

Heart of England NHS Foundation Trust

# Birmingham Heartlands Hospital

## Quality Report

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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

Accident and emergency	Requires improvement	
Medical care	Requires improvement	
Surgery	Good	
Intensive/critical care	Good	
Maternity and family planning	Requires improvement	
Services for children & young people	Good	
End of life care	Good	
Outpatients	Requires improvement	

# Summary of findings

## Overall summary

### **The ratings in this report were awarded as part of a pilot scheme to test CQC's new approach to rating NHS hospitals and services.**

Birmingham Heartlands Hospital is the largest of the three hospitals run by the Heart of England NHS Foundation Trust. It provides general and specialist hospital and community care for the people of East Birmingham, Solihull, Sutton Coldfield, Tamworth and South Staffordshire. The hospital has about 700 beds and is a regional centre for thoracic treatment taking patients from across the Midlands. It also has an extensive research department that supports all the services the site provides. We did not inspect the community services.

We inspected this trust as part of our new in-depth hospital inspection programme. This programme is being tested at 18 NHS trusts across England, chosen to represent the variation in hospital care across England. Before the inspection, our 'Intelligent Monitoring' system indicated that the Heart of England NHS Foundation Trust was a medium-risk trust. It had a longstanding history of struggling with turnaround times in the accident and emergency (A&E) department. The management team had put initiatives in place to reduce the amount of time people were waiting in A&E but these had yet to have an impact.

This hospital has been inspected six times under the previous inspection methodology. It was inspected three times in 2011 and found to be not meeting the standard on the management of medicines. The next inspections took place in February and June 2012, when the hospital was meeting all inspected standards. The hospital was inspected for the sixth time in January 2013 and was meeting all inspected outcomes.

Before the inspection, we looked at the wide range of information we held about the trust and asked other organisations and four focus groups arranged by volunteer organisations to share their knowledge and experience of it. During the inspection we held three listening events, one near each hospital location, and spoke to more than 60 people who attended. We carried out announced visits to Birmingham Heartlands Hospital

between 11 and 14 November 2013. We looked at patient records of personal care or treatment, observed how staff were providing care and talked with patients, carers, family members and staff. We reviewed information that we had asked the trust to provide.

The trust scored below average in the Friends and Family Tests introduced in both the A&E department and for inpatients. However, during the inspection we heard positive feedback from patients who felt that, overall, care was responsive and provided in a sensitive and dignified manner despite caring staff being busy.

In general, we found Birmingham Heartlands Hospital to be responsive to the needs of its population, providing an effective and reasonably safe service that was well-led by senior management. However, there was no effective triage facility for patients within the A&E department, and the speed of decision making and treatment was poor. Within the medical unit, the care given to patients mostly met their needs but the documentation of this care was sometimes poor. The hospital struggled with patient flows as the A&E department continued to see increasing numbers of patients. However, of the three hospitals, Birmingham Heartlands Hospital was more effective than the other hospitals in the trust in managing its patient flow. Staff used 'JONAH' boards to ensure that patients were reviewed by a multidisciplinary team and that those who were medically fit for discharge were discharged. This ensured that beds were available for new patients who needed to be admitted.

The trust was aware that there was a shortage of nursing staff, and that had had an impact on the care given to patient. It had decided to make it easier to recruit band 5 nurses and band 2 staff by quicker approval of vacancies and by introducing a rolling programme of recruitment. This was beginning to have an effect in some of the ward areas. However, the full impact of this recruitment programme may not be felt until early 2014. In the meantime, patients and staff said that shortages of nursing staff were preventing people from receiving good treatment and care.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### **Are services safe?**

Patients said that they felt safe while being treated at Birmingham Heartlands Hospital. We found that there were systems in place to identify where there were staffing needs and the hospital had the ability to cover any shortages in the ward areas. However, we noted some nursing staff shortages and delay in assessment within A&E, which had an effect on patients' safety.

### **Are services effective?**

In general, we found that the services at Birmingham Heartlands Hospital were effective. Staff were beginning to see the effect of the recent recruitment programme, as new staff joined ward teams. The hospital managed its number of beds reasonably well to ensure that patients who needed a bed were given one. However, this sometimes had an impact on the availability of short-term beds for people undergoing surgical operations.

### **Are services caring?**

Patients said that staff were caring despite being busy, and we saw some good examples of good care being delivered on the wards. In some areas, patients declared that the care was "exemplary" and were able to describe how staff had gone "the extra mile" to ensure that patients and their families felt cared for.

### **Are services responsive to people's needs?**

Overall, we judged that the services provided at Birmingham Heartlands Hospital met the needs of the people it served. People told us that, despite not having English as their first language and the hospital having limited information available in other formats or signs in other languages, the hospital met their cultural needs as well as their health needs.

### **Are services well-led?**

We found that at, a local ward or department level, the staff felt well-supported and well-led by their local managers. However, there were some concerns expressed by staff that they did not feel as well supported by the senior management team. We saw that on the whole there were systems in place to develop and learn from incidents that occurred within the service.

# Summary of findings

## What we found about each of the main services in the hospital

### Accident and emergency

The A&E department at Birmingham Heartlands Hospital was very busy during our inspection and we were informed that this was not unusual. The trust is often below the national target for treating people within four hours, and we had concerns with regards to how well the staff were able to assess and therefore effectively prioritise the order in which people were seen. Although there was an ongoing recruitment programme, the effect of this was yet to be felt in the department and staff were noted to be very busy.

Requires improvement



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

The medical department is very busy within Birmingham Heartlands Hospital. Staff were reported as being caring by the patients they served and we saw some good examples of compassionate care. However, record keeping was not always kept up to date or updated with appropriate information. This did not affect the care given to the patients. There were variations in the numbers of staff and quality of care given to patients with dementia. The hospital also needs to review the way in which it moves patients through the system, and to continue to forge links with community services so that patients do not stay in hospital any longer than necessary.

Requires improvement



### Surgery

We had few concerns about the surgical unit of Birmingham Heartlands Hospital. The wards were safe, well-led and the staff were found to be caring. The day surgical unit was not always used appropriately for day surgical patients in that other specialities 'borrowed' beds, which had impacted on the responsiveness of the unit. This caused some delays in admitting patients to the ward and in the care provided. The trust will also need to address the late starting of operating lists so that patients receive treatment in a timely manner. In order to speed up discharges the staff at the unit had developed a system of daily review appointments with slots in the CT scanner, so patients who could wait until the following day for a scan could go home and come back for this the next day

Good



### Intensive/critical care

We found good practice in the critical care unit. These included effective communication between teams, the critical care outreach team and the support given to families. The high bed occupancy gave us cause for concern, but the outreach team was managing this at the time of the inspection and the trust had plans in place to increase bed numbers. However, the trust will need to keep this under review as winter approaches and traditionally demand for critical care beds escalates.

Good



# Summary of findings

## Maternity and family planning

We found that maternity services were sometimes overextended and the flow of women through the service up to and including discharge was disjointed and fragmented. The staff we spoke to all described a feeling of being stretched and that at busy times the running of the service was largely dependent on their goodwill. Staff told us they often worked over and above their allocated shift, sometimes working 13 hours without breaks. All the staff we spoke to told us they felt there was a disconnection with the senior management of maternity services. Some staff were unable to tell us the names of their head of midwifery and their deputy and associate heads. We saw an extensive governance framework and noted that incidents, complaints and audit findings were escalated through a committee structure to the board. However, a number of staff were unable to tell us how they learnt from incidents and complaints, or how the governance framework drove forward practice within the trust.

Requires improvement



## Services for children & young people

Children's safeguarding procedures were robust and had been improved in response to findings from a serious case review. Assessments of patients' needs were undertaken on admission by both nursing and medical staff, and care and treatment were delivered effectively by caring staff. There was a strong management presence in the form of the head of nursing, matron and supervisory ward sisters or managers. There was evidence of regular senior meetings and completion of audits to monitor the quality of service provided. There was also evidence of learning and improving as a result of incidents that had occurred. However, the hospital was not responsive to the management of children and adolescents or young people with mental health needs. This was because staff had received no mental health training, and there were no policies (other than one for suicidal patients) or pathways in place to ensure consistency in practice. Risk assessments were undertaken but were not robust enough to minimise the potential risks to these patients.

Good



## End of life care

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service. The hospital had worked hard to meet the needs of its local ethnic population and to ensure that the religious and cultural needs of people at the end of their life were met in a timely and sensitive way.

Good



# Summary of findings

## Outpatients

Some of the outpatient services were in old parts of the hospital that were not currently fit for purpose: the roof leaked and people could hear private conversations in consultation rooms. Patients often misunderstood which outpatients department they were meant to be in and this could cause delays in clinics. Patients were satisfied with the care they received, although we did see one example of a patient not being assisted by a member of staff.

**Requires improvement**



# Summary of findings

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

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. The results have been used to formulate NHS Friends and Family Tests for A&E and inpatient admissions.

The trust scored 68, out of a possible score of 100 in the August inpatient Friends and Family Test, significantly below the national average of 72, with a response rate of 19%. The trust scored 35 out of a possible score of 100 for

the A&E department, again significantly below the national average of 64. The response rate was 15.1% for the department, which was above the national average of 11.3%.

The trust was performing below the national average in inpatient scores and A&E scores. This resulted in an overall score of 46, 19 points below the national score of 63.

## Areas for improvement

### Action the trust MUST take to improve

The care provided in the all of the A&E departments, particularly around the timing and type of initial assessment

Ensuring patients are cared for on appropriate wards and clinical areas.

Reduction of the use of agency and bank staff through continued recruitment of permanent staff.

Documentation relating to patient care

### Action the trust COULD take to improve

The efficient running of operating lists to reduce the number of cancelled operations.

Sharing information to monitor performance and quality of care.

Training for staff working with children, adolescents and adults with mental health issues.

## Good practice

Our inspection team highlighted the following areas of good practice within the hospital:

The E-JONAH system to highlight patients who were medically fit for discharge and to promote multidisciplinary working to discharge patients effectively.

The work undertaken by the end of life care team in ensuring that relatives were involved and continued to feel cared for after the death of their loved one.

The support of the critical care outreach team to other hospital staff while patients were awaiting a critical care bed.

# Birmingham Heartlands Hospital

## Detailed findings

### Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

## Our inspection team

### Our inspection team was led by:

**Chair:** Ian Abbs, Medical Director, Guys and St Thomas NHS Foundation Trust

**Team Leader:** Fiona Allinson, Care Quality Commission (CQC)

The team of 35 included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers.

## Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Before the inspection, our 'Intelligent Monitoring' system indicated that the Heart of England NHS Foundation Trust was a medium-risk trust. It had a longstanding history of struggling with its turnaround times in the A&E department.

We held four focus groups arranged by volunteer organisations and three listening events during which we spoke to a wide range of people who shared their experience of the trust with us. Some of the issues they identified were that staff were caring despite being busy, information from the trust was not always in an acceptable format, and difficulty finding the right people to speak to within the trust. We used this information during our inspection.

## How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

# Detailed findings

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients

Before visiting, we looked at a variety of information we held about the trust and asked other organisations, such as the Clinical Commissioning Group and Royal Colleges of Nursing, Surgeons and Anaesthetists, to share what they knew about it. We carried out an announced visit between 11 and 14 November 2013 and during our visit we held

focus groups with different members of staff as well as different groups of people who used the services, which were arranged by voluntary groups. We also held three listening events. We looked at patient records of personal care or treatment, observed how people were being cared for and talked with people who used the services. We talked with carers, family members and staff, and we reviewed information that we had asked the trust to provide.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced in the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

# Are services safe?

## Summary of findings

The majority of the services we visited were safe, but improvements were needed to maintain safety. Insufficient numbers of full-time, permanent medical and nursing staff at Birmingham Heartlands Hospital meant that, on occasion, the A&E service was unsafe. The lack of effective triage in a busy department could put patients at risk and certainly ensured that they did not always receive timely care and treatment.

There were vacancies in most departments and many wards relied on bank nurses (staff who work in the trust as overtime), agency nurses and locum medical staff who, on occasions, were unavailable. The trust continued to recruit to increased staffing levels but the effects of this were yet to be felt in the ward areas.

Arrangements to minimise risks to patients were in place, including incident reporting, infection prevention and control, child protection and safeguarding vulnerable adults, but some areas, such as the nursing documentation, needed to be improved.

## Our findings

### Staffing

There was an escalation system in place to identify a shortage of nursing staff. Nursing numbers were entered onto a computer and a rating of 1, 2 or 3 given to the number of nursing staff available on a ward. The senior nurse then sought spare capacity to ensure that shifts were filled as quickly as possible. The trust had recently made all ward sisters supervisory. This meant that they were available for monitoring quality and supervising junior staff.

### Learning from incidents

The trust had reported five 'never events', which are events that should never happen, in the previous year. While none of these were reported at Birmingham Heartlands Hospital, we reviewed the mechanisms for collecting information on incidents and accidents. We found that there were systems and processes in place that were familiar to all staff for the reporting of incidents or accidents. The investigation of these was done at a local level and reported through the governance committee structures to senior managers. Lessons to be learnt were fed back to staff – for example, in team briefings and notifications attached to wage slips. When asked, staff were able to describe to inspectors some of the lessons learnt.

Staff were able to talk about the challenges that the hospital faced. The greatest of these was the pressure on the A&E department. They spoke of the need to ensure that patient pathways (this is the expected treatment and milestones of a defined treatment) were followed and that timely discharge of patients was undertaken in order to free capacity. The use of the E-JONAH system was widely reported to have helped identify when patients were ready to go home, and then bring other support staff together to arrange discharge.

### Escalation policies

We found that in some areas, such as A&E and medicine, risk assessments were not undertaken in a timely manner and that care documentation did not always reflect the care given. This meant that patients did not always receive the care they needed in areas such as A&E but that once on the wards the care did respond to their individual needs, although it may not have been written down. There was a lack of ownership of patients' care within the A&E department as too few nurses struggled to care for large numbers of patients. This gave rise to patients being left on trolleys without a clear idea of what was happening to them.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

We found a mixed picture as to how effective the trust was as a whole. Some areas such as surgery, end of life care, maternity and children's care provided effective care, despite the challenges they faced. We found that the A&E department was not as effective as it could be, as there was a delay in healthcare professionals triaging patients. We also found delays to accepting patients brought in by ambulance. In the critical care area, while the team were performing well in most areas, they were not as effective as they could have been due to the capacity to accept patients into a bed within this area. The trust had put systems in place to ensure the safety of patients, but the area could not be effective.

## Our findings

### **Evidence-based treatment / Clinical audit**

Our inspectors reviewed this data and spoke to staff and patients. They found that staff were aware of the never events at the other hospitals and were currently using the systems that the trust had put in place to prevent them from occurring.

We looked at the waiting times in the A&E department and found that patients were not being assessed appropriately

on arrival and that the system that was in place to assess people quickly was ineffective when the department became very busy. We saw people who were brought in on ambulances waiting in the corridor to be assessed. This meant that the ambulance staff had to wait with these patients until they were seen by the A&E staff. Then, once seen, people who needed to be admitted were waiting up to 12 hours before being moved to a ward. This was because of the level of pressure on beds within the hospital and the need to wait for an appropriate bed to become available.

We saw that the bed occupancy in the critical care department was around 93%. This meant that all the beds were nearly always occupied. The trust had put systems in place to support people needing this level of care within the hospital. This support came from the critical care outreach team, a group of nurses who visited the wards where people needed intensive nursing care, to support the nursing staff looking after those patients. While the critical care outreach team was seen to provide excellent support to nursing staff, it was noted that when referrals to the team are high telephone support only is provided to the ward medical and nursing staff.

The trust needs to review these issues in order to provide an effective service to its patients.

# Are services caring?

## Summary of findings

<Summary here>

## Our findings

### Patient-centred care

In all the wards and departments we visited, patients said they felt that the staff had cared for them. This was supported by talking to patients and their relatives at the listening events during our inspection. Without fail, patients said that staff were “caring but very busy”. However, when asked if they were too busy to care, patients said they felt that staff were “caring despite being busy”. Patients also told us that they expected to wait for care to be provided.

With regard to the A&E department, it was often said by patients that “you expect to wait for hours to be seen as the department is so busy”. One patient said, “You don’t go to A&E with a minor problem because you know that you will have to wait.”

### Observation

Staff in specialised departments were particularly respectful of patients in their care. The paediatric and maternity departments showed that they respected every individual using their service. These departments were able to give examples of where the department had implemented a specific service to address needs of patients and their families. Similarly, the critical care department was specifically caring in respect of patients and their families who were at the end of their life.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

Most of the hospital was responsive to the needs of its patients. However, it must do more to improve waiting times in A&E, to make services available to all and to capture more effectively the experiences of patients, their families and friends.

## Our findings

### Access to service

We found that in the A&E department patients were waiting more than four hours for treatment. The hospital had failed to meet this target on a regular basis for a number of months. Staff struggled to get everyone seen within the four-hour target but, because of the number of patients, this was not always possible. Staff were aware of the escalation procedure when the department was busy, and the systems in place to find beds for people who were to be admitted, which included contacting the senior nurse for the hospital. However, these were not seen to be working effectively when we visited the department.

### Treatment of vulnerable patients

Birmingham Heartlands Hospital is in the centre of a culturally diverse area of Birmingham. A significant number of people do not have English as a first language. We were surprised that the trust did not have information or signage in languages other than English. We were told by a number of managers and staff that it was not a problem to make people understand when their first language was not

English. People often brought with them a member of the family who could speak English. The trust executives told us that they had discussed issues such as food and the death of family members with the local community groups and language had not been raised as a concern. However, at one focus group we attended, we were told by women that this was a problem and they were able to give examples of when they had been at a loss within the hospital and felt that they had not been treated with respect while using some of the hospital services. Staff told us that interpreters were available through the use of the language line, but that there was often someone on duty who could interpret and explain information to patients.

### Complaints

We saw that the hospital used the family and friends test extensively. Every ward and department visited was seen to have a board that explained what this was and provided cards for people to complete. However, we noted that on a number of boards there were no cards left for people to provide comments. We spoke to a number of staff in a variety of areas who told us of initiatives that had been started by a patient or their relative making a comment or complaint about care. These initiatives had gone on to improve care for others. Examples of this included the use of a patterned quilt cover when people were at the end of life in critical care to reduce the clinical feel of the unit, the implementation of compassion packs (packs of food and drink and other necessities) for relatives of patients at the end of their life, and the installation of softer furnishing in side rooms to make the experience of being in hospital at the end of life more pleasant.

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

## Summary of findings

The senior management team at the trust was relatively new and had an understanding of the issues that the hospital faces. The team was currently facing further changes because the chief nurse was currently acting up to this position and the medical director was about to leave. This presented challenges of stability of leadership throughout the trust. However, the decision to treat each hospital as its own directorate was welcomed by the staff within Birmingham Heartlands Hospital, because they felt an ownership of the hospital and its services.

## Our findings

### Leadership and vision

Most departments felt that their immediate line managers were supportive of them and the services they provided. We received three whistleblowing reports that said that senior staff were not visible within the hospital and that there was a perceived lack of communication between staff in the ward areas and the senior management staff. We could only find examples of this in the maternity unit where staff said that leaders were not visible or supportive. In every other department, we were told that the local management team was very supportive. In maternity, the staff reported that senior management were interested solely in the systems and processes, and not in supporting staff to provide a good level of care. Staff in this area felt that they were working in a culture where mistakes were feared and not allowed to be used as a learning opportunity.

Staff welcomed the introduction of the supernumerary status of the ward manager. They felt that this gave them an extra level of support. We were also able to see the impact on the amount of information available to the general ward staff about how well an area was performing. While not every information board was up to date, staff were aware of how well they were performing and were proud of their achievements.

### Management of risk

Throughout the hospital, staff commented on staff shortages. However, in some areas, a number of staff told us that more staff had been recruited by the trust and that, in particular, bands 2 and 5 staff had become easier to recruit. These bands related to healthcare assistants and to junior staff nurses. The management team told us that the process for the recruitment of bands 2 and 5 staff had been improved with people getting into post in a more timely manner. We were also told that the trust had increased its staffing levels to accommodate sickness, training and annual leave. The full impact of the latest recruitment drive was expected by January 2014.

### Cohesion

We saw some excellent examples of multidisciplinary working in the ward areas across the hospital. All staff in the ward teams felt valued and able to contribute to the care of the patients. Staff told us that training was provided but that at times it was difficult to attend because of the pressures in the ward areas. We were unable to see the percentages of staff trained in specific issues by hospital site because this information was not produced by the trust in this manner.

# Accident and emergency

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

## Information about the service

The accident and emergency (A&E) department had 17 major and 15 minor cubicles, five resuscitation trolleys (including nine cubicles for children, which are ring-fenced). There was a further eight beds situated in a Clinical Decisions Unit (CDU).

Last year the adult emergency department saw in excess of 110,000 patients.

## Summary of findings

The A&E department at Birmingham Heartlands Hospital was very busy during our inspection and we were told that this was not unusual. The trust is often below the national target for treating people within four hours. We had concerns with regards to how well the staff were able to assess and therefore effectively prioritise the order in which people were seen. Although there was an ongoing recruitment programme, the effect of this was yet to be felt in the department and staff were noted to be very busy.

# Accident and emergency

## Are accident and emergency services safe?

Requires improvement 

### Risk assessment

We spoke to staff about the management and prevention of pressure sores. There was a designated nurse who had specialist knowledge about pressure sores in the department. We were told that patients were nursed on hospital beds rather than trolleys when they were assessed as at risk of developing pressure sores, and we saw that some patients had been provided with hospital beds while in the department.

We looked at care and treatment records for patients in the A&E department. We saw that, in most cases, risk assessments had not been completed. Venous thromboembolism (VTE) risk assessments were blank. VTE risk assessment was used to reduce the risk of deep vein thrombosis and pulmonary embolism for patients admitted to hospital.

Some patients had the emergency department frailty risk assessment completed. This was a predictor of risk rather than an assessment of risk. This assessment required the staff member to implement care rounds where a score of four or above was achieved. We saw that for one patient with a high risk score care rounds had been carried out.

### Staffing

Staff reported that they were often short-staffed especially when the department was full and there were no beds available in the hospital. We saw examples of this when looking at the staff off duty. They told us that 15 band 5 nurses had recently been recruited and they felt that this would relieve the problem. There was a separate paediatrics area. This was staffed with registered sick children's nurses at all times.

We attended a site team handover. We were told that at 8pm there were 100 patients in the department. Between 5pm and 6pm, 18 patients arrived by ambulance. This caused delays in patients being seen by a doctor. A patient who had suffered a trauma discharged themselves because they had been waiting in the department for nine hours.

### Equipment and environment

There was a separate bay, known as 'resus', with two adult beds and one paediatric. On the day of our inspection, we found that the resus beds were all occupied by adults who did not fit the criteria of needing close observation or resuscitation. People had been moved to this area because the department was full and there was no other available space. Resus beds should be protected so that they are available in the case of an emergency.

We spoke to staff about security. They told us that security staff were based in the department at night but not during the day. Staff had access to a panic button. Most had received conflict resolution training. A card system was used when patients were aggressive to staff. This meant that, if a patient was given a red card, they could not attend the department unless their condition was life threatening.

### Cleanliness

The department looked clean and we saw cleaners attending to spillages swiftly.

### Learning from incidents

We asked staff about reporting incidents and accidents. They told us they used an online reporting system. Most staff told us they always reported such events, but they did not always receive feedback about the reports they had made.

### Escalation policies

Patients who walked into the A&E department (rather than arriving by ambulance) had reported to a reception desk and were streamed by reception staff. This means that reception staff made the initial decision about the appropriate area for patients to be treated. This is an established practice but it is recommended that a healthcare professional reviews the patient within 15 minutes. When the department is not busy it undertakes 'rapid assessment' where patients are seen soon after arrival by experienced clinical staff, after which early decisions are made regarding treatment and management. However the department was high attendance rates and is usually busy.

On the day we inspected the A&E, 18 patients arrived within one hour (between 5 and 6 pm). The department struggled to continue to see to patients as soon as they arrived, and there was a queue of patients in the corridor awaiting assessment.

# Accident and emergency

We talked to staff about safeguarding policies and procedures. They knew the correct procedures to follow in the event of suspected abuse. Most had received level 3 safeguarding training, and knew how to access the trust's safeguarding link for advice and guidance. We asked staff to describe the action they would take in the event of suspected abuse. They knew the correct procedures to follow, when to raise concerns and whom to report them to. This included making referrals to outside agencies such as the local authority safeguarding team when this was needed.

We spoke to the staff about safeguarding children. The documentation used contained prompts to ensure that staff asked routine questions about safeguarding. Systems were in place to identify and alert staff if a child was known to social services or had a higher than normal attendance record. All children attending the department had their records reviewed from a safeguarding perspective and appropriate referrals were made.

## Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate 

### Evidence-based treatment

Heartlands participated in several of the College of Emergency Medicine audits, including consultant sign off, renal colic (adults) and severe sepsis and septic shock. They perform in line with national comparators in all of these audits.

### Training

Both nursing and medical staff confirmed that they received appropriate training to undertake their roles within the department. There were 11 qualified nursing staff and two healthcare assistants on duty over a 24 period. There were seven nursing staff with specialist children's training covering the 24-hour period. There are four Emergency Nurse practitioners covering the department from 8am to 2am

### Working with others

We observed two patients being treated in the resus area. Staff were alerted before their arrival and were prepared

when they arrived. There were clear lines of responsibility for each member of staff involved and staff communicated effectively with each other. Staff also managed the patient's relative in a kind and compassionate way.

In February 2013 the department was inspected by the Emergency Care Intensive Support Team, who reviewed the effectiveness of the department. The team found that overall, there had been significant improvements in patient flow at the Heartlands hospital since their last visit, but there was evidently still more to do. They recommended that the trust establish patient flow which would allow more timely admission from the A&E department, capacity to undertake rapid assessment of patients, and clarity around the expectations of the pathology service. Our observations at inspection would concur with the findings of this report nine months earlier.

## Are accident and emergency services caring?

Requires improvement 

### Patient experience data

Since April 2013 people have been asked to complete the Friends and Family test for A&E. This measures whether patients were either likely or extremely likely to recommend the service. The trust scored 35 out of a possible score of 100 for the A&E department, significantly below the national average of 64. The response rate was 15.1% for the department, which was above the national average of 11.3%. This means that although more people responded to the survey they said that they were unlikely to recommend the service to their family or friends. Data from the adult inpatient survey showed the A&E service as being comparable with other organisations.

### Patient-centred care

We spoke to patients and relatives. Most told us that staff treated them with respect and dignity, and were helpful and kind. Some patients told us they did not know what was happening next and were not aware of the plan for their care and treatment. At times the doors in the waiting area were left open and patients told us they were cold. There were no disabled access toilets in the waiting area.

# Accident and emergency

## Observation

We saw that many patients on trolleys in the corridor did not have their privacy and dignity respected. One patient was vomiting and there was a delay in staff attending to them. There was no system of comfort or intentional rounding for patients. Intentional rounding involves health professionals carrying out regular checks with individual patients at set intervals to ensure that they are comfortable and have their basic needs met. We saw that one patient had received two-hourly comfort rounds, but this did not appear to be routine. There were no hot meals available for patients but hot drinks and sandwiches were provided for patients who were waiting.

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

Requires improvement 

## Access to service

The Department of Health's national target for A&E is that 95% of people should be seen and treated within four hours. We were shown weekly reports for the four weeks before our visit regarding patients waiting for more than four hours in A&E. Records showed that there were in excess of 100 patients delayed each week trust wide.

We asked staff about the action they took when patients were in the department for longer than four hours. They told us that, when the department was busy and patients were nursed in the corridors, they informed the site lead. This was a nurse who had responsibility for the whole hospital and was aware of the current number of beds available within the hospital. Bed meetings were held at least three times a day in order to review the flow within the department and to identify available beds within the hospital. The trust sent us a flow chart of actions staff were required to follow in response to internal triggers in the department. For example, if patients were waiting more than two hours or there was a high volume of patients, then key members of staff were required to be informed and take action. We could not see evidence of this procedure being followed. Staff told us that breaches to the four-hour

wait and a full department were frequent occurrences. They said the department became busy when there were no beds available in the hospital and this made some staff feel stressed.

During our visit the department became extremely busy. There were 32 people in the waiting room. There were 12 ambulances outside the department. Patients were waiting in a queue on trolleys in the corridor. Patients were waiting for over three hours to be seen in the 'minors' area. We were told there would usually be an assessment nurse working in 'minors' but no such nurse was there during our visit.

There was an area known as the clinical decisions unit within the department. We were told that patients should not remain in this unit for more than 24 hours but we saw that some were waiting there for more than 24 hours for a bed to become available. One patient had been there for four days. Many of the staff were concerned that patients were cared for as A&E patients even when they had been kept waiting in the department or were in the clinical decisions unit for several hours. This meant that patients only had their very basic needs met and were not cared for by consistent staff who knew and understood their issues. Staff felt they did not have the time to respond to and look at the wider issues when the department was full.

## Treatment of vulnerable patients

The hospital covers a population that is very culturally diverse. We asked staff about how they met the needs of people whose first language was not English. They told us they had access to the language line. This was a translation service; there was a dual receiver telephone so that the patient and the member of staff could hold a conversation. They also told us that there were many staff working in the department who could speak other languages. We looked at records and saw that a doctor had recorded "difficult to assess as patient speaks very little English". We asked staff how they had managed this situation. They told us a member of staff had been found who could speak the patient's language. All information leaflets and signage we saw were only available in English.

A psychiatric team was available to see patients with mental health needs, and there was a room designated for such patients. The team was available day and night. Staff felt the room was too isolated from the rest of the department and preferred to use a cubicle for seeing and treating patients with mental health needs.

# Accident and emergency

Staff we spoke to were not aware of any specialist nurse or consultant within the hospital to provide advice and guidance to staff caring for people with dementia or learning disabilities. They told us that they could ask a member of staff to provide one-to-one care to a patient if this was needed. However we learnt from other areas that these specialists were in post at the trust.

## Complaints

Patients who we spoke to were confident that any complaint would be dealt with. However they generally accepted that they would have to wait to be seen.

## Are accident and emergency services well-led?

Good 

## Leadership and vision

We talked to staff about leadership in the department. They spoke highly of the A&E matron. They told us she spent a lot of time in the department and was very supportive. During our visit there was a team development day taking place. This involved training about conflict resolution, staff appraisals and the communication of any recent changes.

Doctors in training told us they felt supported and that the teaching was good. Most staff we spoke to told us that they felt supported by their line manager, they had received the training they needed and development opportunities were available. Some staff told us they felt stressed when the department was busy.

A member of staff told us that the trust had listened to their concerns about staffing levels and had taken action.

## Management of risk

There was a consultant-led audit programme. A monthly magazine known as Risky business was published. This provided examples of lessons learnt and improvement strategies. We could not find any evidence of nursing metrics being included in the clinical governance programme in the documentation we reviewed.

## Cohesion

We spoke to staff of all professions who said that all the A&E staff worked as a team and supported each other. We saw this in action while we inspected the department.

# Medical care (including older people's care)

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

## Information about the service

Birmingham Heartlands Hospital provides medical care on 16 wards that offer general and specialist medical care to patients. These included wards for people who had had a stroke, people with respiratory illnesses, renal disease, infectious diseases and diabetes, and frail older people.

We made both announced and unannounced visits as part of our inspection of these wards. We visited the acute medical unit (AMU), often the first ward for patients admitted via A&E, and 13 other medical wards including wards for older people, people with infectious diseases, renal disease, cystic fibrosis, cardiology, and diabetes, and the stroke unit.

## Summary of findings

The medical department is very busy within Birmingham Heartlands Hospital. Staff were reported as being caring by the patients they served and we saw some good examples of compassionate care. However, record keeping was not always kept up to date or updated with appropriate information. This did not affect the care given to the patients. There were variations in the numbers of staff and quality of care given to patients with dementia. The hospital also needs to review the way in which it moves patients through the system, and to continue to forge links with community services so that patients do not stay in hospital any longer than necessary.

# Medical care (including older people's care)

## Are medical care services safe?

Good 

### Staffing

Senior sisters on most wards said that the hospital had been recruiting staff who were due to start shortly once recruitment checks had been completed. Staff told us that recruitment procedures had been improved so that pre-recruitment checks were completed more quickly and therefore vacancies were filled sooner. During our inspection, we saw that there were sufficient staff on the wards we visited. Staff reported that numbers of staff had increased very recently. Most of the 14 wards we visited displayed on a board how many staff should be working on each shift, so that patients, staff and visitors could see staffing levels on the ward. The wards we visited were staffed to these numbers.

They reported that they were often moved between wards when there were shortages of staff, and that there was high usage of bank and agency staff. This meant that there was a risk of lack of continuity of care for patients. The ability of the hospital to remain safe for patients and to have effective systems in place for reporting and learning from incidents depends on adequate staffing levels being maintained.

Staff told us that there were often patients from other specialities on their wards. This was monitored by the trust. When patients were cared for away from their base ward, there was a risk that there could be a delay in their receiving care and treatment. Staff told us that they could usually access the appropriate doctors easily, but that they were trying to improve the patient flow to ensure that patients were cared for on the correct ward.

### Equipment and environment

We saw that the equipment appropriately stored away, apart from in one ward that was being used while a further ward was redeveloped. In this ward, there were large items of equipment that were stored in general areas and could have been a trip risk for patients and staff. Within patient records, we noted that risk assessments were completed and that the trust had a measuring tool for the risk of patients developing pressure sores. Staff had access to specialist pressure-relieving equipment if they felt a patient needed this. This meant that patients were kept safe.

### Medicines management

Medicines cupboards were securely locked and checks of the resuscitation trolley were completed on a daily basis.

### Cleanliness

We saw that the wards were clean. Hand gel and washing facilities were available in the ward areas. We saw staff practising good hand hygiene and wearing protective equipment such as aprons, gloves and masks when necessary.

### Learning from incidents

Staff were aware of the need to report incidents and how to do so. We saw evidence that they were investigating incidents: on Ward 8, the senior sister was undertaking a root cause analysis on a hospital-acquired pressure ulcer. Staff were able to identify how information from complaints on their ward had been used to improve care. They told us they received feedback from incidents in a number of ways including newsletters, meetings, emails and notice boards. We found some good examples of how learning from incidents was shared, but it was not consistent across all wards and often Heartlands specific. This meant that there was a risk of the same incident recurring.

The trust had a high rate of falls per thousand bed days. This was being addressed in a number of ways. Falls had been identified as a priority for 2012/13 and was to remain as one for 2013/14. The trust also had a Commissioning for Quality and Innovation (CQUIN) target for falls reduction. There was one falls coordinator for the whole trust. This person provided support to all the trust's sites as well as providing a twice-weekly clinic at Birmingham Heartlands Hospital for referrals from the community.

The coordinator provided support to reduce falls in many ways, including increased training, increased vigilance surrounding reporting and monitoring practices and promotions such as 'leave it low before you go'. The falls coordinator was able to provide information to show that, while the trust's rate of falls per thousand bed days were still above the national average, they were decreasing at all three sites.

We found evidence that staff learned from incidents. On the ward for patients with cystic fibrosis, they had identified that patients were developing pressure sores on the bridge of their nose because of the breathing masks, and they found a solution to prevent this happening. This had been

# Medical care (including older people's care)

shared with the ward at Good Hope Hospital that cared for patients with similar needs. However, we found no other evidence that lessons were consistently shared across specialities and sites to improve practice. Staff we spoke to were hopeful that the introduction of the supernumerary band 7 senior sisters would help embed the practice of learning lessons from incidents and complaints.

At Birmingham Heartlands Hospital, we saw that, while most records were up to date, care was being delivered appropriately even when records had not been updated. For example, a patient who had had two falls on Ward 21 had not had their manual handling risk updated at the time of their first fall. However, the patient had been moved to a high visibility bed and their call bell was available to summon help. We found other issues with care records not being up to date but, on checking with the nursing team, care was being given appropriately. This included a patient who was assessed as not requiring a nutritional risk assessment despite their initial assessment highlighting a low body mass index (BMI) and a subsequent weight loss. A further patient was found with pressure sores but no up-to-date risk assessments undertaken in respect of nutrition, manual handling, etc. However, this patient had been referred to the dietitian and actions taken to improve their nutritional status in order to promote healing of the pressure sores.

## Escalation policies

We spoke with the acting chief nurse who told us about the escalation procedures when there were staffing shortages on a ward. This was recorded electronically so that the site coordinator could see an overview. Staff were then moved usually within the speciality to support those wards who had higher levels of dependency or lacked some staff. This process was known to all staff and worked well to cover shortages.

**Are medical care services effective?**  
(for example, treatment is effective)

Requires improvement 

## Evidence-based treatment

The trust provides primary angioplasty at the Heartlands site. Reviewing the most recent myocardial ischaemia national audit project (MINAP), it demonstrates that their “door to balloon time” i.e. admission to treatment, is

slightly below the national average (81.4% vs 91.7%) and that their “call to balloon time” i.e. the time the staff are alerted to the fact that the patient requires treatment to treatment, could be improved as it is currently at 66 minutes compared with 40 minutes nationally.

Although out of hours stroke thrombolysis is provided at the Solihull site, from 9-5pm it is performed at Heartlands. They therefore contribute to the Stroke Improvement National Audit Programme (SINAP). This demonstrates that it provides a good service to the local community.

## Training

The trust had a training plan for dementia that was part of its dementia care CQUIN target. Training was provided in a variety of ways including drop-in sessions and training days. The trust had a plan to improve dementia care. It aimed to have 5% of staff as dementia champions and 70% of staff as dementia aware. Hardly any of the 14 wards we visited had a dementia champion. There were variations across the wards in how many staff had dementia training. The training figures provided by the trust were not broken down into sites or specialities so we were not able to see clearly how many staff working on medical wards had received dementia training. Staff told us that they could not always attend training because of staffing levels. The trust was now providing some training online, although some staff were unhappy that protected time was not available for training. The recruitment of more nursing staff and supernumerary ward managers should also improve access to formal training and ad hoc training on wards.

## Working with others

We saw examples of good multidisciplinary team collaborative working. Physiotherapists told us that medical staff had recently donated money from their study fund to support physiotherapists, because they could see the benefit for patients and staff from physiotherapists trained in specialist areas. Staff we spoke to at the physiotherapist and occupational therapist focus group were able to tell us the trust's values. Staff said that it was a good place to work and many we spoke to had worked there for their entire career.

## Clinical audit

Wards displayed information on their performance against metrics. The amount of detail varied between wards. Ward 8 had a very clear display of performance against targets and what actions were being taken to improve performance. On Ward 21, there was only the bold figure for

# Medical care (including older people's care)

metrics without sufficient detail to show what was working well and where improvements could be made. The number of falls on the board had not been updated since January 2013. The board was difficult to see because there was equipment in front of it.

The hospital used a 'red jug' system to identify patients who needed support with eating and drinking. When patients were identified as needing support, we saw that there was a red jug lid in place, and staff recorded how much patients had eaten and drunk when this was needed.

## Are medical care services caring?

Good 

### Patient experience data

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average. This means that people are unlikely to recommend the unit to their family and friends as a place to attend.

Five wards were identified by patients as 'extremely unlikely' to be recommended to friends and family. At Birmingham Heartlands Hospital this included the medical wards 3, 9 and 12. We visited all of these wards while inspecting and we had concerns in wards 9 and 12 about the care for patients with dementia.

### Patient-centred care

All the patients we spoke to said that they were happy with the care they had received. We also observed staff providing good levels of care. We saw staff take their time to listen to patients and answer their questions, even when the ward was busy. Patients used words such as "brilliant" to describe the care they had received. The wards, although busy, were very calm. Nobody raised any concerns about the care that they or their families had received. Patients we spoke to said that doctors and nurses had discussed their care and treatment with them in their first language. They also told us that staff kept them informed and that they felt listened to. Staff we spoke to also understood the importance of involving patients in decisions about their care and treatment.

### Observation

Patient experience was included as part of the information used to evaluate care as a whole. On Ward 8, the senior sister said that volunteers were used to ask patients about their experiences. There were friends and family test boxes outside all the wards we visited, but mostly there was no information on what patients had fed back or what the ward had done in response. Some of the boxes were empty of cards for patients to comment on. Many of the patients we spoke to were not aware of how to make a complaint despite signs on the wards that told people how they could do so. Some wards such as Ward 30 held a weekly drop-in session for relatives to speak to staff and ask questions. This was good practice and the ward felt very welcoming. There was a statement about values at the entrance and large photos reflecting the ethnicity and diversity of the patient group.

On Ward 21, there were signs offering to contact doctors for relatives. One of the relatives told us they had been asking to speak to the doctor ahead of their relative's discharge but it had been difficult to arrange a time. The doctor saw them while we were visiting.

## Are medical care services responsive to people's needs? (for example, to feedback?)

Requires improvement 

### Access to service

The ability for a trust to conduct safe and timely discharges is important for overall patient flow through the hospital. Patients need to be discharged when ready and any information and support provided to ensure the patient does not need to be re-admitted into hospital. In the most recent patient survey the trust scored similarly to other trusts in respect of the information and timeliness of discharge.

### Treatment of vulnerable patients

The hospital serves a diverse population with many non-native English speakers, but information was only available in English. One of the steps of the falls care pathway was for

# Medical care (including older people's care)

the patient and/or relative to be given a falls leaflet. This was only available in English. There were effective systems in place to access translators. The cultural mix of the staff reflected the community that they were providing care for.

The faith centre was very welcoming. There was access to leaders of all the major faiths. There were prayer facilities too, as well as a quiet room.

## Discharge planning

Because of the pressures on beds in the trust, the hospital had taken steps to improve patient flow. There were external pressures that also had an impact on the hospital's ability to discharge medically fit patients and these included the availability of beds in care homes and intermediate care. From an internal perspective the trust had been taking multiple steps to alleviate their bed pressures, including: encouraging early discharges with daily discharge targets, using JONAH boards for early identification of patients ready for discharge, increasing the number of discharge coordinators and having multiple bed meetings.

The five discharge coordinators worked closely with colleagues on the wards to manage the discharge process. The discharge coordinator on Ward 8 spoke to patients, families and care homes staff, and acted as a point of contact. Medical and nursing staff were very positive about the value of the discharge coordinator. They told us that the presence of discharge coordinators freed staff to deliver care, and they expressed concern about the plan to reduce the number of discharge coordinators to three and amend their role. JONAH boards, which are used by the multidisciplinary team to highlight when patients are ready

for discharge and appeared to be working well on most of the wards we visited. There was also a rapid enhanced assessment clinical team (REACT), which provided a timely discharge for patients and was spoken of highly by staff in assisting patients' discharge.

## Are medical care services well-led?

Good 

### Leadership and vision

We saw that medical staff were well-led. The nursing staff we spoke to were positive about the introduction of supervisory status for senior sisters. Staff also told us that matrons and senior nurses were visible and available to support them. Medical staff told us of improved leadership, that they felt supported and able to raise concerns.

### Management of risk

We saw good examples of lessons learnt being implemented at ward level. This demonstrated that the management of incidents, the results of the investigations held and the lessons learnt from these were making a difference to the care patients received. This also demonstrated that within this directorate information was cascaded from the senior management team to ward level.

### Cohesion

Doctors and nursing staff worked well together and we heard examples where other members of the paramedical team efforts were recognised and rewarded, in particular the physiotherapists.

# Surgery

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

## Information about the service

Birmingham Heartlands Hospital provides emergency and elective surgical care to its local population. There are seven wards delivering surgical treatments across a variety of specialities. We visited all these wards and talked to staff, patients, two visitors and two visiting social workers.

## Summary of findings

We had few concerns about the surgical unit of Birmingham Heartlands Hospital. The wards were safe, well-led and the staff were found to be caring. The day surgical unit was not always used appropriately for day surgical patients in that other specialities ‘borrowed’ beds, which had impacted on the responsiveness of the unit. This caused some delays in admitting patients to the ward and in the care provided. The trust will also need to address the late starting of operating lists so that patients receive treatment in a timely manner. In order to speed up discharges, the staff at the unit had developed a system of daily review appointments with slots in the CT scanner so patients who could wait until the following day for a scan could go home and come back for this the next day.

# Surgery

## Are surgery services safe?

Good 

We received positive feedback from patients, who felt it was a safe hospital. One patient told us how staff checked their name wrist band three times before they were anaesthetised. A visitor told us they had no concerns at all and that their relative was being looked after “in a safe way”. They said their relative would tell them if they were concerned about anything that was happening on the ward.

### Risk assessment

We saw good practice in the prevention and care of patients with pressure ulcers, including appropriate risk assessments, care plans and use of equipment. Two ward managers confirmed that patients with a pressure ulcer had access to specialist advice on tissue viability if needed. On two of the wards we visited, we were told people did not have any pressure sores.

### Staffing

During our visit we saw sufficient numbers of staff on duty to care for the patients that were on the wards. There were escalation procedures in place which staff were aware of if shortage of staff occurred. Despite the increase in the number of beds on the day surgical unit on the day of our visits we were satisfied that there were sufficient staff for the number of patients on the ward.

### Cleanliness

The wards were visibly clean. Hand sanitisers were available outside the wards, bays and side rooms. Information on infection control was displayed at strategic points. Patients told us that their wards and the hospital were always clean. One person told us they had observed cleaners “doing a good job”. We saw that staff wore gloves and washed their hands between seeing patients, and that patients with infections were treated in side rooms as required.

### Learning from incidents

We discussed never events with a consultant surgeon and the theatre nurse manager. They explained how they implemented the World Health Organization’s safe surgery checklist to reduce the risk of never events. The theatre nurse manager told us they used both a paper copy and an

online copy (via an iPad), and that these were regularly audited. The never events that had happened at the hospital were on display in the theatre area, to ensure staff were reminded to use the safe surgery checklist at all times.

### Escalation policies

Staff told us that medical patients were being treated on the surgical wards. This was because there were not enough beds on the medical wards. Two ward managers told us that sometimes they had to ‘chase’ consultant teams or ‘remind’ them of where the patients were. One medical patient said they were aware they were on a surgical ward but “the care was excellent”. They were told they would be moved when a bed became available on one of the medical wards, but did not know when this would be. Risk to patients increased if they were admitted to an inappropriate ward or moved between wards. The hospital was coping with a large number of emergency medical admissions during our inspection and patients were not always admitted to an appropriate specialist ward.

## Are surgery services effective? (for example, treatment is effective)

Good 

### Evidence-based treatment

The hospital operated a protected mealtimes policy. We were told that clinical staff were not encouraged to visit the wards at this time. On two separate occasions, we were asked to leave the ward to ensure patients had their meals without interruption. People told us they enjoyed the meals and were given a choice of what they could have. A diabetic patient told us they were given choices suitable for their medical condition. We saw that people were given fluids throughout the day.

### Training

All staff spoken to felt they had good training opportunities and support from management to attend study days. They all were very proud of the work they did. The trauma unit had a seven-day theatre list, but used to have two trauma co-ordinators and now only had one. There were no plans to replace this person. This meant that sometimes operations were delayed because demand outweighed capacity.

# Surgery

Staff on the surgical trauma and orthopaedics ward said that, because of staffing issues, the pressures on core surgical trained junior staff meant that they didn't get time to assist in theatre and, when they did, the time was limited. Similarly, the vascular surgery team said that at times it was felt there was no availability of emergency cover and that delays were caused by a lack of high dependency beds. However, staff told us that the critical care outreach team was very supportive and helpful.

## Are surgery services caring?

Good 

### Patient experience data

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average.

Five wards were identified by patients as 'extremely unlikely' to recommended to friends and family. At Birmingham Heartlands Hospital this included the surgical ward 12. We visited all of these wards during our inspection. We were not concerned by the care given at this location.

### Patient-centred care

All patients spoken to felt that the staff were kind and caring, and we observed some good examples of caring professionals. Patients told us their privacy and dignity was respected. They said staff always treated them with respect. One person in the day surgery unit said, "I have seen real compassion in this hospital today."

### Observation

We saw some examples of good care while visiting the wards. We visited over lunchtime on one ward and we could see that the staff nurse we were talking to was looking uncomfortable. As we knew about the protected lunchtimes we asked if we should leave. The staff nurse agreed that it is better for her patients if we did. This shows that despite the presence of the inspection team this member of staff wanted to provide the best care for her patients.

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

Requires improvement 

### Access to service

The trust was meeting the targets set around the time it takes for a patient to be referred by their GP to having treatment. The Department of Health monitor the proportion of cancelled elective operations. This can be an indication of the management, efficiency and the quality of care within the trust. The trust was performing similar to expected in comparison with other trusts.

The day surgical unit received patients for day surgery and also those for longer stays as a short-term measure when capacity on the wards was high. Staff from the unit reported that delays to starting operations on patients on lists such as trauma could have a knock-on effect on surgery scheduled for the day unit. This reduced the unit's ability to be responsive to the needs of its patients. Patients re-routed to day surgery for admission were occasionally forgotten by the relocating ward team. The nurse told us that there had been occasions when they had had to ring the ward to remind them of 'their' patients waiting in the day care unit.

All patients we spoke to told us they had not been waiting long for their surgery. They had been asked to sign a consent form and their operations and follow-on treatment had been explained thoroughly to them. Patients in the day surgery unit confirmed they had been visited by the consultant and the anaesthetist the morning of their surgery. We saw completed consent forms on some of the files we looked at.

### Treatment of vulnerable patients

We discussed safeguarding with two visiting social workers who were in the hospital to assess two patients due for discharge. They felt that the staff had a sound awareness of safeguarding procedures, and staff we spoke to were able to discuss safeguarding procedures and knew how to escalate any concerns they might have. Staff confirmed they had training in safeguarding and said it was mandatory.

# Surgery

## Complaints

We saw that people were encouraged to give feedback on how they felt the trust could improve, and there was a 'comments' box at the entrance to each ward, called 'You said, We did'. We did not see the findings of any issues raised by patients and visitors to the wards. Staff told us that the boxes had only been installed recently and they had not had any feedback.

## Are surgery services well-led?

Good 

## Leadership and vision

Staff we spoke to on the surgical and day wards told us that they felt well-supported and that their wards were well-led.

Senior staff told us that matrons were visible and supportive. We were told at senior management level that the process for recruiting nursing staff had been made quicker; however, staff on the wards did not know about, or had not felt the impact of, these changes.

## Management of risk

Safety and quality of care were monitored and action taken in response to concerns. A ward manager explained that each ward monitored its performance against department standards. Staff were informed of the outcome of quality monitoring to improve performance. For example, there were infection control audits of hand washing as well as audits of incidences of falls and pressure sores.

## Intensive/critical care

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

### Information about the service

The critical care unit (comprising of both intensive care and high dependency beds) at Birmingham Heartlands Hospital had 19 beds. We spoke to seven medical and eight nursing staff working in the critical care unit, as well as three relatives, three patients and a priest.

### Summary of findings

We found good practice in the critical care unit. These included effective communication between teams, the critical care outreach team and the support given to families. The high bed occupancy gave us cause for concern, but the outreach team was managing this at the time of the inspection and the trust had plans in place to increase bed numbers. However, the trust will need to keep this under review as winter approaches and traditionally demand for critical care beds escalates.

# Intensive/critical care

## Are intensive/critical services safe?

Good 

### Staffing

There was a coordinated and embedded critical care outreach service that operated 24 hours a day 7 days a week. In addition to providing support to ward staff when patients deteriorate suddenly, the outreach team also provided support for patients and their families. The outreach team will also follow up patients on the wards once patients are well enough to be stepped down from the unit.

The team provided and collated audits of the support they provided in order to monitor trends and analyse the function and success of the project. This information identified that the trust did not always meet the standard of admission to critical care within four hours following a peak in March and April 2013 when 11 and 18 patients were managed outside critical care for more than four hours.

Staff confirmed that staffing arrangements were safe. One trained nurse provided care for each person who was assessed to be level 3 and one nurse provided care for up to two people who were level 2 patients in accordance with national guidelines for critical care

### Equipment and environment

The space in the unit was very limited when considering the high demand for beds. Information provided before the inspection identified 100% bed occupancy. This was corrected by a consultant who said that the bed occupancy was actually 93%, although this remained high. There was a risk that additional demand for beds over the winter period could adversely affect the unit. However, there were plans in place to provide an additional four high dependency unit beds to address this.

To address the limited space available within the ITU three offices have recently been converted into side rooms to enable the unit to cater for patients with infections. The majority of national standards for critical care were found to be met. However, the ratio of patients to consultants (recommended to be 1:14) was not being met because there were 19 beds on the unit and only one consultant available between 1pm and 9am.

### Learning from incidents

Staff told us that 'lessons learnt' throughout the hospital were included on the hospital intranet. Within the critical care department, they discussed during each handover for a week 'nuggets' of communication, such as the use of specialist equipment to avoid soreness for people requiring breathing assistance. A doctor told us that the 'Lesson of the month' had been stapled to their payslip to ensure they were aware of the incident and to minimise the risk of similar occurrence in the future.

## Are intensive/critical services effective? (for example, treatment is effective)

Good 

### Clinical outcome data

Results from the Intensive Care National Audit & Research Centre (ICNARC), demonstrate that Heartlands performs within expected limits on all parameters except for the number of delayed discharges to the ward.

### Training

All staff received a six-week induction to critical care nursing. All nurses then undertook introductory modular training that included critical care competencies in which they had to be assessed as competent before they could complete their induction. After at least 18 months' experience, they then undertook advanced modular training in critical care nursing. After that they could apply for a critical care nursing qualification. We were told that only nurses who had an additional critical care qualification could apply for band 6 positions. At the time of our inspection, 60% of nurses had this qualification. Staff told us that they felt supported to undertake training to develop their practice and the department's practice.

### Clinical audit

The ITU used a system of colour-coded personal protective equipment that was unique to each bed space. The senior sister in charge said this enabled senior staff to easily observe that staff washed their hands and changed their aprons when moving between patients. We looked at patients' records, which showed that patients had a recorded and multidisciplinary plan of care that was reviewed by the medical staff at least twice daily. Nursing care observations and checks were done at least hourly and actions taken as necessary. The records we looked at

# Intensive/critical care

confirmed that people received the care and treatment they needed. Staff spoken to confirmed that the critical care department had effective multidisciplinary working and that everyone was equal.

## Are intensive/critical services caring?

Good 

### Patient-centred care

The staff we spoke to were caring and highly motivated to provide good care to the patient and support for their family. We reviewed records where it was clearly recorded that identified loved ones had been kept informed of care and treatment needs and, when bad news was discussed, this was done compassionately and sensitively.

Staff told us about initiatives such as the 'bereavement trolley' that contained information on, for example, a variety of religious needs, and equipment including a 'nice quilt' cover. Staff were unhappy with the visitors' overnight room, which was on another floor and only had basic furniture including a sofa bed. We saw that this facility was useful when a patient's condition deteriorated suddenly. We saw that arrangements were in place to meet people's spiritual needs when requested.

### Observation

We observed that privacy screens were in use in the critical care department. However, the current screens gave inadequate privacy because patients were clearly visible where the screens folded. We did not see any notice to remind staff or other people to ensure people's dignity by not going through the screens.

## Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Good 

### Access to service

Capacity was an issue with the department and in the last year 40 patients were transferred to other hospitals because of a lack of critical care capacity. This was corroborated by the Intensive Care ICNARC data. We were told that the service was in the process of planning how to

respond to expected additional demand over the winter period. There were plans to enlarge the separate high dependency unit by using a bay that was currently a stroke ward. This would increase the number of high dependency beds by four. The consultant focus group also identified concerns around general capacity within the hospital and the increasing demand for beds that affected the quality of care provided.

### Complaints

We discussed complaints with senior staff and found them responsive to concerns. Staff told us that they supported colleagues on the wards with seriously ill patients and records we saw confirmed this.

## Are intensive/critical services well-led?

Good 

### Leadership and vision

The matron told us that, since there had been additional demands on capacity, she had been based solely in Heartlands critical care department. Staff confirmed this. The matron told us that she supervised staff and reviewed a selection of records each day to ensure that people received the care they needed. There were clear roles and responsibilities for all staff. Weekly meetings were held. Staff told us that they had a mentor group and all confirmed that they had an annual appraisal and the training they needed. Some staff had an excellent induction; however, not all staff received the same induction because this was dependent on their previous employment and experience.

### Management of risk

To provide effective use of staff and to maintain their skills, the department used all its staff across both hospitals in the critical care department. Staff were in agreement that this provided flexibility and ensured that they could be responsive to patients' needs.

### Cohesion

Discussions with staff confirmed that the critical outreach service was well-led and provided appropriate support. Critical outreach staff told us that they struggled with the demands of the service and were late going off shift at least 50% of the time.

# Maternity and family planning

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

## Information about the service

Maternity services were provided at all three hospitals with women able to choose where they had their babies. Women were also able to access maternity-led services and water birth facilities. Birmingham Heartlands Hospital opened the Princess of Wales Maternity Unit in 1992, and this housed one of Birmingham's major neonatal units. The neonatal unit had 7 intensive care beds, 3 high dependency and 12 special care cots. The unit delivers approximately 7,500 babies a year.

## Summary of findings

We found that maternity services were sometimes overextended and the flow of women through the service up to and including discharge was disjointed and fragmented. The staff we spoke to all described a feeling of being stretched and that at busy times the running of the service was largely dependent on their goodwill. Staff told us they often worked over and above their allocated shift, sometimes working 13 hours without breaks.

All the staff we spoke to told us they felt there was a disconnection with the senior management of maternity services. Some staff were unable to tell us the names of their head of midwifery and their deputy and associate heads.

We saw an extensive governance framework and noted that incidents, complaints and audit findings were escalated through a committee structure to the board. However, a number of staff were unable to tell us how they learnt from incidents and complaints, or how the governance framework drove forward practice within the trust.

# Maternity and family planning

## Are maternity and family planning services safe?

Requires improvement 

### Staffing

Staff told us that the environment was built for 3,500 births per year but recently the birth rate had escalated to 7,000 – 7,500 births per year. The trust currently has 108 hours of consultant time in the delivery but has plans to increase this to 168 hours. This increase will bring it in line with the recommendations from the Future Role of the Consultant guidance produced by the Royal College of Obstetricians and Gynaecologists. We walked around the maternity unit and found staff working in difficult circumstances. We discussed this with patients, the meeting held with the head of midwifery and associate heads of midwifery who all said that staff were under pressure. The trust had identified the problem and were addressing the issue through the Pelican Project. This was a way to explore the options available to overcome the capacity concerns within the unit. Staff were engaged in the process and able to describe to us the possible solutions. The long term solution was to resolve issue with expanded current site or new build but was not due for resolution until 2016. During our visit, we were told that at busy times women gave birth in other areas of the hospital, such as the main ward areas, because there were not enough delivery rooms available.

Most staff were working long shifts without breaks and the unit relied on bank staff to cover gaps within the rotas. However the midwife to birth ratio was at the recommended level of 1:28. A small number of staff told us that roles were sometimes blurred because of the shortage of staff. Examples of this were ward clerks assisting women with feeding, and midwifery support workers fulfilling the role of a domestic. We saw from the rota's and from the documents provided about how many hours staff worked that the permanent midwives were working extra shifts to provide adequate cover. This meant that on a daily basis they were able to provide safe care however the trust may like to note that staff were working above recommended guidelines.

### Learning from incidents

We saw good reporting of incidents and appropriate escalation to the trust board. We saw evidence of serious

untoward incident investigations and changes to practice implemented as a result of the investigation. However, despite seeing memos and newsletters, staff at Birmingham Heartlands hospital told us they did not always receive feedback from their line manager.

All three sites had good governance structures and specialist midwives with responsibility for governance and implementation of national policies and guidance.

### Escalation policies

We spoke to the matrons at Birmingham Heartlands who showed us escalation policies. These appeared appropriate and staff were aware of them.

## Are maternity and family planning services effective?

(for example, treatment is effective)

Good 

### Clinical audit

According to the Royal College of Obstetrics and Gynaecologists Clinical Indicator Audit, the Good Hope maternity department performs on par with the national average.

### Evidence-based treatment

The trust had a dedicated specialist midwife who had responsibility for the implementation of policies. National guidance was discussed at the Clinical Risk and Audit Committee. Robust systems were in place for the ratification of new policies and guidance. The special midwife for guidelines explained that, when National Institute for Health and Care Excellence (NICE) guidance was not implemented, there was always documented evidence to show the rationale behind this decision.

### Training

We saw evidence that staff were able to access a variety of mandatory training and there were opportunities for further development. This training included formal courses, self-directed study and emergency skill drills. However, when questioned the majority of staff were unclear what mandatory training should be attended and how often. We

# Maternity and family planning

spoke to maternity support workers who said they were well supported within their role by the project midwife. The project midwife told us their focus was on the continued development and training of support workers.

## Clinical audit

The trust undertook a variety of daily, weekly, monthly, quarterly, six monthly and annual audits. The results were displayed in each ward and department. Staff were able to see on monthly basis whether they were improving. We saw evidence that a monthly metric was undertaken on a sample of 10 care records. The clinical risk midwife explained that this in-depth review of care records identified gaps in care, treatment and documentation throughout the antenatal, intrapartum and postnatal period. Performance against the metric standards was reported through the governance committee structure and results were fed back to staff through the staff brief. We saw evidence in the staff brief for September 2013 that results were given to all staff, although staff were not always able to describe the results to us.

## Are maternity and family planning services caring?

Good 

## Patient experience data

We saw evidence that the family and friends test was carried out and the results displayed in the ward areas for staff and people using the service to view. We saw comment books available for people to write in and the complaint process was explained to women and their families should they wish to make a formal complaint.

## Patient-centred care

At Birmingham Heartlands Hospital, women and their partners told us they were involved in their care and birth plans. We had few adverse comments, except one woman at Heartlands told us: "My baby was poorly and was taken away from me for treatment. I did not see them for over an hour and it was the next day before I understood fully what had happened."

## Observation

We saw evidence that two-hourly comfort rounds were undertaken. Staff explained that these rounds were used to ensure women were comfortable and their needs being

met. A matron told us that staff dealt with any requirements but had an escalation process should they be unable to fulfil the required need. We walked around the location and saw that doors and curtains were closed and people knocked on doors before entering. This showed us that people's privacy and dignity were respected.

## Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Good 

## Treatment of vulnerable patients

The trust had a variety of specialist midwives. We saw specialists for bereavement, domestic violence, mental health and female genital mutation. Many of the specialists told us that they held community events or visited people in their home. Staff had access to interpreters, a list of staff members who spoke different languages, and use of the language line. When asked how useful these services were, they were inconsistent in their responses. Some said that they used the language line; others felt that it did not maintain people's privacy, especially in the reception area. Some staff were not aware of all the services available. All the signage was in English, which did not cater for people whose first language was not English. We did find some evidence to demonstrate that interpreters were used; overall, however, the use of interpreters was inconsistent.

## Discharge planning

We saw delays in patient flow during our visit. Staff explained to us that these delays were caused by excessive documentation, duplication of paperwork, IT systems and longer neonatal pathways.

## Complaints

As with incidents, we saw and heard about the escalation of serious complaints but staff told us learning and communication following the investigation of complaints was poor.

# Maternity and family planning

## Are maternity and family planning services well-led?

Requires improvement 

We spoke with a number of staff at Birmingham Heartlands Hospital who told us that senior managers and leaders were not visible in the clinical areas and that communication was poor from the most senior of midwifery staff. The medical profession in contrast felt supported at Birmingham Heartlands Hospital. We spoke with the head of midwifery who told us they also felt they were not visible due to the pressure of work.

### Leadership and vision

Matrons were very visible to us during our visit and staff told us they were well supported by the matrons. However the more senior leaders and management were not visible on this site. The staff felt that the management was only interested in systems and processes rather than the support of the workforce.

We saw evidence that 66% of staff had received an appraisal, with a target of more than 75% by the end of the year. Supervisors of midwives were available for support and were on call throughout the day and night. The ratio of midwife supervisor to midwife was slightly higher than the

recommended national standard of 1:15. The midwifery support workers were supported by the project midwife and the newly qualified midwives were supported by a preceptorship midwife. A preceptorship midwife is a midwife with experience who supports newly qualified midwives. The band 7 midwives and modern matron were very visible during our visit.

### Management of risk

We saw a robust governance framework and reporting structure to the trust board. There were four dedicated governance midwives employed. Incidents, serious untoward incidents, complaints and audits were analysed and reported through the committee structure to the trust board. However, despite seeing various methods used to communicate the findings and learning to staff from previous incidents, we were repeatedly told staff did not understand the trends, learning and changes to practice. Some staff explained to us they felt mistakes resulted in supervised practice rather than learning, which was creating a culture of fear among the workforce.

### Cohesion

Capacity, staffing and leadership had an impact on the cohesiveness of the service. Staff felt over stretched at Birmingham Heartlands Hospital and that the department functioned on the good will of the staff.

# Services for children & young people

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

## Information about the service

Birmingham Heartlands Hospital offered children and adolescent inpatient and outpatient services for patients between the ages of 0 and 16 years.

The inpatient service consisted of a 17-bedded paediatric day case ward that provided short-stay pre- and post-operative care Monday to Friday, closing overnight, and a long-stay general paediatric ward with 18 beds, which also included a paediatric high dependency unit with four beds. There was a 'flexi ward', which had capacity for 12 beds, was opened on an as required basis and also contained the paediatric assessment unit. This unit consisted of 8 assessment beds and 4 observation beds that enabled patients to be assessed quickly. This included GP referrals and some patients with long-term complex medical needs who had 'passport' status. These were children and adolescents who were placed on the system by consultants; this meant that they had direct access to the paediatric assessment unit and would be reviewed quickly. Within all three wards, there were single rooms for isolation purposes. There were a few overnight rooms for parents to stay; however, there were beds available on the wards.

The neonatal unit was a level 3 unit and consisted of a total of 36 cots of which 20 were special care, 6 were high dependency and 6 were neonatal intensive care cots. The unit provided a whole range of medical neonatal care for the local population such as care of premature babies and term babies who were fragile or sick.

## Summary of findings

Children's safeguarding procedures were robust and had been improved in response to findings from a serious case review. Assessments of patients' needs were undertaken on admission by both nursing and medical staff, and care and treatment were delivered effectively by caring staff. There was a strong management presence in the form of the head of nursing, matron and supervisory ward sisters or managers. There was evidence of regular senior meetings and completion of audits to monitor the quality of service provided. There was also evidence of learning and improving as a result of incidents that had occurred.

However, the hospital was not responsive to the management of children and adolescents or young people with mental health needs. This was because staff had received no mental health training, and there were no policies (other than one for suicidal patients) or pathways in place to ensure consistency in practice. Risk assessments were undertaken but were not robust enough to minimise the potential risks to these patients.

# Services for children & young people

## Are services for children & young people safe?

Good 

### Staffing

An electronic staff rostering system was in place across all wards and this helped to support the effective planning of staff numbers and skill mix on any given shift. Staffing levels on the general ward were based on the Royal College of Nursing guidance 2013 for general paediatric wards. The neonatal unit had two advanced neonatal nurse practitioners who supported the nursing and medical staff team.

### Cleanliness

All the areas of the paediatric service were clean and tidy. There were wall-mounted alcohol rubs on the wards (not in cubicles for safety reasons) and hand wash basins at various locations. Staff had access to protective personal equipment (gloves, aprons). There were visible notices on hand hygiene.

### Escalation policies

Children who were admitted to the inpatient wards were risk assessed on admission and care was planned accordingly. A paediatric early warning system (PEWS) was used across the wards to assess children's clinical observations and this alerted nurses to take action when scores were high. We saw evidence of pressure ulcer prevention records, fluid charts and integrated multiprofessional daily records. Ward nurses attended medical handovers to ensure there was good communication between doctors and nurses about each child's care. All these processes ensured that treatment was delivered effectively.

We saw evidence on the day case ward of robust checks completed pre-operatively. Children were routinely checked at least three times before starting a procedure – first on the ward, second in the anaesthetic room and third in theatre. Surgical areas were marked on the ward to reduce the likelihood of errors. A paediatric day case booklet was used to record all pre-operative checks and observations done in theatre and recovery. This reduced the need for several separate forms. However, it was noted that, although PEWS was used by ward staff to record

clinical observations on the ward, the observation charts in the booklet, used on day surgery, were different. The extended use of PEWS into theatre would improve consistency in recording of clinical observations.

## Are services for children & young people effective?

(for example, treatment is effective)

Good 

### Training

There was evidence of close unit and good team working between nursing and medical staff across sites. Staff confirmed that they had received mandatory training and records showed that this was currently at 93%. Newly qualified nurses had a preceptorship programme and a rotation across the paediatric services. Student nurses said they liked working on the paediatric wards. Junior doctors in the neonatal unit reported a teaching and training culture with visible and accessible consultants. Medical staff were given a neonatal guideline book that was updated every year on the intranet.

### Working with others

We reviewed the facilities for transitional care by speaking to the children's respiratory nurse who gave us an example of transitional care for children with cystic fibrosis. This included early planning and support for patients going through transition. The transition of care from paediatric to adult cystic fibrosis nurses took place in an organised manner.

## Are services for children & young people caring?

Good 

### Patient-centred care

Parents had open access to the paediatric wards and siblings between 10am and 7.30pm. There were separate visiting times for other visitors. There was a parents' lounge shared between the paediatric services with facilities for parents to make themselves a hot drink. However, there was no information informing parents of this on the paediatric wards. Parents were able to stay overnight with

# Services for children & young people

their child. There were two overnight rooms, shared with the neonatal unit, which parents of very sick children could use. Camp beds were available for other parents to sleep beside their child.

There were toys and activities available for children within the paediatric wards. Play specialists and teachers were based on the ward providing education facilities Monday to Friday. There was a play room for children to use. We saw that there was a lack of staff interaction with a baby on the ward who did not have parents with them. It was evident that this baby's care needs were being met but there was no evidence of how their social and emotional needs were being met.

Some parents felt that, when there were areas of improvement, these were mainly related to staffing levels that would have an impact on the quality and safety of care. Nearly all the parents told us that they were happy with the care and treatment that the hospital had provided and that the staff were helpful. Almost all told us that the staff listened to them, they were kept informed and involved in their child's care, and communication with the staff was good.

**Are services for children & young people responsive to people's needs?**  
(for example, to feedback?)

Good 

## Treatment of vulnerable patients

We saw evidence of how improvements in safeguarding procedures were made in response to the serious case review. These include:

Improved training for paediatric consultants.

An alert system on the electronic records to make A&E staff aware of information such as safeguarding concerns.

A&E paper records, including prompts for routine questions regarding whether the patient had a social worker, health visitor and common assessment framework in place.

A paediatric health visitor liaison service to look at all children's A&E admissions and ensure that information was shared with the health visiting team in the community.

Mandatory training for all staff in safeguarding children.

All the actions from the management review for the trust in response to the findings of the serious case review were implemented.

We were concerned about the responsiveness of the trust to children and adolescents with mental health needs. Staff we spoke to had little or no training in dealing with this client group whose numbers were increasing. We saw that there was no child and adolescent mental health services (CAHMS)-specific trust protocol, policies or pathway in place. The head of nursing told us that they had seen an increase in admission of children and adolescents with mental health problems and recently there had been eight patients in Birmingham Heartlands Hospital. A registered mental nurse would be booked if there were a number of patients requiring this type of support but this was difficult to secure out of hours. The trust was reviewing the need for an inpatient mental health unit for children and adolescents at the Heartlands site.

Birmingham Heartlands Hospital sits in the middle of a very diverse community. The executive team told us that, following engagement with the community, it had been decided that information would be provided in English as the main language. However, written information in other languages was available if requested. Parents we spoke to said that they could use the services of a translator but generally a family member was used to translate.

**Are services for children & young people well-led?**

Good 

## Leadership and vision

Staff spoken to were positive about the care that they provided and felt supported in their role. There were some inconsistencies in what staff said about feedback from complaints and incidents; some staff said feedback was given and others said not. The band 7 staff had supervisory roles within their working week, which meant that they were able to observe and monitor the quality of service provided. There was always a band 7 staff member during weekdays who was the paediatric bleep holder and would respond to any issues across the Heartlands and Good Hope sites; this was delegated to a band 6 staff member during the evenings and weekend.

## Services for children & young people

### Management of risk

There were 'Success, learn and change' posters on the paediatric wards, which were feedback on paediatric quality and safety; these informed staff of the key themes from incidents over the past month. An example of this was in July 2013: the poster referred to an increase in CAHMS patients and actions to be taken. For example, any transfers must be escalated to the on-call nurse to identify availability of beds, and all patients must receive daily risk assessments to help ascertain if specialist 1:1 care was required from a registered mental health nurse. The aim was to give feedback to staff on incidents that had occurred so that learning could take place.

### Cohesion

There was evidence of regular quality monitoring audits (nursing metrics) that looked at key areas – for example, infection prevention. An overall score of how the ward was performing was given and this was on display on the ward notice board, so visible to all. Any areas that required improvements were highlighted as 'The lesson of the month'.

# End of life care

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

## Information about the service

Birmingham Heartlands Hospital had a palliative care team that supported all wards in the hospital. The team provided end of life care directly to patients throughout the trust, where appropriate, as well as supporting and training staff on the wards.

We spoke to five patients and ten members of staff, including staff nurses, the lead nurse for end of life, the co-ordinator for end of life, end of life consultants, a social worker, bereavement service officers and ward sisters. We observed care and treatment and looked at four patient records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service. The hospital had worked hard to meet the needs of its local ethnic population and to ensure that the religious and cultural needs of people at the end of their life were met in a timely and sensitive way.

# End of life care

## Are end of life care services safe?

Good 

### Staffing

Services at Birmingham Heartlands Hospital were safe in respect of end of life care. The palliative care team was led by a palliative care consultant who was also the medical director at the local hospice. This ensured that there were good links with community-based services.

### Equipment and environment

Side rooms in the hospital wards were fitted with light dimmers, soft furnishings and black-out blinds in order to promote a less clinical environment

### Learning from incidents

The Liverpool Care Pathway had now been withdrawn and the hospital was working with the National Council for Palliative Care to develop a new approach to care. However, the care teams continued to discuss the wishes of the person and their family in order to ensure that people's experience of death was as positive as possible.

## Are end of life care services effective? (for example, treatment is effective)

Good 

### Evidence-based treatment

The service had now stopped using the Liverpool Care Pathway as advised by the Department of Health. However we saw examples of current guidance in place and that this was having a positive impact on the patients and their families.

### Training

Training was provided in end of life care, swallowing assessments, moving and handling, and staff were supported to undertake further study either through the local hospices or within the hospital. The trust had developed master classes in compassionate care, which included enabling staff to have the necessary difficult conversations with relatives and patients. The feedback from staff on this programme had been very positive. The

hospital offered a range of qualifications in care at the end of life from certificate to master's level. It had a programme called 'Compassionate employers', through which it supported staff appropriately.

## Are end of life care services caring?

Good 

### Patient experience data

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average.

### Patient-centred care

Care plans were checked daily to ensure that staff were providing appropriate care. People we spoke to said that the nursing team was very caring and always available to answer their questions. Staff had been part of developing the 'It's the little things' project, which reviewed the small things staff could do to make the death of a loved one a better experience. As a part of this project, a compassionate pack was made available to relatives who did not want to leave their loved one. This contained a few items such as juice, crisps, pen, paper, etc. in order that the relative did not have to leave the side of their loved one.

## Are end of life care services responsive to people's needs? (for example, to feedback?)

Good 

### Access to service

The Cancer Patient Experience Survey (CPES) is designed to monitor national progress on cancer care. 155 acute hospital NHS trusts took part in the 2012/13 survey, which comprised of a number of questions across 13 different cancer groups. Of the 64 questions for which the trust had a sufficient number of survey respondents on which to base findings, Heart of England NHS Foundation Trust was rated by patients as within the top 20% for six questions and being in the bottom 20% of all trusts nationally for five of

## End of life care

the 64 questions. The five questions rated highly by patients were around the information given to patients and care planning while those in the bottom five related to management of pain and explanation given by doctors.

### Treatment of vulnerable patients

Birmingham Heartlands Hospital had worked with religious leaders in the local community to ensure that people dying at the hospital had as good an experience as possible. The hospital developed a DVD with the Muslim community and for staff going to the coroner's court. The trust was doing well on meeting their CQUIN target in respect of the preferred place of death. It also ensured that bodies of Muslim patients were released to the family quickly, irrespective of the day of death.

### Discharge planning

The work that the trust had done with the religious leaders in the local community had had a positive impact on the timely release of the body to the family, and had ensured that hospital staff understood what a good death was for different religions.

The mortuary service had worked with funeral directors to ensure that they could accommodate everyone using their service. The bereavement midwives had just won the Butterfly award (which is a recognition from Mumsnet designed to raise awareness of the death of a baby) and had bereavement suites on both the Heartlands and Good Hope units that they supported. The medical examiner, who was also the medical examiner, spoke to every relative about the death of their loved one, and explained the

medical terminology on the death certificate. Four weeks after the death, contact was made to ensure that the family were coping and to offer advice about organisations that might be helpful for support.

### Are end of life care services well-led?

Good 

### Leadership and vision

The palliative care team was led by a specialised palliative care consultant and a dedicated team of palliative care nurses. Staff on all wards reported that they felt well supported by this team. There was a designated head nurse who was also the head of bereavement services. This person championed the needs of the end of life service. She supported the successful palliative care business case for the expansion of the palliative care team to the trust board and worked with the medical examiner to ensure that every death was as positive an experience as possible.

### Management of risk

The medical examiner worked with his colleagues and reviewed every death. This ensured that lessons were learnt and that care could be improved. He worked with the junior doctors teaching them about end of life care.

### Cohesion

Nursing staff were encouraged to work with the local hospices in order to enhance their knowledge of good end of life care.

# Outpatients

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

## Information about the service

The outpatient department was on two sites at Birmingham Heartlands Hospital. The older site was in need of repair and upgrading because the roof leaked when it rained. The other part of the outpatient department was located in a newer part of the hospital. Outpatient appointments were booked across the three sites with patients able to choose which location they attended based on the amount of time they had to wait for their appointment.

## Summary of findings

Some of the outpatient services were in old parts of the hospital that were not currently fit for purpose: the roof leaked and people could hear private conversations in consultation rooms. Patients often misunderstood which outpatient department they were meant to be in and this could cause delays in clinics. Patients were satisfied with the care they received, although we did see one example of a patient not being assisted by a member of staff.

# Outpatients

## Are outpatients services safe?

Requires improvement 

### Staffing

There were enough staff on duty at the time of our visit. Staff we spoke to told us they regularly stayed late because of delays with the patient transport service, in order to make sure that patients made it home safely.

### Equipment and environment

The outpatient department was held in two locations at the hospital. The older (main) site was clean but we were told that the environment needed to be upgraded. Staff said that when it rained the roof leaked and they used buckets to collect the rain water. The issue had been reported and acted on by the trust's maintenance department but the problem was persisting. Staff told us, "When it rains we run for the empty sharps bins and use these to collect the water." We spoke to the matron of the service who said, "Yes it happens, but it is an old building." We were told there were no plans to address the issue by the trust. One member of staff told us, "This is perhaps the first time a patient uses our service. It doesn't make a great first impression."

## Are outpatients services effective? (for example, treatment is effective)

Not sufficient evidence to rate 

### Training

Staff working in the department had access to training and we saw that there were sufficient numbers of nursing staff to health care assistants on duty.

### Working with others

The trust was meeting the 18 week referral to treatment targets. This means that within 18 weeks of being referred to the hospital by your GP your treatment had begun. This would involve the initial contact with the consultant through the outpatients department. Therefore because the trust was meeting this target it would appear that the outpatient department was functioning well.

## Are outpatients services caring?

Good 

### Patient-centred care

Patients we spoke to said they were happy with their care. One patient told us, "The staff are very polite and helpful." We observed staff speaking to patients politely and giving them time to respond. On one occasion we did, however, see a patient asking for assistance. A member of staff approached the person and stood by them. They made no attempt to speak to them or help the patient, but instead walked away. The patient was assisted by a member of the public.

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

Requires improvement 

### Access to service

Staff were concerned about the service being delivered in two locations at the hospital (outpatients and the medical innovation development research unit (MIDRU). They told us this had an impact on the smooth running of some of the clinics because patients often went to the wrong department and then had to be redirected to the MIDRU. We saw this when we attended a clinic at the MIDRU and there were three patients who arrived late because they had gone to the wrong department.

We spoke to staff about the volume of patients they saw in clinics. They told us that bookings were arranged off-site. We were also told about a recent event when some patients had missed their appointments because of breakdown in the computer system. Staff had recognised this and taken action to contact all the patients concerned, and new appointments had been arranged for them.

The trust was meeting the targets set around the time it takes for a patient to be referred by their GP to having treatment.

### Complaints

We saw patients being greeted by reception staff. All the staff were polite, took time to check the patient's details

# Outpatients

and informed each person whether there was a delay in the clinic that day. We were able to hear patients' consultations through the walls. Staff told us, "We have raised this as an issue and some of the consultants have complained that they can hear private conversations and asked that other doctors keep their voices down. It isn't ideal."

We found information displayed around the department about how to make a complaint and whom to speak to. We saw information about the friends and family test encouraging patients to complete this. We noticed that information leaflets were in limited supply in this department.

## Are outpatients services well-led?

Good 

### Leadership and vision

Staff felt they were supported by the sisters in charge of the department. However, they said they did not see senior management but knew the matron was available if needed. The staff were concerned that no arrangements had been made in the trust to cover the matron's position once the matron had left. They also said that clinics were regularly over-booked and the trust relied on their goodwill and commitment to patients for the clinic to run well and patients to be supported.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice within the hospital:

The E-JONAH system to highlight patients who were medically fit for discharge and to promote multidisciplinary working to discharge patients effectively.

Patients were positive about the care they received from staff, many of whom were positive about working for the trust.

The work undertaken by the end of life care team in ensuring that relatives were involved and continued to feel cared for after the death of their loved one.

The support of the critical care outreach team to the rest of the hospital while awaiting a critical care bed.

## Areas in need of improvement

### Action the hospital **MUST** take to improve

The care provided in the all of the A&E departments, particularly around the timing and type of initial assessment.

Ensuring patients are cared for on appropriate wards and clinical areas.

Reduction of the use of agency and bank staff through continued recruitment of permanent staff.

Documentation relating to patient care.

### Action the hospital **SHOULD** take to improve

None

### Action the hospital **COULD** take to improve

The efficient running of operating lists to reduce the number of cancelled operations.

Sharing information to monitor performance and quality of care.

Training for staff working with children, adolescents and adults with mental health issues.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of patients.</p> <p>People who use services were not protected against the risks of receiving treatment that is inappropriate or unsafe as there was no timely assessment of the needs of the person using the service. Regulation 9 (1) (a) The planning and delivery of care did not always occur in the A&amp;E department to ensure that the patient's basic needs were attended to. Regulation 9 (1) (b)(i) (ii)</p>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff.</p> <p>Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time. Regulation 23 (1) (a).</p>

Regulated activity	Regulation
Maternity and midwifery services	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff.</p> <p>Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time. Regulation 23 (1) (a).</p>

Regulated activity	Regulation
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This section is primarily information for the provider

# Compliance actions

Surgical procedures

Regulation 23 HSCA 2008 (Regulated Activities)  
Regulations 2010 Supporting staff.

Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time.  
Regulation 23 (1) (a).

## Regulated activity

## Regulation

Diagnostic and screening procedures

Regulation 23 HSCA 2008 (Regulated Activities)  
Regulations 2010 Supporting staff.

Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time.  
Regulation 23 (1) (a).

## Regulated activity

## Regulation

Treatment of disease, disorder or injury

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing.

Patients did not always have their health, safety or welfare needs met due to the lack of sufficient numbers of staff on duty. Regulation 22.

## Regulated activity

## Regulation

Maternity and midwifery services

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing.

Patients did not always have their health, safety or welfare needs met due to the lack of sufficient numbers of staff on duty. Regulation 22.

## Regulated activity

## Regulation

This section is primarily information for the provider

# Compliance actions

Surgical procedures

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing.

Patients did not always have their health, safety or welfare needs met due to the lack of sufficient numbers of staff on duty. Regulation 22.

## Regulated activity

## Regulation

Diagnostic and screening procedures

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing.

Patients did not always have their health, safety or welfare needs met due to the lack of sufficient numbers of staff on duty. Regulation 22.