention.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) paperwork was completed accurately and appropriately where indicated. There was evidence that decisions had been discussed with patients and their relatives.
- We saw comprehensive and well documented wound management plans. These showed wounds were assessed; treatment records were in place evaluated to show progress of healing.
- In most areas records were not stored securely; there were instances where patient records were stored in unlocked trolleys at nurse's stations. This increased the potential for patient confidentiality to be breached.

- Documentation relating to the decision, review and care of patients using hand control padded mittens was not robust, for example, care plans, checklists and multidisciplinary review meetings had not been recorded for all patients using mittens.

Safeguarding

- Staff were aware of the trust safeguarding policy and the processes involved when raising an alert.
- Staff received training at induction and at three yearly intervals. Medical staff achieved 98% attendance against the trust's 85% target for Safeguarding adults (basic awareness) level 1, and met the target of 85% for safeguarding (enhanced awareness) level 2.
- Staff knew the name of the trust safeguarding lead, were well supported and told us they would seek advice if they had safeguarding concerns.
- We saw safeguarding alerts were completed within the recommended 24 hour timeframe and alerts were relayed verbally during staff handover times to ensure all staff were aware of patient's safeguarding issues.
- Three patients on ward 17- acute stroke care had been assessed as requiring hand control padded mittens to reduce the risk of patients pulling out their NG (nasogastric tube) and self-harming. This is considered as a form of restraint and can be in the best interest of the patients.
- None of the patients had been supported with a DoLS (deprivation of liberty of assessment) or had received a mental capacity assessment. We were told by nursing staff that all three patients had dementia and were unable to make decisions for themselves. One of the patients had mittens in place for six weeks, without a multi-disciplinary review to agree the need to continue wearing them. The mittens were visibly dirty.
- Staff told us mittens were removed and patient's hands were washed and dried three times a day and mittens reapplied. However, no staff on ward 17 could tell us when that day had the mittens been removed or how often should mittens be replaced with fresh ones. The trust care plan and guidelines stated the mittens to be replaced each day. There was a daily checklist in place for staff to sign when mittens had been removed; however, this was not up to date for all three patients.
- Staff were unable to replace the soiled mittens as they had none in stock.
- There was an inconsistent and relaxed approach to the care and management of hand control padded mittens across Heartlands and Good Hope hospital sites.

Mandatory training

- Ward sisters told us staff attendance to mandatory training was an area for improvement, we saw this was an issue across all three hospital sites. The trusts target for mandatory training attendance was 85%, across the medical directorate this was achieved in areas of falls awareness, manual handling theory and health and safety. However, attendance to fire safety was 60% and manual handling for patients was 73%. Specialist training for administering blood transfusions was 50%, attendance to basic life support was 63% and advance life support attendance was 30%.
- Nurses and healthcare assistants told us they knew there were some gaps with their mandatory training, however the priority was ensuring safe staffing levels and training came secondary.

Assessing and responding to patient risk

- An early warning score system was used throughout the trust to alert staff if a patient's condition was deteriorating.
- We saw that the early warning indicators were regularly checked and assessed. Where the scores indicated that medical reviews were required staff had escalated their concerns. Medical reviews and repeated checks of the early warning scores were documented.
- Patient wristbands had a colour coded system to alert staff if the patient had known allergies or there was a risk of the spread of infection.
- Where patients required NG (naso-gastric) tubes we saw that scans were used to ensure the tubes were correctly inserted into the stomach, reducing the risk of aspiration.
- Patients who were at risk of pulling out their NG tubes were identified and supported with padded mittens to reduce the risk of self-injury.
- All patients who were at risk of pressure damage were supported with appropriate pressure relieving equipment such as airwave mattresses and cushions.

Medical care (including older people's care)

Nursing staffing

- Ward managers and senior sisters met three times per day, 8am, 11am and 3pm to discuss bed capacity and nursing staffing levels to ensure beds were occupied and staffing levels and skills were appropriately deployed and shared across all wards.
- Ward sisters across all wards told us staffing levels was a daily concern and a high usage of agency staff was common practice.
- Agency staff did not have access to electronic medication administration and were unable to assist with medication rounds; nurses told us this placed increased pressure on permanent staff who were administering medication and also ensuring agency nurses were supported during the shift.
- Nurses did not attend wards rounds as they were too busy, this made communication between nurses and medics fragmented.
- Nursing staff had been moved from their regular ward to another ward to due to staff shortages. Staff did not feel that they had the skills or experience to adequately care for patients on their new ward; we saw this was a similar picture across all three hospital sites.
- Wards used the AUKUH acuity and dependency tool, designed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and patient flow. We were told by ward sister's data was collected and analysed annually to predict staffing level needs, however ward sisters were told they could escalate to matrons at any time if they had concerns about staffing levels or a patient needed one to one support.
- Three patients on ward 2 required one to one support to maintain their safety, we were told they were unable to fill each agency request and we saw one healthcare assistant attending to each patient in rotation and unable to provide individual and continued support to maintain patient safety.
- We saw there were gaps in the rota for some wards which were unsuccessful in filling vacant shifts.
- Staff told us they regularly work over their contracted hours due to staff shortages.
- Ward 24 and 26 staffing levels were safe and staff responded to patients needs in a timely manner.
- Reduced levels of porters at weekends meant staff were frequently asked to escort patients to the X-ray department several occasions throughout the weekend which left the wards short on occasion.
- Proportion of shifts reported as having nursing shortfalls showed ward 2 at 26%, AMU at 67% and Beech ward at 26%.

Medical staffing

- Medics from all levels from junior doctors to consultants reported being under pressure, particularly on Fridays, especially with the challenge to discharge as many patients as possible to make room for weekend admissions.
- Ward rounds by consultants were daily on weekdays and at weekends only for newly admitted patients.
- Locums were used to backfill medic vacancies, sickness and annual leave.
- Medical Care Consultants reported good relationships with surgeons and radiology department with sound collaborative working.

Are medical care services responsive?

Requires improvement

Summary

Whilst staff responded to patients needs across medical wards there was continual pressure to free up ward beds for newly admitted patients. This meant that some patients could not be placed in the right bed at the right time for their needs. Discharges were sometimes rushed which resulted in complaints from families or readmission to hospital.

Service planning and delivery to meet the needs of local people

- As a result of high admissions medical patients were admitted to non-medical wards, known as outliers. For example ward 17 acute stroke ward, 50% of patients were outliers with conditions such as respiratory, unstable diabetes, dementia and systemic infection conditions.
- Ward 2 had 4 outlier patients.
- Ward managers advised us there was a system in place to ensure that medical outliers were reviewed regularly by a consultant. However, nurses and medics expressed concern that there was a risk that patients did not receive the care and treatment they required because they were not in the "right bed".

Medical care (including older people's care)

- Nurses told us, there is a risk that medical patients may get missed from the ward round especially if a locum doctor was on duty that was not familiar with all the patients, occupying beds in other wards.

Access and flow

- Wards 2 and 17 were described by nursing staff as being in a transitional stage and appeared disorganised and complex in terms of admission criteria and discharges.
- Patient discharges rarely occurred before mid-afternoon.
- Ward 2 discharges were triggered by ward nurses. Nurses told us they did not have time to coordinate and follow up discharge plans and that the Discharge Liaison nurses were only involved if discharge were complicated. Out of 34 patients on ward 2, 13 were medically fit for discharge but had social reasons such as awaiting social service assessment or funding for packages of care preventing their discharge.
- Junior doctors reported increased pressure particularly on Fridays, exhorting teams to discharge as many patients as possible to make room for weekend admissions, both nurses and doctors confirmed rushed discharges had occurred across medical wards resulting in readmissions and poor patient outcomes.

Meeting people's individual needs

- Risk assessments were completed and care plans in place for patients in most wards, though not always updated at regular intervals.
- Single-sex bays were in place across all medical wards.
- Specialist nurses for dementia, dietician, tissue viability and heart failure provided individualized care for patients with specific conditions and supported staff.
- Support was provided by the speech and language therapists for patients with aphasia following a stroke.
- The chaplaincy team offered religious and spiritual support to patients and relatives.
- Interpretation services were available in both language line (a telephone translation service) and face-to-face interpreters; however staff did not always use the service. We saw three occasions when patients translated for other patients in their bay as staff could not understand and respond to patient's needs. For example one patient was crying for assistance. We alerted a member of staff who told us "X is fond of crying". The patient opposite advised us her oxygen mask was causing her pain and she wanted to remove it. This was relayed to staff who attended to the patient.
- Consultants reported Endoscopy suite at Heartlands Hospital was not fit for purpose, due to limited facilities, cramped conditions which adversely impacted on the medical team's ability to ensure patients received procedures in a timely manner

Learning from complaints and concerns

- Patients across all medical wards were satisfied with the quality of service they received. We were told by several patients nurses were kind and caring but often rushed around the ward.
- Staff followed the trusts complaints policy and provided examples of when they would resolve concerns locally and how to escalate when required.
- PALS (patient advice and liaison service) leaflets were not readily available for patients as they were often displayed by nursing station and not by the patient's bedside; this was a similar picture across all three hospital sites.
- AMU service demonstrated good complaints management. Complainants were invited to meet a senior member of staff. The meeting was recorded and a copy of the recording was given to the complainant in the form of an audio disc. Staff explained the new system worked very well for both complainant and staff and the outcome of the complaint was shared among staff to share lessons learned to improve future practice.
- There was an inconsistency across services about giving patients information and details about how to raise concerns or complaints. Some wards displayed information in communal areas which was not easily accessible for patients who rarely mobilised outside their bays.

Are medical care services well-led?

Requires improvement

Summary

Staff could not articulate the trust vision and values and felt decisions were made without their engagement. Staff felt ignored by middle management and the trust executive team unless there was a problem and then a 'heavy handed approach was adopted. There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated.

Medical care (including older people's care)

The culture was top-down and directive. It was not one openness and transparency. Staff across all medical wards were dedicated and compassionate, despite the majority of staff feeling despondent. Local leadership was supportive and nurturing. Ward sisters and ward managers demonstrated they cared for their staff as much as their patients.

Vision and strategy for this service

- We talked to 100 staff from various disciplines and grades across eight wards and no one could articulate what the trusts or their respective service's vision or future strategy was.
- Individual staff spoke with pride and compassion about what they thought good care looked like and how they demonstrated this on a daily basis.
- Some senior staff were clear on the direction of travel of the trust, however local staff were confused and one ward manger told us it's an achievement if we have a full complement of staff each day.

Governance, risk management and quality measurement

- Governance initiatives were carried out monthly to measure risk and quality on medical wards. These included patient safety thermometer audit conducted on each ward monthly and a monthly audit of areas of potential risk to include: falls, pressure ulcer prevention, cannula checks, and commode cleanliness. However, the risk register did not include all risks identified such as high usage of agency staff and the impact this had on quality of care and the inability by many medical wards to facilitate timely discharges for patients.
- Ward results were displayed and any wards that fell into the red area were given an action plan to follow to improve future practice.

.Leadership of service

- All nursing staff spoke highly of senior sisters and ward managers as local leaders and told us they received good support.
- We observed good working relationships between nursing, therapists, specialist nurses and medical staff across all medical wards.
- Annual staff appraisals had not been conducted for all staff. Nurses told us appraisals were rushed and they were linked to the pay incremental process. This meant if staff did not receive an annual appraisal, there was a risk they will not receive their pay rise.
- Communication between senior managers and local managers was poor. We were told senior staff had agreed and signed off plans for a phased approach to use 10 additional assessment spaces beginning 22 December 2014 within AMU. However, this information had not been communicated to AMU staff that had heard of the new model but had not been involved in the consultation. Staff told us "even if managers are not planning to use our existing staff to support these additional ten beds, this will impact on us and we should have been told properly".
- Staff from wards 2, 17 and 28 explained they have ideas how to improve services for patients, however senior staff do not listen, one ward sister told us " They are resistant to change and not responsive to ideas".

Culture within the service

- In general we found the culture of care delivered by staff across all medical wards was dedicated and compassionate, despite the majority of staff feeling despondent. We found staff were hard working, caring and committed to the care and treatment they provided.
- Staff spoke with passion about their work and conveyed how dedicated they were in what they did.
- Senior sisters and ward mangers told us they felt decisions relating to the management of their wards and staffing were often taken without their involvement and usually with very little notice.
- Staff were aware of some members of the executive team but felt they were not approachable and described the overall trust management style as; forceful, aggressive and oblivious.
- Decisions were often made by senior and executive managers with minimal communication with staff.

Public and staff engagement

- The NHS Staff survey 2014 showed the overall indicator of staff engagement trustwide was worse than the national average and ranked in the bottom 20% of trusts of a similar kind.
- Staff recommendation of the trust as a place to work or receive treatment was also worse than the national average, worse than 2013 figures and ranked in the bottom 20%.
- Sickness rates from October 2014 showed AMU at 2.3%, this was an improvement on the previous month which was 12.6%. Ward 28 sickness rate for October 2014 was

6.3%, which showed a slight increase compared to 5.6% for September 2014. There was a significant increase in sickness rates for ward 2 from 15.4% for September to 24.8% in October 2014.

- Wards were closed and reopened without prior engagement with ward staff.
- Communication from middle management required improvement as nurses told us they had little opportunity to voice their opinions or concerns and one senior sister told us, " We do what we are told ".
- Staff felt a 'heavy handed approach' was taken to problem solving, for example, ward closures, reopening wards, and management of underachieving wards.

Innovation, improvement and sustainability

- The opportunity for clinical excellence to flourish across medical wards depended on individual team's workload. Many staff we talked to reported their focus was purely on delivering patient care.
- The practice placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.

Surgery

Safe	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

Heartlands hospital provides inpatient and day surgery which account for 60%. Specialisms including cardiothoracic, general and vascular surgery.

We inspected theatres, the day surgery, pre-operative assessment unit and five wards. We spoke with 24 staff and eight patients. We observed care and reviewed records as part of this inspection.

Summary of findings

Staff received feedback on lessons learnt from reported incidents. Five never events took place across the trust pertaining to surgery. The World Health Organisation (WHO) five steps to safer surgery checklist was not always done in the anaesthetic room, data was input later due to IPAD connection problems which could lead to errors. An acuity tool was not being used to assess staffing levels on some surgical wards. Therefore staffing levels could not be accurately identified as adequate or not. However planned and expected staffing was monitored.

There were delays transferring patients from recovery to the wards because the wards were not ready to receive them. The discharge hub was not working well to assist in the discharge of medically/surgically fit patients. The surgical wards did not use the “All about me” documentation (booklet with personalised information provided by family) to support people living with dementia.

There was no clear structure for theatre management. We could not identify clear leadership/ownership. Staff said they did not feel supported by the trust senior management team. They said they were “Talked at not talked to,” and were not consulted about things that concerned them such as ward risks.

Surgery

Are surgery services safe?

Not sufficient evidence to rate

Staff received feedback on lessons learnt from reported incidents. Staff told us incidents are reported at the time of occurrence. Post incident learning took place informally at ward level. We saw evidence of a folder showing route cause analysis of incidents. Junior nurses are also taken to serious incident meetings so that learning could be shared. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Five have been reported across the trust in surgery; two wrong implant, two retained foreign objects and one wrong site surgery. As part of the trusts response we saw that a "Lesson of the month" produced to raise staff awareness. This was across all sites.

The safety thermometer was in use by the surgical directorate within the wards. This was visible in the surgical wards. There was no data for theatres. For BHH harm free care was 95% for October 2014 which was fairly static for the last 6 months. We saw that the data indicated good compliance with VTE assessments, prevention of UTI's in catheterised patients and pressure area care and assessment.

Staff were following infection control policies and procedures. Personal protective equipment such as gloves and aprons were being used appropriately.

There was a shortage of hoists to share amongst the surgical wards. There was a shortage of hoists to share between the surgical wards. One member of staff told us that a patient was left on the floor for 30 minutes whilst a hoist was found from another ward. Resuscitation equipment was clean and in good order. This was checked regularly by staff. Staff told us and we observed that the World Health Organisation (WHO) five steps to safer surgery checklist was not always done in the anaesthetic room, data was input later due to IPAD connection problems which could lead to errors.

Documents supplied by the trust demonstrated that of the surgical medical staff just over 50% of staff had undertaken safeguarding adults level 2 training (34 of 62). Of the 34 who had undertook this training 19 of them had undertook training in 2012, with three having last completed their training in 2011.

Ward 12 we saw that the number of falls had reduced from August 2014 where there were six reported to October 2014 where there were two reported. Ward 8 since August had seen a steady decline in the occurrence of pressure ulcers recording in October 2014 zero occurrences. Also on ward 8 100% of patients had been screened for VTE (venous thromboembolism). We also noted the number of falls with injury was zero from March to October 2014.

An acuity tool was not being used to assess staffing levels required on some surgical wards. Therefore staffing levels could not be accurately identified as adequate or not. Other wards said they did use a 'dependency score' to help justify booking extra staff. One of the sisters explained that they had to attend a bed meeting three times a day rather than phoning in to one coordinator. They felt this wasted up to an hour a day when the wards were already very short staffed. There were no nurses present on medical ward rounds. Staff were hoping to commence this once staffing levels improved. Documents supplied to us from the trust demonstrated that nursing staffing shortfall was significant. We looked at five surgical wards for October 2014 and the average reported staffing shortfall was around 30%.

Are surgery services responsive?

Not sufficient evidence to rate

There were delays transferring patients from recovery to the wards because the wards were not ready to receive them. This caused patients to remain in recovery for six to seven hours. The discharge hub was not working well to assist in the discharge of medically/surgically fit patients. The wards should refer patients who are medically/ surgically fit for discharge for them to coordinate. This did not seem to work very well. There is no discharge lounge as this was closed so there is nowhere for patients to sit whilst waiting for medication and transport.

There were 62 surgical cancellations in all theatres for trauma and orthopaedics between 1/9/14 and 9/12/14.The trust reported a deterioration in the time to surgery in

Surgery

2013/14 (51.8%) vs 2012/13 (63.1%). The target is set at 90%, but the trust failed the target for the 12 month period of 2013/14.Response times to answer call bells were up to 15 minutes on an orthopaedic ward.

Staff described an 'Enhanced Recovery Pathway' for orthopaedic patients as an example of implementing national best practice. This involved patients pre-operatively attending weekly education sessions by the multi-disciplinary team called 'joint school'. The aim of the pathway was to provide patients with information to enable them to be partners in their care to enable earlier discharge.

The trust used both language line a telephone translation service, and translators to support people whose did not speak English.

The surgical wards did not use the "All about me" documentation (booklet with personalised information provided by family) to support people living with dementia.

The number of complaints for BHH had reduced slightly in Q2 from Q1. Within general surgery there was a pilot to improve both informal and formal complaints which commenced in March 2014.

Are surgery services well-led?

Not sufficient evidence to rate

There was no clear structure for theatre management. We could not identify clear leadership/ownership. Different people had different 'leader' roles but there was no clear over-arching direction.

Staff said they did not feel supported by the trust senior management team. They said they were "Talked at not talked to." They said they felt unsupported and were not consulted about things that concerned them such as ward risks.

People's opinions of surgery was gained via friends and family scores. Friends and family data was collected by the surgical wards, we looked at the response rate for October 2014 for wards 8, 11 and 12 and found the rates were 39, 22 and 43%. The response rate is a target set with commissioners at the time was 25% for inpatients. The trust as a whole met the target that month.

Some clinical trial work was being undertaken in the surgery department. Trust wide the thoracic and vascular surgery patients were involved in clinical trials to improve knowledge and outcomes

Maternity and gynaecology

Safe	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Maternity service at Birmingham Heartlands Hospital manages 6,500 births a year, providing care packages for women who require both consultant led (high risk) and midwifery-led care.

During our inspection we spoke to 15 staff, three student midwives and seven patients. We visited the Labour Ward, three combined antenatal/postnatal wards and the birth centre.

Summary of findings

Safer staffing materials were not visible for women and visitors to the ward. The midwife to birth ratio was worse that the recommended average. Current arrangements for the cover of a second obstetrics theatre needed to be improved. The hospital did have an onsite consultant 24 hours a day, 7 days a week which was meeting national guidelines.

Staff involvement in future planning of service delivery was lacking. We also noted that facilities and specific arrangements for people with disabilities was not robust.

There was a lack of visible leadership and the staff were unclear about the maternity strategy and felt powerless to affect service development and delivery. Staff worked well in their teams, but there was little interdepartmental co-operation.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Summary

Maternity services needed to improve with the safe domain. Learning from incidents was available to staff through the publication Maty Matters. Although staff felt that feedback to incidents they had raised was not always timely.

Transparency of safety standards at Birmingham Heartlands Hospital could be improved, as there were no 'safer staffing' materials displayed in ward areas to inform staff and the public about staffing levels.

The birth intervention rates for both caesarean and Induction of labour rates were higher than the England average.

Safety systems and processes could be unsafe. There was a lack of syringe drivers and staff were not able to demonstrate competency in the use of a hoist within the birthing pool.

The Midwife to birth ratio was worse than the recommended average, with the Labour ward carrying significant vacancies. There were concerns raised about a poor midwife skill mix and inadequate staffing of the second obstetric theatres at night and how this affects safe care.

The Hospital had onsite, consultant cover on Labour ward for 24 hours a day, 7 days a week which meets national guidelines.

Incidents

- Four Never events for maternity had been reported since 2012, all relating to a retained foreign object after surgery. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Serious untoward incidents had been carried out appropriately carried after each of these, with recommendations to improve practice.
- Most staff said they were aware of how to report an incident but there was mixed response to whether they would receive feedback. Wider learning would be disseminated in the staff communications 'Matty Chat' and the Governance Team Newsletter
- Staff highlighted that the electronic incident reporting system did not easily allow them to report staffing incidents, and it was found that the 'staffing' category had been removed. Staff believed that this had happened as too many staffing incidents were being reported. It was still possible to report incidents attributed to poor staffing, however staff had developed a 'workaround' in order to do this

Safety thermometer

- The trust was taking part in a national pilot of a Maternity Safety Thermometer and had submitted data in six of the possible 11 months the pilot was running
- There were no dashboards displayed for staff or visitors displaying key safety or infection control indicators. Staff were informed about performance against key performance indicators by a trust wide communication 'Midwifery Metrics News' which detailed site and individual ward performance but was not linked to Trust wide or National targets
- In September 2014 Birmingham Heartlands Hospital reported a total caesarean rate of 28.6%, 3.6% above the rate for England in 2012-2013 (BirthchoiceUK, 2015) and an Induction of labour rate of 25.9%, and 2.6% above the average rate for England in 2012-2013 (BirthchoiceUK). Neither of these statistics were reported against trust or hospital targets or appeared on the communication circulated to staff or on the Midwifery dashboard.

Cleanliness, infection control and hygiene

- Infection control standards and results are published monthly as a cumulative percentage across the three acute hospitals. In November 2014, the trust scored 100% for hand hygiene, 95% for bed space cleaning and 100% for alcohol gel being available
- Compliance for hand hygiene, bed space and cleaning, uniforms, and alcohol gel were merged with privacy and dignity indicators and aggregated to a final percentage score. This was circulated to staff via the Midwifery Metrix news although displaying of individual ward compliance was not observed.

Maternity and gynaecology

Environment and equipment

- Staff reported lack of equipment especially syringe drivers and blood pressure cuffs on Labour ward.
- There were no records available demonstrating staff competency specifically to use the hoist over the birthing pool, or an evacuation procedure documented.
- Staff said that the pool room on Labour ward was rarely used although there were 13 births (2.4%) reported in January within it.

Medicines

- Emergency drug boxes were available, easily accessible well stocked with drugs that were in date. Medicines and controlled drugs were kept in locked cabinets; however drugs were seen to be kept in unlocked fridges and freezers.

Records

- A new electronic record keeping system had recently been introduced which was being used alongside paper records. Staff confirmed that although they saw this as an improvement in the long term, the transition phase meant there was duplication in record keeping causing delays in patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff receive safeguarding training every three years which included Mental Capacity Act training.

Safeguarding

- There were adult safeguarding procedures in place supported by mandatory staff training, in September 2014 the training records demonstrated the Trust had met its target of 85 % compliance for Safeguarding Adults and Children's Training level 1 and 2.
- We found that there were safeguarding policies in place with clear procedures for staff to follow should they have a concern.
- There was a safeguarding team of four specialist midwives who dealt with adult and child safeguarding concerns and provided training across the three sites.
- The trust has a Female Genital Mutilation (FGM) service and in 2013 saw 349 women who had suffered FGM

Mandatory training

- The process for monitoring compliance of mandatory training is set out in the Training Needs Analysis for the Obstetric Department and appears robust, staff advised us they were able to book and attend mandatory training
- Training did not appear as a standing item on the weekly Band 7 meeting or the Head of Midwifery and Senior Managers Meetings.
- Overall Trust compliance for mandatory training in the Women's and Children's Division, September 2014 stood at 74% year to date, against a target of 85%.
- The Trust had produced a booklet 'Mandatory Matters' which documented mandatory training requirements and how to access this for every staff group.

Assessing and responding to patient risk

- The Obstetric Modified Early Warning System (Obstetric MEWS) training was delivered to all staff as part of the Obstetric Emergency Day (Skills Drills).
- The trust had devised a bespoke risk assessment form to determine women's risk status for delivery at 36 weeks gestation. In November 2014, this was completed in 85% of all women, against a target of 95%

Midwifery staffing

- Labour ward was 17 whole time equivalent midwives under established. Some of this was due to sickness and maternity leave. The trust was part way through a staff funding programme which was due for completion 2015. There was no visible safe staffing matrix in the ward area.
- Staff told us about their concerns about the skill mix on Labour ward and that there had recently been an increase in recruitment of Band 5 Midwives who needed a greater level of support. This impacted on their ability to always safely staff the High Dependency beds, and meant the Labour suite co-ordinator sometimes had to lose her supernumerary status. However the trust made us aware of a three year investment programme which would impact positively on this.
- The Obstetrics Directorate used Birthrate Plus as an acuity tool and a review (across the three hospitals) and was conducted in 2011 and 2012. A 1:32 Midwife to Birth ratio was reported, as opposed to the 1:28 which would be recommended for a midwifery unit caring for women

who were high risk. This inadequate midwife to birth ratio led a member of staff to say "safety was being maintained, but this came at a high personal cost to the staff".

- There was a particular concern raised about the staffing of the second obstetric theatre at night, as women requiring an emergency caesarean section could not go to theatre in a timely manner as there was no second scrub nurse on the premises. This was sometimes resolved by a Midwife leaving the patient she was caring for and scrubbing in theatre. This was documented on the Obstetric Risk Register.

Medical staffing

- The Hospital has the provision for 168 hours per week consultant presence for Labour ward, in line with Royal College of Obstetrician and Gynaecologists guidelines.
- There was 24 hours of anaesthetist cover available, with consultants present during the day to service the elective list and emergencies, and a trainee or a registrar present at night.

Are maternity and gynaecology services responsive?

Requires improvement

Summary

Although there is an active Maternity Services Liaison Committee, there was little evidence of staff or patient involvement in service planning and delivery to meet the needs of local people.

Some people were not able to access the services for assessment, diagnosis or treatment when they needed to. There was no RAG rating system to triage patients in the day assessment unit, generally it was first come basis.

People found it hard to access services because the premises were not appropriate. Due to the lack of space in the clinical areas, facilities for patients with a disability or for partners to stay overnight were poor.

Complaints were not used as an opportunity to learn. Staff said that they were not aware of any lessons learned or changes of practice that arose from complaints.

Service planning and delivery to meet the needs of local people

- We saw minutes of the Trust Maternity Services Liaison Committee which met Bi-monthly. Clinicians and managers from all three sites attended, along with representatives from SANDS (Stillbirth and Neonatal Death Society), and other local community groups representing women and children.
- We were advised that the maternity service estate redesign 'Pelican' Project would be meeting with local groups to involve them in the planning and delivery of maternity services, and that MSLC (Maternity Services Liaison Committee) and SANDS representatives were already engaged. Staff were aware of the project and were aware that its aim was to create more space and to make their building fit for purpose
- Partners were not encouraged to stay overnight in any area of the hospital due to space restrictions.

Access and flow

- No RAG rating system was operational in triage or the Day Assessment Unit, so patients were generally seen in the order in which they arrived into the department with no formal risk assessment undertaken
- Staff told us relationships between assessment areas, labour ward and antenatal and postnatal ward areas regarding the availability of beds could sometimes be difficult, with not all areas being transparent about their workloads.

Meeting people's individual needs

- There were no adapted rooms for women with disabilities or wheelchair users, although there was one room on the high dependency area that could be used. There was no specific support or facilities for women with learning disabilities and they were generally referred to the teenage pregnancy midwife for support.
- Translators were based in antenatal clinic and available from 9am-5pm, Monday to Friday and could be contacted by a bleep system. Language line was also well used, although it's use was restricted to certain locations so privacy during conversations could not always be guaranteed
- There was no information for patients and visitors to see what action the staff had taken following suggestions on patient information boards, and board information that was displayed was out of date.
- The Hospital had achieved Level 1 UNICEF Baby Friendly accreditation. The Infant feeding co-ordinator role had

recently been realigned to cover both Good Hope Hospital and Birmingham Heartlands Hospital, and was recruiting and training peer support infant feeding volunteers to support women with breastfeeding.

Learning from complaints and concerns

- Staff described the complaints procedure and understood the escalation procedure if a complaint could not be resolved immediately. They were encouraged to be open and honest with the complainant and apologise if they felt they had received poor care. PALS leaflets were available; however staff said that they were not aware of any lessons learned or changes of practice that arose from complaints.

Are maternity and gynaecology services well-led?

Requires improvement

Summary

The Trust had a clearly documented, easily available strategy for maternity services; however knowledge of this was not demonstrated by staff we talked to, and some of the practices we saw did not support this vision, for example lack of support for low risk birth.

Not all leaders had eh necessary capacity or capability to lead effectively. We found a lack of visible leadership with no clear plans to address this, and a workforce that felt powerless to affect quality and service delivery. Teams worked well within their clinical areas, but did not support other departments.

Staff satisfaction was mixed, staff did not always feel actively engaged. The 'Pelican Project' would have benefitted from more staff involvement.

Vision and strategy for this service

- The trust had set out its' vision in a maternity strategy document, which was available on its website and in several different languages, however all staff questioned who were band 7 and below did not know of its existence or content.
- Staff were aware of the Pelican Project but non appeared to be involved or were able to provide any insight or details of its progress or timescales for completion
- Senior anaesthetists told us that they were concerned about the lack of vision and cohesive working over the three sites, feeling that the elective workload was being managed on a day to day basis, rather than a long term plan to address the capacity issues being devised.

Governance, risk management and quality measurement

- We observed an attitude to risk management which was sometimes reactive rather than evidence based. An example of this was that previously midwives had been able to prescribe a drug used in the induction of labour for a specific group of women. After an incident when a junior doctor incorrectly prescribed the drug, the policy changed to prevent midwives prescribing it in the future.
- There appeared to be a lack of ownership of the elective theatre list with anaesthetists concerned about the complexity and acuity of the workload, but felt that they received no support from consultant obstetricians.

Leadership of service

- Staff spoke of a lack of senior leader visibility, with many not familiar with the senior leadership structure and unable to tell us the names of senior leaders within the Maternity directorate or to say when they last saw them. Many staff said that they rarely saw senior leaders in the clinical environment, and this was perceived as unsupportive.
- The Head of Midwifery stated that it was impossible for her to be visible across the 3 sites, however had invited all Band 7 to attend a meeting with her to support their development and increase her visibility.
- There was positive feedback about clinical leadership up to Matron level, but it was felt that senior leaders 'left them to get on with it'

Culture within the service

- Student Midwives advised us that they saw Midwives struggling on a daily basis to cope with their workload, however they were trying to normalise birth for women. Student Midwives told us they would apply to work at this Hospital once they had qualified as it had an excellent preceptorship programme.
- The most recent Local Supervisory Report stated that the Supervisor of Midwife to Midwife ratio for the overall Trust was 1:18 (worse), against a recommended 1:15, however they were reassured that the Trust was actively

recruiting Midwives to become Supervisors of Midwives to address the deficit. There was a Supervisor of Midwives rota that provided 24 hour a day, 7 day a week on-call cover across the 3 sites.

- The hospital supported low risk birth with the provision of a three bedded birth unit, however staff reported that this was frequently shut due to staff being moved to Labour ward to manage increased demand. This led to tension between the birth unit staff and the Labour ward staff and lack of co-operative working, for example support cover for breaks.

Public and staff engagement

- Senior managers described the 'Pelican Project' which addresses redesigning the maternity estate and pathways, although they commented that this needs to be re-energised and staff and stakeholders needed to be engaged more.

Innovation, improvement and sustainability

- The trust strategy sets out an improvement in midwifery (especially community) resources, a focus on normal birth, and improved choice and outcomes for women and their families as their key priorities for 2014/2015. No staff we talked to were aware of these proposals.

Outpatients and diagnostic imaging

Safe	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The outpatient service is mainly housed within the outpatient department in the front of the hospital. We visited a number of centres within the outpatients and diagnostics services including general clinics those for sexual health, infectious diseases, cardio respiratory and the ENT clinic which was a short distance from the main area. We also visited the radiology, pathology and pharmacy departments.

We spoke with 10 members of outpatients staff, the bookings manager, nine members of diagnostic services staff and 12 patients.

Summary of findings

The outpatient department at Heartlands Hospital require improvement to ensure that patients receive a service which is responsive to their needs and is well led. The lack of performance information, use of complaints and patient feedback meant that the service could not adapt and improve services for patients. There was a lack of visibility of senior managers within the department and no clear vision for the services undertaken within outpatients. Diagnostic services and specialised services were led by enthusiastic and creative leaders who improved service for patients based on information and comments from patients.

Whilst patient complaints were low we could not ascertain if this was due to low expectations or lack of formal reporting of complaints. Patients we spoke with were generally satisfied with the service provided but expressed concern over delays, booking systems and the poor environment. There was a lack of information available to patients both in written form and verbally on their care and treatment. Some areas inspected such as the cardio respiratory waiting area was unfit for the purpose.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

Summary

Information about safety is not always comprehensive or timely within the outpatients service at Good Hope Hospital. Safety concerns are not consistently identified or addressed quickly enough. There was limited use of systems to record and report safety concerns, incidents and near misses. Staff reported that they rarely reported incidents however the department had reported a significant number of incidents in the previous six months. Feedback from these incidents was not given to staff in order that services could improve. Infection control processes required improvement to ensure that the department was clean and that staff adhered to current trust policies. In other areas such as sexual health, infectious diseases and in departments such as radiology, pathology and pharmacy services were safe as incidents were reported and action taken. Staff in these areas were aware of safety issues and took action to address deficits in care.

Incidents

- Staff in the outpatients department felt that the department was safe as they rarely reported any incidents on the electronic system. We saw that the department had reported 94 incidents within the previous six months.
- Although most staff were aware of how to report incidents or to raise concerns they stated that they would not report late running of clinics or cancelled clinics as an incident this meant that opportunities for trending and learning and hence improvement were lost.
- We could not follow an incident within the main outpatient clinics to ensure that investigation and learning staff reported that they could not remember when the last incident occurred. Neither could staff discuss any action taken as a result of an incident within the hospital or trust.
- We visited the sexual health and infectious diseases clinics we found that staff were aware and had reported incidents the outcomes of which had been feedback. We found that practice had changed as a result of these issues raised. An example of this was that the sexual health clinic had changed blood labelling procedures to a printed format to reduce errors.
- Staff in diagnostic areas report that they do report incidents and sometimes receive information on lessons learnt from these. Action is taken to address root cause of issue
- The diagnostic services had strong systems in place to ensure the safety of the processes carried out within their department. This included the compliance with Ionising Radiation (Medical Exposure) Regulations (IRMER) through monitoring and reporting of incidents.

Cleanliness, infection control and hygiene

- The environment was visibly clean and there were records in place to confirm that clinic rooms had been cleaned. Staff told us that they cleaned the clinic rooms at the start of a clinic. However cleaning schedules were not available to the inspection team as staff could not locate these.
- Staff were aware of infection control processes such as use of personal protective equipment and hand hygiene. However during our inspection we did not witness staff washing or gelling their hands between patients.
- In ENT clinics we noted that staff were not following the trusts bare below elbows policies. However we also noted that staff wore jewellery including stone rings and watches. Doctors were also noted to be wearing long sleeved attire. Nursing staff reminded doctors about the bare below elbows policy but they continued to fail to observe this trust policy.
- In sexual health there was an infection control check list which was up to date.
- Diagnostic areas were visibly clean and within the pathology department staff took active measures to ensure that infection control issues were appropriately dealt with.

Environment and equipment

- Equipment was maintained and PAT tested in line with trust policy. Labels were seen on equipment which identified when this had been last checked. All equipment seen had been checked within the previous year.
- We checked seven resuscitation trolleys throughout the outpatients and all equipment was seen to be within the expiry date and checks had been undertaken.

Outpatients and diagnostic imaging

- Equipment within the diagnostic departments was well maintained in line with manufacturer's instructions and trust policy. Quality assurance processes were in place for specialised equipment.

Medicines

- Medicines were kept in locked cabinets and keys were maintained by outpatient personnel.
- Contrast medium was within date and appropriately stored and administered within the radiology department.
- The pharmacy department had systems and processes in place which safely stored, recorded and maintained medications. Electronic prescribing was in place which allowed the monitoring of prescribing and administration. This ensured that issues in respect of medication was reported and action taken to address deficits.

Records

- Medical records were available for clinics. We saw that records were available for patients attending the clinics we visited.
- Medical records were not always maintained securely as they were often left on the side tables of clinics so that patients and the public could access these.
- Medical staff recorded in patient's records and care staff recorded basic monitoring of patients weights and diagnostic tests as appropriate.
- Nurse led clinics were undertaken where nursing staff recorded detailed notes of patients care whilst in the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients were aware of caring for people who may have limited capacity but were unaware of the deprivation of liberty safeguards. In other areas the awareness of patient's capacity was generally lower than in the outpatient areas.
- Staff undertaking procedures were aware of consent implications and completed the appropriate documentation as necessary.
- Implied consent was taken for examinations and basic testing of patient's metrics (e.g. height and weight). Staff explained procedures and patients willingly submitted to having these undertaken.

Safeguarding

- Safeguarding training had been undertaken and information showed that current attainment level was over 95%. However six of the ten members of staff we spoke to felt that this didn't really apply to their department.

Mandatory training

- Staff undertook mandatory training and most rates were between 95 and 100%. This was done through e-learning and through face to face training.
- Staff were able to access time for training when clinics were quieter.
- There was an electronic prescribing system in place which included an educational element in order to reduce the risk of prescribing an incorrect dosage or drug interaction.
- Staff in the radiology department had undergone IRMER training and were complaint with these regulations.

Nursing staffing

- Health care assistants undertook less complex clinics where nursing experience and knowledge was not required. We saw that the department had sufficient numbers of staff on duty during our inspection and that healthcare assistants had easy access to registered nurses if necessary.
- Trained nurses were used to undertake complex clinics and undertook nurse led clinics.
- In other clinics we visited there were sufficient staff that had the appropriate knowledge, skills and experience of their dedicated specialism to support patients.

Medical staffing

- Medical staffing was provided by the specialty holding the outpatient clinic. A variety of medical and allied healthcare professionals were available within the outpatient department.
- In general clinics were held by senior medical professionals.
- Whilst staffing in radiology is a national issue we found that there was sufficient staff present to undertake the services required during our inspection.
- The pharmacy department confirmed that they had sufficient staff to cover the wards and departments in the hospital.

Outpatients and diagnostic imaging

Major incident awareness and training

- Staff were unaware of a major incident plan and had had no training as to what to do in the event of a major incident occurring.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Summary

The outpatient department was not responsive to the needs of patients using this service. Services are delivered in a way that is inconvenient and disruptive to people's lives. Clinics are not available out of working hours apart from a few new clinics initiated recently. This is despite most staff reporting that the biggest single complaint from patients following car parking charges was the delay in clinics and the need to return to work. Complaints are not used as an opportunity to learn. Booking systems were ineffective with patients being sent to the next clinic rather than clinics held in their local hospital. There are disparate systems for different types of referral which mean that some patients referred by written letter waited longer for appointments than those who are referred either electronically or through Choose And Book systems. It was unclear as to how many clinics were cancelled at either short notice or within the allotted six weeks as no audits were undertaken. Similarly audits were not undertaken of delays and overrunning clinics. This meant that improvements in responsiveness cannot be planned or implemented.

Service planning and delivery to meet the needs of local people

- We saw that clinics had been planned for weekend mornings. Staff were not sure why these had been initiated and told us that this was in response to waiting times rather than to be more flexible in service delivery to meet the needs of patients. Services were staffed by the staff from outpatients who worked overtime to cover these. In general clinics ran between working hours and there were no planned evening clinics allowing greater flexibility for patients.
- Patients were able to choose and book clinics which were nearer to their home via the electronic system however booking staff at the central office sometimes booked patients into the next available clinic rather than those occurring at their local hospital. The trust had a system by which most clinics were available on all sites to improve access to patients and provide a local service.

Access and flow

- The hospital was not meeting 18 week referral to treatment times and were beginning to undertake some initiative clinics to address this issue.
- Bookings are collated centrally for all outpatient departments. The trust ran two systems for waiting lists one of which ran the risk of breaching the 18 week RTT. There was no evidence of monitoring the length of time it takes to book patients from GP referral letter.
- Within the outpatients department, clinics are signposted by number and patients report to the appropriate reception desk on arrival. There were individual waiting areas for clinics although patients sometimes sat in adjacent waiting areas when clinics were busy.
- Staff could tell us which clinics always ran late and which were often delayed. We saw that signage was available for informing patients of delays to clinics. This consisted of boards with pre-printed signs announcing delays of 30, 45 and 60 minutes. We witnessed members of staff informing patients of delays in clinics however no explanation as to why clinics were delayed was given. Concerns from patients were not addressed during our inspection however water was offered to patients who had been waiting.
- The flow of the breast clinic is currently under review to ensure an efficient and responsive service. There are on-going discussions between medical, care and radiography staff as to how best to manager this service.
- The cardio respiratory clinic was not responsive to the needs of its patients. This clinic was at the end of what appeared to be an administrative area. The waiting area was cramp and relatives and patients often had to stand whilst waiting. There were no risk assessments on this area undertaken. Patients in this area often had to undergo a number of tests which meant that they were in the clinic for prolonged periods of time which led to the congestion of the area. There was little consideration given to the comfort of patients and relatives waiting in the area.

Outpatients and diagnostic imaging

Meeting people's individual needs

- We noted that signage from the main hospital area was good as the entrance to the outpatient area had moved and patients could not enter from the main hospital entrance.
- Staff were aware of dealing with patients who may be vulnerable. They did this by seating them close to the clinic area so that they could see them. Patients arriving in wheelchairs were placed in the area by the clinic although the current configuration of the department did not have allocated space for wheelchairs.
- There was an awareness of dementia but no special training had been given. Care is dependent on the person organising the clinic.
- There were a number of specialist staff available in clinic to provide information to patients however whilst there were some specialist information available information leaflets for many conditions was lacking and shelving was empty.
- In the cardio respiratory clinic patients and relatives reported to inspectors that there was no emotional support offered to them as to the care and treatment of their conditions. Patients did not feel involved in their care and relatives were not supported to care for their loved ones.

Learning from complaints and concerns

- Staff in the outpatients department stated that patients did not complain formally but informally to them. Staff dealt with informal complaints but did not record or report these. This meant that there was little learning or action taken from complaints in the outpatient department.
- In other departments such as sexual health patient complaints were addressed and an example of this was the lack of privacy and dignity at the reception desk which had been addressed through a change to procedure and the availability of a private room for discussions with patients.
- The sexual health department undertook regular audit and governance meetings and there was a clinical audit lead (a member of the consultant staff) within the department.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Summary

The arrangements for governance and performance management did not always operate effectively. Opportunities for improvement in the service, identified through audit and monitoring of the service, needed to be initiated and embedded. Whilst staff felt passionate about giving a good service they did not feel actively engaged or empowered. Teams were working in silos and did not always work cohesively. There was a limited approach to obtaining the views of people who use services and other stakeholders. Feedback received was not always reported or acted upon in a timely way. There was a lack of systems and processes for collating, disseminating and learning from these processes was poor. However in other areas such as sexual health, infectious diseases and diagnostic services leadership was good and information about the performance of staff and the service was disseminated and services improved as a result of this.

Vision and strategy for this service

- There was no recognition of a strategy, vision or values within the department. Staff were unable to articulate a vision or plan for the department.
- Staff were clear about their role in contributing to the overall goal of the department and were determined to provide a good service to patients.

Governance, risk management and quality measurement

- There is a lack of governance systems to ensure the department improves.
- We saw no evidence of any audits or improvements to the outpatient service. However other areas such as sexual health, infectious diseases and in diagnostic services audits were undertaken and action taken to address deficits in care were put in place.
- Staff in outpatients were unaware of any audits undertaken.
- Staff spoke about the cancellation and delays within clinics but we were unable to corroborate this information as data as it was not collated at departmental or booking centre level.
- General risk assessments were undertaken within the radiology department for a variety of risks.

Outpatients and diagnostic imaging

Leadership of service

- The outpatient sister worked predominantly in the outpatient's clinic at Heartlands but also covered the outpatient service at Solihull Hospital. The matron also covered all three trust locations. This meant that leadership visibility was poor at other sites.
- Staff and leaders told us that team meetings rarely occurred. Information for staff was available via the intranet or via email. There were no minutes of these meeting available.
- In outpatients there was a communications book which staff were aware of which allowed communication of issues to staff. However on review of this book we found that the last entry was dated 2013. There were no entries for 2014.
- Staff told us that appraisals were undertaken annually but there was no other form of formal supervision.
- Medical leadership within the radiology department was good as was the leadership in specialised clinics.

Culture within the service

- Staff within the department felt that local managers did support the team working in the departments we visited. However staff felt invisible to managers above matron grade. There was a sense that issues were raised but not listened to and that action taken to address issues was limited at best. An example of this was the issues raised by staff in the cardio respiratory clinic which had not progressed to improve services to patients.
- Staff felt that the managers had an open door policy and that they were approachable. However there was a lack of systems in place to ensure that staff received information to assist in improving practice within the outpatient's service.
- Staff reported that the department was a close knit community of people who had worked there for some time and took a genuine interest in each other. However managers felt that some policies such as the sickness policy was too rigid and this did not support genuinely ill staff.
- Staff reported that they felt that the hospital was target driven and that they could not provide feedback on initiatives that the hospital management took to increase services.
- Staff felt that the department was staffed on the goodwill of its staff. This meant that staff covered for each other and undertook extra shifts to cover shortfalls in staffing.
- The diagnostic departments were well led whilst the staff may have had a low morale due to decisions made by senior managers they felt that local managers supported them in their day to day working lives. Managers complained that the relationship with the senior managers was "brash. "It was explained that senior managers may listen but no action was taken.

Public and staff engagement

- There was little evidence of staff or public engagement in the main outpatient department. Information for staff was cascaded through use of the internet and emails. However staff felt disengaged in the running of the department and that they could not personally contribute to improvements which they saw could easily be made but did not suggest as they did not feel listened to.
- Specialist clinics and diagnostic departments took steps to involve staff within the improvement of the areas and responded to staff improvement ideas sometimes without a formal approval from the hospital management.

Innovation, improvement and sustainability

- There was a consultant of the day in radiology who would take phone calls patients and any queries from the department which ensured that others could complete their workload in a timely manner.
- The radiology department provided a radiographer-led implantation service for central venous lines within the hospital. This busy service was responsible for the insertion of around 600 central lines per annum and was carried out in the interventional suite where ultrasound and X-ray screening were available in order to position the central lines accurately and minimise the risks of complications.

Outstanding practice and areas for improvement

Outstanding practice

The Practice Placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.

Areas for improvement

Action the hospital MUST take to improve

BHH wide

- The trust must address the ambivalence held by staff about reporting incidents as they may be underreporting and trust could miss important trends.

ED

- The trust must ensure that staff are clear about clinical responsibility for patient's awaiting handover by Ambulance services.
- The trust must take effective action to achieve consistent staff compliance of infection control procedures.
- The trust must take effective action to address the crowding in the majors area of the ED department and ensure that staff on duty can see and treat patients in a timely way.

Medicine

- The trust must ensure all patients requiring items of restraint such as hand control padded mittens are supported with a mental capacity assessment, a DoLS and are regularly reviewed by the MDT which is recorded in the patient's notes and mittens are replaced when soiled. A consistent practice must be adopted across the trust.

Surgery

- The trust must improve arrangements regarding patients following surgery having to wait in recovery over 30 minutes.

Maternity

- The trust must provide sufficient staff to operate the second obstetrics theatre at night, and prevent delays occurring.

OPD

- The hospital must improve the information available to departments to ensure that these are monitored and action taken to improve services through audit, trending and learning.
- The hospital must take steps to improve adherence to infection control processes to ensure the safety of patients. This includes the monitoring of hand washing practices and the bare below elbows policies.

Action the hospital SHOULD take to improve

BHH wide

- The trust should ensure that staff are made aware of a vision and strategy for the service and their contribution to achieving it.
- The trust should ensure that patient's with complex needs such as mental ill health, dementia or learning disability are appropriately supported through their experience of services.

ED

- The trust should ensure that patient's whose first language is not English are supported to understand the emergency department services and systems.

Medicine

- The trust should improve on mandatory training attendance and also specialist training such as: administering blood transfusions and advanced life support training.
- The trust should continue with its Registered Nursing recruitment process and reduce the use of agency staff as a priority.
- The trust should ensure staff are given training how to report poor staffing levels via incident reporting software.

Outstanding practice and areas for improvement

Surgery

- The trust should improve the connectivity with the iPads in use within anaesthetics.

Maternity

- The trust should review the number of syringe drivers and blood pressure cuffs to meet the needs of women in maternity.
- The trust should ensure staff have an opportunity to contribute to planning of future service delivery.

OPD

- The hospital should consider improving the information available on delays for patients and consider what actions are taken to alleviate these to ensure a responsive service that meet the needs of patients.
- The hospital should consider the environment for patients waiting in the cardio respiratory clinic to ensure that patients are waiting in an environment which is safe and conducive to the need of patients and carers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1)(2)(a) Nursing staffing was insufficient in places having a direct impact on patients. For instance not being able to staff the second obstetrics theatre in maternity. The appraisal rate for staff within the trust was at 38%. This rate had the potential to impact on the level of care patients received. Manager also lost the opportunity to support staff and identify areas where additional support was required. In addition the visibility of the head of midwifery continues to be an issue as identified during our previous inspection November 2013.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (4)(b) (5) Safeguarding processes were not in place for people wearing mittens within the trust.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	15 (1) (f) Lack of equipment and faulty equipment not being replaced in a timely fashion.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g)(h) Within ED cleaning practices needed to improve. Within the trust staff were not adhering to the trust policy. Where emergency medications were required within maternity they were not readily available, staff were unaware of its whereabouts and they had not been checked regularly to ensure they were still in date and safe to use.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2)(b)(f) Lack of robust incident reporting and feedback which could result in learning opportunities lost. Management of patient handover, overcrowding and timely assessments undertaken in ED Patients waiting over 30 minutes in recovery Service delivery and improvement in OPD with the use of management reporting data